

Accountability Report

Corporate Governance Report

Directors' Report and Corporate Governance Disclosures

The Trust Board comprises a non-executive Chair, five other non-executive directors and five executive directors. During the year there was one temporary executive vacancy as described below.

Non-voting members of the Board include associate non-executive directors and other executive directors.

Significant interests of all Board members can be found in the Board's Register of Interests, which is published annually on the Trust's [website](#)

Non-Executive Directors during 2024/25		
Name	Skills and Expertise	Audit Committee Member
Russell Hardy MBE, Chair	Finance, executive leadership, board leadership – private, public and charitable sector.	✗
Simon Murphy, Deputy Chair	Leadership, management, strategy, politics.	✓
Dame Julie Moore	Nursing, NHS executive leadership	✗
Colin Horwath	Accountancy, audit, NHS board leadership.	✓
Tony Bramley	Executive leadership, housing, NHS Board leadership	✓
Karen Martin	Human resources, organisational development, NHS executive leadership, board leadership.	✓

All the non-executive directors are considered to be independent.

Two non-executive directors have served on the Trust Board for more than six years from the date of their first appointment:

- Dame Julie Moore was appointed as Non-Executive Director on 1 October 2018 and her current term is due to end on 30 September 2027.
- Colin Horwath was appointed as Non-Executive Director on 1 February 2019 and his current term is due to end on 10 October 2026.

NHS England is satisfied that both non-executive directors remain independent.

Executive Directors during 2025/26		
Name	Role	Skills, Expertise and Experience
Stephen Collman	Acting Chief Executive	Mental health nursing, NHS operational management and executive leadership
Neil Cook	Chief Finance Officer	Financial accountant, financial and executive leadership, NHS acute, commissioning and regulatory
Sarah Shingler	Chief Nursing Officer	Nurse consultant, emergency and critical care, NHS clinical and executive leadership.
Dr Juliette Walton	Chief Medical Officer	Consultant in Emergency Medicine
Hayley Flavell	Chief Nursing Officer	Senior nurse, executive nurse leadership, strategic advisor
Katie Osmond	Interim Chief Finance Officer	NHS financial accountant, senior finance executive.

On 1 April 2025 Glen Burley was seconded to a national role with NHSE, retaining his position as Foundation Group Chief Executive but stepping back temporarily from his responsibility as Accountable Officer for the Trust until 31 March 2026. Stephen Collman, Managing Director was appointed Acting Chief Executive for the for the duration of the interim secondment as a joint role for both the Trust and for Wye Valley NHS Trust, its Foundation Group partner.

On 1 April 2026 Glen Burley returned to his role as Chief Executive Officer at the Trust and Stephen Collman returned to his role as Managing Director.

Neil Cook left the Board on 6 January 2026 but remained employed by the Trust until 31 March 2026. Katie Osmond joined the Board as Interim Chief Finance Officer on 12 January 2026. Jo Kirwan, Deputy Chief Finance Officer provided temporary cover for the role between 6 and 12 January 2026.

Sarah Shingler, Chief Nursing Officer left the Board on 3 September 2025. Hayley Flavell joined the Board as Interim Chief Nursing Officer on 4 September 2025 and was appointed to the post substantively on 8 October 2025.

Non-Voting Board Members during 2025/26		
Name	Role	Skills, Expertise and Experience
Michelle Lynch	Associate Non-Executive Director	Accounting and finance, strategic leadership.
Sue Sinclair	Associate Non-Executive Director	Consultant in Anaesthesia and Critical Care Medicine, NHS management, governance and leadership.
Alex Moran	Associate Non-Executive Director	Senior executive leadership in healthcare and charity.
Catherine Driscoll	Associate Non-Executive Director	Strategic transformation in public sector, health, social care and community services.
Ali Koeltgen	Chief People Officer	Human Resources and organisational development, senior NHS leadership.
Chris Douglas	Chief Operating Officer	Senior NHS leadership – operations, transformation, performance and regulatory.
Jo Newton	Chief Strategy Officer	Senior executive NHS leadership – provider and commissioning.
Julian Berlet	Chief Clinical Strategy Officer	Consultant Anaesthetist, senior operational NHS leadership.
Rebecca Brown	Chief Digital Information Officer	Senior NHS and local government leadership.

Alex Moran resigned from his Board role during the year and his term ended on 31 January 2026.

Jo Newton left the Board on 27 June 2025. Her responsibilities were passed to Julian Berlet.

Chris Douglas was Interim Chief Operating Officer from 2024/25 until he was appointed substantively to the post on 1 February 2026.

Rebecca Brown was Interim Chief Digital Information Officer from 2024/25 until she was appointed substantively to the post on 1 February 2026.

Board and Committee Meeting Attendance

Name Title	Trust Board	Audit & Assurance	Quality & Governance	Remuneration	People & Culture
Russell Hardy MBE, Chairman	12/14	n/a	n/a	5/6	n/a
Simon Murphy, Non-Executive Director and Deputy Chair	14/14	5/7	8/10	4/6	1/6
Dame Julie Moore, Non- Executive Director	10/14	n/a	9/10	4/6	n/a
Colin Horwath, Non-Executive Director	9/14	7/7	n/a	1/6	4/6
Tony Bramley, Non-Executive Director	12/14	7/7	n/a	3/6	n/a
Karen Martin, Non-Executive Director	10/14	4/7	n/a	4/6	5/6
Glen Burley, Chief Executive Officer	4/14	n/a	n/a	n/a	n/a
Stephen Collman, Managing Director	14/14	4/7	n/a	5/6	4/6
Neil Cook, Chief Finance Officer	9/11	4/5	n/a	n/a	n/a
Sarah Shingler, Chief Nursing Officer	5/6	n/a	2/5	n/a	0/3
Hayley Flavell, Interim Chief Nursing Officer	6/8	n/a	4/5	n/a	1/3
Dr Juliette Walton, Chief Medical Officer	11/14	n/a	9/10	n/a	5/6
Michelle Lynch, Associate Non- Executive Director	7/14	n/a	9/10	3/6	n/a
Sue Sinclair, Associate Non- Executive Director	10/14	n/a	6/10	4/6	4/6
Alex Moran, Associate Non- Executive Director	7/11	n/a	n/a	1/5	n/a
Catherine Driscoll, Associate Non-Executive Director	12/14	n/a	n/a	3/6	n/a
Ali Koeltgen, Chief People Officer	11/14	n/a	n/a	5/6	5/6
Chris Douglas, Chief Operating Officer	14/14	n/a	1/10	n/a	n/a
Jo Newton, Chief Strategy Officer	2/2	n/a	n/a	n/a	n/a
Julian Berlet, Chief Clinical Strategy Officer	10/14	n/a	n/a	n/a	n/a
Rebecca Brown, Chief Digital Information Officer	13/14	n/a	8/10	n/a	n/a

The Trust Board regularly meets alongside the three Boards of the other members of the Foundation Group. Three of the 14 meetings referenced above were Foundation Group Boards meetings.

Audit and Assurance Committee membership comprises non-executive directors only. The Chief Finance Officer routinely attends all meetings of the Audit Committee. The Acting Chief Executive attended four of seven meetings. Other executive directors attended meetings by invitation to contribute to discussions relevant to their roles or to present the management response to an Internal Audit for which they were the lead manager.

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Code of Governance disclosures

Personal data related incidents reported to the Information Commissioner

Five information governance incidents were reported to the Information Commissioner during the year. More information about these incidents is provided in the Annual Governance Statement later in this document.

Partners

The Trust’s relationships with its key Integrated Care System and Foundation Group partners are described in the Performance Report. Governance arrangements relating to these partnerships include:

- Membership of Integrated Care Board, committees and working groups.
- Foundation Group four Boards meetings.
- Foundation Group Strategy Committee.

Stakeholders

Our most important stakeholders are our patients and their families and our staff. Information about how we have engaged and consulted with staff during the year is included in the Staff Report. Engagement with patients and our communities includes:

- A patient story at each of our Trust Board workshops.
- An active Patient and Public Forum (PPF).
- A biannual report on the work of the PPF presented to the Trust Board in public by the PPF Chair.
- Regular observation of Board meetings by the PPF Chair.
- Live streaming and recording publication of Trust Board meetings.
- External Learning Disabilities Stakeholders Group.
- Big Quality Conversation survey about people’s experiences of care at our hospitals.
- d/Deaf Community Workshop.
- Cancer Patient Forum
- Growing our volunteer service. The service now includes discharge response, wayfinding, patient experience (supporting completion of Friends and Family Test surveys), Ward and Emergency Department Volunteers, Clinic Volunteers, Chaplaincy Volunteers, Transformation Team, Administration support, Breast-Feeding Friends, Dementia Buddies, end of life care support and Therapy Dogs.

Opportunities and risks to future sustainability

This information is included in the Performance Report and the Annual Governance Statement.

Activities to promote the wellbeing of the workforce

Information about how the Trust invests in and promotes the wellbeing of its workforce is included in the Staff Report.

Work of the Remuneration Committee

This information is included in the Remuneration Report.

Emergency Preparedness, Resilience and Response

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 increasing from 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, 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 Emergency Planning Committee, Trust Management Board, and Trust Board.

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Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust have been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed:



Chief Executive

Date:

6 August 2026

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

Signed:



Chief Executive

Date:

6 August 2026

Signed:



Chief Finance Officer

Date:

6 August 2026

Annual Governance Statement

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Worcestershire Acute Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Accountable Officer, I have overall responsibility for risk management, including the maintenance of a Board Assurance Framework that supports the identification of emerging and principal risks to achievement of the Trust's strategic objectives.

The Trust Board is responsible for approving the Risk Management Strategy and for considering the Trust's most significant operational risks alongside the Board Assurance Framework.

The Audit and Assurance Committee's role is to review the effectiveness of the system of risk management.

Oversight of risk management is the responsibility of the Board's committees. This includes the Executive Risk Management Committee, which meets regularly to review all high and extreme rated risks with the senior divisional leadership teams who have responsibility for risk management within their own areas. Through this forum, leaders are also guided about risk assessment, mitigation and recording.

Other committees are responsible for overseeing management of risks specific to their terms of reference, including Quality Governance (safety, experience and effectiveness), People and Culture, Health and Safety, Information Governance and Digital Risk.

Risk management guidance is available to staff on the Trust intranet, including the risk management framework and associated policy and guidance on the use of the Trust risk register system.

Support and advice are provided to staff by the Risk Team, with executive leadership from the Chief Digital Information Officer.

The Freedom to Speak Up Guardian can also provide advice to staff by directing them to the most appropriate reporting route, including incident and risk reporting, as well as the raising concerns process.

Staff are encouraged to share learning from incidents, good practice, transformation and Quality Improvement (QI) through a range of methods, including:

- Improvement System Showcasing Walls.
- Patient Safety Lessons of the Week.
- Learning from Inquests briefings.
- Annual Foundation Group Improvement Week.
- Transformation Tuesday session.
- Wide sharing of learning from Patient Safety Incident Framework (PSIRF) thematic reviews, including with national patient safety specialists.
- Divisional meetings.
- Department and team huddles.

4. The risk and control framework

The Trust's Risk Management Framework sets out the Trust's aim to promote:

- A risk awareness culture in which all risks are identified, assessed, understood and proactively managed.
- A way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.

The Board recognises that to deliver its strategic objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This may be achieved through an open and just culture where risks, accidents, mistakes and near misses are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk.

The Risk Management Framework sets out:

- the responsibilities for risk management of leaders, staff and committees.
- the risk assessment process using a likelihood and impact risk matrix.
- Risk reporting, escalation and monitoring.
- Risk tolerance, or appetite.

The Trust Board recognises that risk is inherent in the provision of healthcare and its services and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of its aims and objectives.

The Trust’s Risk Appetite Statement makes clear the Board’s expectations in relation to the category of risks and the level of such risk that is acceptable. The statement is based on the premise that the lower the risk appetite, the higher the levels of controls that must be put in place to manage the risk.

Risk appetite for each category of risk is assessed using the following matrix:

Avoid	Avoidance of risk and uncertainty is a key organisational objective
Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Each risk is recorded on the Risk Register with a target risk score, which is aligned to the risk appetite for the relevant risk category.

The Trust has in place a digital risk management system (Datix) which is used by staff to assess, record, monitor and report risks. New risks are reviewed at a divisional and executive level to ensure they are appropriately assessed and scored, with mitigations and controls properly described. Once agreed, risks are regularly monitored to ensure they are appropriately updated at a frequency in line with the Risk Management Policy. Risks are closed with executive approval based on assurance that the risk has been effectively controlled and the target risk score has been achieved.

5. Quality Governance Arrangements

The Quality Governance Committee (QGC) oversees the Trust’s quality governance arrangements on behalf of the Board. It sets an annual reporting schedule aligned to the quality framework (safety, effectiveness and experience) and regulatory compliance comprising key reports on matters of compliance, risk and assurance.

Quality Governance Committee Reporting 2025/26	
Sub-Committee Reports	
Improving Patient Safety	Infection Prevention and Control
Fundamentals of Care	Safeguarding
Clinical Audit and Effectiveness	Medical Devices
Other Regular Reports	
Safe staffing	Perinatal safety
Medicines safety and optimisation	Learning from Deaths
Integrated Performance Report	Learning Disabilities
Patient safety alerts	Deep-dive reviews – divisions, departments, risks and QI projects
Urgent and Emergency Care	High-scored risks
End of life care	Health and Safety

Additional Areas of Focus During the Year	
Nursing education	Antimicrobial resistance and stewardship

Through this broad oversight of the Trust's clinical services through a quality lens, the Quality Governance Committee is able to identify and obtain assurance regarding any risks to compliance with Care Quality Commission (CQC) registration requirements.

The Trust's overall CQC ratings remain as follows:

Location	Rating
Alexandra Hospital (ALX)	Requires Improvement
Kidderminster Hospital and Treatment Centre (KHTC)	Good
Worcestershire Royal Hospital (WRH)	Requires Improvement

The most recent CQC inspections of Trust services were as follows.

Service	Location	Publication date	Rating
Services for Children and Young People	KTC	February 2025	Good
Services for Children and Young People	ALX	April 2025	Good
Medical Care (including older people's care)	WRH	February 2025	Requires Improvement
Urgent and Emergency Services	WRH	November 2024	Requires Improvement
Critical Care	WRH	May 2024	Good

The Quality Governance Committee oversaw the implementation of action plans to improve the areas highlighted by the CQC reports.

The Quality Governance Committee also oversees the selection and prioritisation of Quality Improvement (QI) schemes based on monitoring of quality risks and compliance issues and receives regular updates on progress in addressing these quality priorities. The Health and Safety Committee oversees the management of risks to the health and safety of the Trust's estate and the people that use it and compliance with relevant regulatory requirements, including those monitored by the CQC.

6. Well-Led Framework

The CQC has not undertaken a well-led inspection of the Trust since November 2022 and the Trust's rating for this domain remains Requires Improvement.

The Trust Board undertook an internal well led board evaluation in January 2024 to identify areas of leadership and governance that would benefit from development. Becoming a full member of the Foundation Group supported a range of improvements, including the adoption of a well-established governance framework, joint leadership posts and the ability to benchmark and share learning.

During 2025/26, following a self-assessment exercise, the Trust's Provider Capability was rated amber/red by NHS England (NHSE) relating to the six domains of the Insightful Provider Board guidance. This rating indicates some concerns of varying seriousness across one or more areas to be addressed with support from NHSE.

Area of focus aligned with the well-led framework during the year included:

- Launch of new Trust values following wide consultation.

- Launch of new Trust mission, vision and strategy following wide consultation.
- A review of executive risk management and compliance oversight.
- Establishing a new Board Assurance Framework process and format.
- Refreshed Foundation Group governance arrangements to maintain the opportunity for each Trust to fully benefit from the Group model following changes in Board leadership.
- Review of the effectiveness of the Audit and Assurance Committee, with a particular focus on its impact on the Trust's governance and internal controls.
- A refreshed Green Plan published for 2025-2028, outlining projects, schemes and activities to lead the Trust towards its target of net zero.

7. Risks to Data Security

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees. This applies to both personal confidential data and special category data (sensitive). The framework is supported by the Data Security and Protection Toolkit and the annual submission process provides assurances to the Trust, partner organisations and data subjects (patients and staff) that personal information is dealt with legally, securely, efficiently, and effectively.

The Information Governance Steering Group (IGSG) manages information risks and is chaired by the Senior Information Risk Owner (SIRO), the Chief Digital Information Officer.

Other senior members of IGSG are the Data Protection Officer and the Caldicott Guardian.

The IGSG reports to the Trust Management Board to provide assurance on data protection and cyber security. Three sub-committees report to IGSG, the IT Security Forum, the Data Quality Steering Group and the Health Records Group.

IGSG met regularly throughout 2025/26 and assessed risks to the security and integrity of information and the management of confidential information. IGSG also monitored the completion of the Data Security and Protection Toolkit (DSPT) submission, oversaw the management of information incidents and risks and ensured an effective framework with up-to-date policies, processes and management arrangements were in place.

Ahead of the DPST submission for 2024/25, the Trust's Internal Auditor undertook an independent review of the Trust's self-assessment. The conclusions were:

- Overall risk associated with the security and information governance control environment:
Low
- Veracity of self-assessment/confidence that the submission reflects the risks and controls:
High

The Trust DSPT submission for 2024/25 was made at the end of June 2025 and demonstrated that the Trust has appropriate technical and organisational measures in place to keep personal, confidential data and special category data secure.

As the Trust did not have the full evidence in place for eight of the forty-seven requirements, additional actions have formed the basis of the Trust's improvement plan. With the submission of an improvement plan, the Trust achieved the status of 'approaching standards'.

The Trust carried out an annual assessment of its position against the Data Security and Protection Standards and submitted a 'Baseline Assessment' on 31 December 2025. An internal audit will ensure that any evidence gaps can be addressed prior to the final submission by 30 June 2026.

The Data Protection and Information Governance Team monitors the management of data security incidents and reviews these regularly with the Data Protection Officer. Any incidents that meet the external reporting criteria are assessed.

The IGSG reviews all incidents each quarter to identify any themes and ensure action is taken to address any issues.

The Trust also has robust processes for incident reporting and the investigation of serious incidents. The process is followed up by lessons learned and provision of guidance or training where required.

The management of cyber security is a key strategic risk area for the Trust and is described in the Board Assurance Framework. The risk of a successful cyber-attack on the Trust's electronic systems is rated as 'extreme' reflecting the potential consequences for patient services and the likelihood of a successful attack due to the evolving nature of the external threat.

8. Major Risks

The Trust Board, its committees and the Trust's Divisions regularly review the Trust's major risks, including strategic, corporate and operational to ensure they are well managed, controlled and mitigated, with appropriate plans to reduce or eliminate the risk. The Executive Risk Management Committee meets regularly to review all corporate, Trust-wide and divisional risk registers including routine reviews of every risk scored 15-25 (extreme) and a regular divisional deep dive into all risks scored 12+ (high).

The major organisational risks are set out below. The impact of these risks and their management is described within the Performance Report earlier in this document.

Risk	Strategic (S) or Operational (O)	In-year (IY) or Future (F)	Management & mitigation	How outcomes will be assessed
Failure to improve Urgent and Emergency Care (UEC) flow	S, O	IY, F	Oversight by new UEC Recovery Board UEC navigators Stress-tested winter plans NHSE support Call Before Convey ambulance process Ambulance pitstop UEC 'sprint' Ambulance handover improvement project	Achievement of emergency access standard Achievement of ED 12-hour standard Achievement of ambulance handovers target
Failure to deliver the Trust's agreed financial plan	S, O	IY, F	Financial Recovery Board oversight Agency Reduction Programme National financial controls adopted. Enhanced financial controls Enhanced controls of temporary staff usage Strengthened forecasting Recovery framework	Achieved financial plan Achieved CPIP Achieved staff agency reduction plans
Poor staff health and wellbeing	S	IY, F	Health and Wellbeing Steering Group oversight Occupational Health service Clinical psychologist support Health @ Work service Menopause Support Group Targeted intervention and support Annual vaccination programme Updated reasonable adjustment support	Sickness absence rate below target Sustained reduction in sickness absence related to work stress Flu vaccination target achieved Improved staff survey scores for 'We are Safer and Healthy' questions.
Failure to deliver workforce transformation and achieve a sustainable workforce	S, O	IY, F	Agency Reduction Programme Vacancy and agency controls Quality Impact Assessments for workforce transformation programmes Job planning consistency panel	Reduction in agency expenditure Reduction in reliance on Bank Staff Reduced vacancy rate Staff turnover below target Consultant job planning completion target met

Risk of a successful cyber-attack on the Trust's systems	S, O	IY, F	Perimeter level cyber security mechanisms Testing exercises Business continuity plans Mandatory staff training Risk-based approach to cyber and infrastructure funding Supplier and third-party controls and oversight	Achievement of malware protection targets Achievement of mandatory data security training targets
Fire safety risk at Alexandra Hospital	S, O	IY, F	Enhanced fire safety management, controls and infrastructure Enhanced fire detection Completed capital works	Sustained achievement of fire safety training targets Reduction in fire alarm activations Positive assurance from Internal Auditor Closed Fire Authority Enforcement Notice

9. Principal Risks to Compliance with the NHS Provider Licence

There are processes in place to identify and mitigate risks to compliance with the NHS provider licence.

In February 2025 NHS England (NHSE) issued new enforcement undertakings regarding Urgent and Emergency Care (UEC) performance, which continued to deliver below trajectory. It was recognised that part of the improvement plan included working with system partners to enhance or share the risks relating to front door demand.

Existing and planned controls of potential risks to compliance with section 4 (governance) of the NHS Provider Licence include the following:

Effective Governance Structures
The Trust has well-established governance structures in place, which mirror those of the other trusts in the Foundation Group. The effectiveness of the overall structure and of the individual components are regularly reviewed with oversight of the Audit Committee. These reviews take into account the most recent regulatory requirements and corporate governance requirements, including the Code of Governance for NHS Providers.
Responsibilities of Directors and Committees
The Remuneration Committee oversees the performance of the executive directors in delivering their responsibilities. Each committee of the Trust Board has approved terms of reference, setting out their responsibilities, which are regularly reviewed and updated.
Reporting lines and accountabilities
In 2025/26 we strengthened reporting lines between some of the Board and executive committees by enhancing reporting from committees to Board, using an escalation and assurance report.
Timely and accurate information
Meetings of the Board and its committees are set at a frequency to ensure a timely flow of information that has been assessed for accuracy and effectively analysed. Where necessary, additional meetings of the Board or its committees are called.
Rigour of oversight
• The Foundation Group has agreed a standard dataset for regular reporting on performance to the respective Trust Boards, which includes national, regional and local priorities and metrics covering quality, operational performance, workforce and finance in an Integrated Performance Report (IPR). • Each quarter a joint four-trust report is presented to the four Foundation Group Boards including performance information aligned with the individual IPRs to enable benchmarking analysis and learning. • Non-executive directors observe executive led finance and performance meetings with the divisions to enhance their knowledge and understanding of divisional level issues and the executive oversight. • During the reporting year the Board continued to use the Financial Recovery Board to oversee management of the risks relating to delivery of the annual financial targets.

10. Code of Governance

The Trust's governance arrangements comply with the provisions of the current Code of Governance for NHS Provider Trusts, which is modelled on the 2018 version of the UK Corporate Governance Code.

11. Governance and Strategy

The Trust's strategy is reviewed and refreshed each year to ensure a continual focus on the key strategic priorities for the Trust. The Board Assurance Framework is aligned to the strategic objectives and reviewed regularly by the Trust Board. A focus on delivery of the strategic objectives

is embedded in the work of the Trust Board and its committees throughout the year, with programme boards established where necessary to oversee delivery of key strategies.

The Board Assurance Framework is used to escalate to Board level strategic risks that emerge during the year through analysis of operational risks. The Board Assurance Framework is then used to inform the review of the strategic objectives at the year end and the development of new strategic objectives for the following year.

The Trust is also a partner in the development and delivery of strategies at a regional level, including production of the Joint Forward Plan for NHS Herefordshire and Worcestershire.

Governance arrangements relating to this work include membership of the Integrated Care Board (ICB) and ICB Finance Committee and Trust Board member attendance at meetings of ICB committees, including Audit and Quality, Resources and Delivery.

12. Embedded Risk Management

Risk management is embedded in the activity of the organisation in a range of ways, including:

- Regular reviews of the risk register within departments and divisions, with advice and guidance from the Risk Team.
- Appropriate escalation of risk through the governance structure to the Board.
- Regular review of the Trust's strategic objectives, using the Board Assurance Framework (BAF) and Risk Register to support decision making for future strategies.
- Use of the Risk Register and BAF to inform the development of an agreed annual Internal Audit Plan targeted at potential internal control issues.
- Setting annual quality priorities based on assessment of the highest risks to quality care through analysis of quality data.
- Oversight within the governance framework of the delivery of strategic objectives and quality improvement priorities based on assessment of risk.
- Openly encouraging incident reporting across the Trust relating to patient and staff safety and data security and ensuring guidance is available to staff on the use of the incident reporting system.
- Established Quality Improvement processes to encourage the development of long-term solutions to quality issues and risks.
- Quality impact assessments undertaken on cost improvement projects and business cases.
- Equality Impact Assessments required for all business cases and policies.

13. Workforce Standards

In 2018 NHS England published a 'Developing Workforce Safeguards' document to help trusts manage common workforce problems, with recommendations to support informed, safe and sustainable workforce decision making.

The Trust has adopted the recommendations into its processes as follows:

- Incorporating evidence-based tools, professional judgement and outcomes in safe staffing processes.
- Regular review of the nursing establishment and skill mix
- Regular safe staffing reports (nursing and midwifery) presented to Quality and Governance Committee and Trust Board and published on the Trust website. This includes the planned

and actual number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

- Triangulation of workforce metrics with quality indicators and productivity measures.
- An annually updated workforce plan.
- Senior nursing staff review of staffing levels at every shift.
- Triangulation of data: review of staffing levels with other indicators of care quality to identify any correlation between staffing levels and the incidence of patient safety events.
- Reporting and investigation of incidents related to staffing levels.
- Reporting and escalation of workforce related risks.

The Audit and Assurance Committee receives assurance each year on areas of staffing governance or process. In the last two years, assurance was received as follows. In each case the Committee was assured by the management response and requested continued oversight by the People and Culture Committee.

Year	Topic	Source	Rating
2024/25	Bank and Agency Staffing (Nursing)	Internal Audit	Moderate Assurance
2024/25	Consultant Job Planning	Internal Audit	Limited Assurance
2025/26	Absence Management	Internal Audit	Significant assurance

Through these processes, tools and sources of assurance, the Trust Board is assured that staffing governance processes are safe and sustainable.

14. Care Quality Commission

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

15. Register of Interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

16. NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

17. Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

18. Freedom to Speak Up

The Trust has well-established arrangements to support staff to raise concerns, including:

- Dedicated Freedom to Speak Up Guardian (FTSUG).
- Non-Executive Director FTSU Champion
- Raising concerns portal.
- Network of FTSU Champions across the Trust's three sites.

- Regular Freedom to Speak Up reports to Trust Board.
- Speak Up training for all staff.
- Sharing of learning from FTSU concerns across the Trust.

19. Fit and Proper Person Regulations

The Trust has designed its arrangements to comply with the Fit and Proper Person Regulations through alignment with the NHS England Fit and Proper Person Test Framework for Board Members. This includes a policy, process and annual report to the Trust Board.

In line with the guidance, the Internal Auditor conducted the first three-yearly review of compliance with the framework in 2025/26, with a rating of significant assurance.

20. Climate Change

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

21. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust has a range of processes in place to monitor and improve the economic, efficient and effective use of resources, including:

- An annual cost and productivity improvement programme (CPIP). CPIP schemes are developed by each division and reviewed by the Executive Team to ensure the completion of an appropriate quality impact assessment before approval.
- The Finance and Performance Executive (F&PE) oversees divisional performance each month across a range of financial operational performance, quality and workforce metrics, including delivery of the CPIP, the use of Model Hospital benchmarking data and key productivity measures. Executive Directors are F&PE members and meetings are observed by Non-Executive Directors to enhance their understanding of performance, risks and challenges at divisional level.
- The Financial Recovery Board (FRB) was established in 2024, with membership comprising all Trust Board members, to undertake a monthly review of delivery of the CPIP and actions to achieve or recover performance on delivery of the financial plan.
- An integrated performance report is presented at each meeting of the Trust Board providing data and analysis on key national, regional and local metrics, including productivity.
- A joint performance report is presented to the four Boards of the Foundation Group at each of its quarterly meetings providing parallel data and analysis on key performance metrics, including productivity measures, enabling comparison, benchmarking and learning.
- An annual review of the Trust's key financial controls is included within the Internal Audit Plan.
- The Audit Committee receives regular reports to provide assurance on financial governance matters including single tender waivers, losses and special payments.
- The Trust Management Board reviews each business case to ensure proposals will achieve value for money before approval and undertakes evaluations of business case implementation to ensure delivery of planned benefits and value for money.
- Business cases that require Board approval under the Standing Financial Instructions are reviewed informally in detail by non-executive directors prior to submission to the Board to ensure that any queries, concerns or gaps are addressed before formal approval.

- An annual review is undertaken by the External Auditor of the Trust's processes to ensure delivery of Value for Money.

The Trust did not deliver its financial plan for 2025/26. In response, NHS England asked the Trust to undertake a lessons-learned exercise and to set out changes that would ensure delivery in 2026/27. This work was undertaken with Board oversight in May 2026. A key part of the plan for 2026/27 will be to establish a Financial Improvement Taskforce as part of the Board financial governance structure to:

- Deliver sustainable financial improvement.
- Embed a culture of continuous improvement, efficiency and value.
- Improve cost-effectiveness and productivity.
- Strengthen financial leadership and accountability.
- Support service and pathway improvement.
- Rebuild the credibility of the Trust through delivery.

This outcome was reflected in the annual Value for Money opinion of the External Auditor, which identified a significant weakness regarding the Trust's financial sustainability as set out below.

22. Information governance

Five serious information governance incidents were reported during the year that met the threshold for reporting to the Information Commissioner's Office (ICO). One of these was a national cyber security incident and remains open. All other incidents have been closed with no further action required by the ICO.

Nature of incident	Internal actions taken	ICO status/response
National cyber-attack on external pathology system	Monitoring external response	Open
Incorrect permissions level applied to internal documents	ICT processes strengthened to prevent recurrence	Closed with no further action required
National data synchronising issue with BadgerNet maternity data system	Monitoring external response	Closed with no further action required
Coding error resulting in clinical letters not linked to correct GP practice	ICT processes strengthened to prevent recurrence	Closed with no further action required
Two patient records incorrectly linked resulting in errors to both sets of records.	Errors corrected. Staff communication, training and learning shared.	Closed with no further action required

23. Data quality and governance

The Trust has dedicated data quality leads and informatics staff to regularly investigate, validate and quality assure performance and waiting time data. Their work is supported by operational business intelligence reporting tools that all staff can access and use for detailed analysis. Nationally available tools such as LUNA complement investigations.

The Trust complies with the national requirement to validate directly with patients waiting over 12 weeks whether they still require their appointments and treatments.

Executive oversight of divisional performance provides an opportunity to triangulate and assess data and identify any areas requiring more detailed analysis or validation.

The Trust works with its foundation group partners to develop a consistent suite of performance metrics for inclusion in its Integrated Performance Report, which is reported each month to the Trust Board. This report includes a Data Quality Mark for key indicators to provide assurance as to the data quality of individual data.

In 2024/25 the Internal Auditor provided a moderate assurance opinion on data quality in relation to diagnostics data (DM01). The Committee received assurance that the improvement recommendations were implemented.

24. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee, Quality Governance Committee and Executive Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board maintains oversight of the system of internal control through a framework of governance and assurance. This includes delegating assurance functions to Board committees and receiving direct assurance from the Executive Directors. Key elements of this framework are set out below.

a. Board Governance and Assurance Framework

Audit and Assurance Committee
Responsible for providing assurance to the Board on the Trust’s financial and internal controls and risk management systems, the integrity of the financial statements and the effectiveness of the internal audit function. This includes: • Agreeing an annual Internal Audit Plan that includes both core internal control matters and areas identified as high risk or high priority for improvement. • Agreeing an annual counter fraud plan that is both proactive in reviewing and establishing fraud controls, and reactive in responding to possible instances of fraud. • Reviewing the Trust’s governance framework and processes, including risk management and the Board Assurance Framework. • Reviewing the processes to ensure compliance with and effectiveness of policies including managing conflicts of interest, the Fit and Proper Person Test and Raising Concerns (Freedom to Speak Up). A review of the work and effectiveness of the Committee during the year has identified full compliance with the terms of reference and a good link between assurance mechanisms and risks to internal control.
Quality Governance Committee
Provides assurance to the Board on the adequacy of controls to ensure the provision of high quality and safe care. This includes: • Oversight of the delivery of quality improvement plans aligned with the priorities set out in the annual Quality Account.

• Receiving regular reports from sub committees and groups focused on the core elements of quality – safety, effectiveness (including clinical audit) and patient experience. • Monitoring compliance in areas such as safeguarding, infection control and safe working environments. • Monitoring the quality of care provision within each Division. • Reviewing independent assurance on quality from regulatory and other review bodies. • Monitoring key quality metrics • Reviewing the effectiveness of governance and assurance processes such as mortality review and Patient Safety Incident Response. A review of the work and effectiveness of the Committee during the year has identified full compliance with the terms of reference and a broad and detailed oversight of risks to the delivery of high-quality services.
People and Culture Committee
Provides assurance to the Trust Board on matters relating to people and culture and the provision of a workforce capable of delivering safe, high quality, patient centred care. Oversees the development, implementation and effectiveness of the Trust's People and Culture Strategy and associated plans, ensuring appropriate alignment with the relevant national, regional and local strategies and plans. Provides assurance to the Board on the operation of effective and robust people and culture practices and governance frameworks.
Remuneration Committee
Oversees the performance of the executive members of the Board and assesses the mix of skills required on the Board.
Executive Risk Management Committee
Provides assurance to the Board regarding: • Appropriate oversight and management of moderate to serious risks by divisions and corporate departments. • Compliance with statutory health and safety responsibilities.
PFI Exit Committee
Provides assurance to the Board on the implementation of a compliant process to manage the expiry of the Private Finance Initiative (PFI) arrangements and associated contracts. This includes identifying and managing future risks, obtaining and following independent advice and effecting a transfer of a well-maintained estate and well managed estates and facilities service at the date of contract expiry.
Financial Recovery Board
Established during 2024/25 in response to below plan performance on delivering the financial plan, the forum was maintained during 2025/26 to support the delivery of a challenging financial plan. Receives assurance on: • Implementation of divisional and Trust-wide cost and productivity improvement (CPIP) schemes. • Identification of additional CPIP schemes or other measures to mitigate gaps or shortfalls. • Identification of CPIP schemes for the following year.
Meeting of the four Boards of the Foundation Group
Each quarter the Trust Board met in parallel with the other three Boards of the Foundation Group trusts. Regular reports include a focus in key performance measures across finance, operations, workforce and quality and enable comparisons and learning to be drawn. This provides additional assurance to the Board on the effectiveness of its own internal controls particularly in relation to the quality of data and the oversight and management of performance.

From March 2026, the Foundation Group adopted a less formal approach, with its meetings replaced by a workshop style forum focused on exploring variations in performance between the four trusts, sharing best practice solutions and aligning strategy to the 10-year plan.

b. Executive Governance and Performance Framework

Trust Management Board
Receives progress reports from subcommittees and programme boards. Reviews cases for investment in line with the Standing Financial Instructions and Scheme of Delegation Provides assurance to the Trust Board regarding the decision-making process and the assessments of value for money and quality impact of each case requiring Board approval.
Finance and Performance Executive
Oversight of delivery by each clinical division of key financial and operational performance targets. Observed by non-executive Trust Board members to gain direct assurance regarding performance management and accountability arrangements overseen by the executive directors.

c. Board Assurance Framework

The areas of priority focus for the Trust Board were reflected in the Board Assurance Framework, which is aligned to the Trust Strategy. The governance and performance frameworks ensured that these priority areas were well controlled and appropriately escalated.

d. Audit and Assurance

The Audit and Assurance Committee is the Board's main source of assurance about the strength of its internal controls and the management of any internal control issues and gaps. During the year the Audit and Assurance Committee considered the following matters:

- Contract governance
- Local security management
- Internal Audit Reviews
- Committee effectiveness
- Worcester UEC capital project value for money
- Financial governance
- Counter fraud
- External Audit Reports
- Digital Programme benefits realisation
- Updated Standing Orders and Standing Financial Instructions
- Conflicts of interest policy
- Fit and Proper Person Test Policy
- Effectiveness of processes for raising concerns

The Committee also undertook a detailed review of the draft financial statements for 2025/26 and considered the going concern assessment and significant critical judgements.

Key sources of assurance for the Audit and Assurance Committee and for the Board Assurance Framework are as follows:

Counter Fraud

The Trust has appointed an independent Local Counter Fraud Specialist (LCFS), which sets an annual counter fraud work plan aligned to the NHS Counter Fraud Authority Functional Standards, provides regular progress reports to the Committee on its proactive and reactive work, assesses fraud risks and engages with staff to encourage the raising of concerns about potential or actual fraud.

A key area of focus during the year was the Trust's compliance with requirements to meet new legislation creating the offence of Failure to Prevent Fraud, whereby an organisation is criminally

liable if an employee, agent, subsidiary, or other “associated person” commits a specified fraud offence intending to benefit the organisation (or its client)”.

The LCFS has supported the Trust to assess its compliance with the NHS Counter Fraud Authority checklist to ensure it has ‘reasonable fraud prevention procedures’ in place in relation to this new offence.

A key source of information on the reasonableness of these procedures is the annual Counter Fraud Functional Standard Return which describes the Trust’s compliance with the 12 components of the standard. The Trust’s return for 2025/26 assessed compliance overall as green, with two amber areas, both of which require more proactive work, which is included in the 2026/27 Counter Fraud Plan.

Internal Audit

The independent Internal Auditor provides the Audit and Assurance Committee with its key source of assurance on its internal controls. The Internal Audit Annual Plan sets out the reviews to be undertaken during the financial year. The plan comprises core reviews, which are key to the findings of the Head of Internal Audit’s Opinion and include financial controls, governance and risk management, and risk-based reviews of areas where the Trust Board requires independent assurance regarding the strength of internal controls. The reviews within the plan are selected and prioritised based on an examination of the Board Assurance Framework and the Risk Register and consultation with Audit and Assurance Committee members and the executive directors.

An assurance rating is applied to each review as follows.

Substantial assurance	Limited assurance
Significant assurance	Weak assurance
Moderate assurance	NHS opinion level (DPST) or Advisory Only

During the year the Committee received reports as follows:

Review	Rating
Safeguarding	Significant assurance
Procurement	Significant assurance
Fit and Proper Persons Test	Significant assurance
Financial Ledger	Significant assurance
Contracted out Payroll	Significant assurance
Consent	Limited assurance
Joint Handover and Transfer of Care	Limited assurance
DPST	NHS opinion level
Fire Safety Enforcement Notice Action Plan	Substantial assurance
Board Assurance Framework	Moderate assurance
Absence Management	Significant assurance

For each review the Internal Auditor made recommendations for improvement. In each case the Audit and Assurance Committee was assured by the management responses to the recommendations and the implementation plans. Where appropriate, oversight of those plans was referred to the most relevant committee; for example, the audit of consent processes was referred to the Quality Governance Committee.

The Audit and Assurance Committee also received regular updates on progress in implementing the Internal Auditor's Recommendations. Progress continued to be positive during the year, with no overdue recommendations in March 2026.

At the end of each year, the Head of Internal Audit provides an annual opinion based on delivery of the plan and the Trust's response. The annual Head of Internal Audit Opinion 2025/26 was:

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.

External Audit

The Trust's external auditor is Grant Thornton UK LLP. No non-audit services were provided by Grant Thornton during the year.

During 2024/25 the Trust participated in a joint Foundation Group procurement exercise for the appointment of an external auditor for each trust. Following a thorough assessment, which included effectiveness and independence, Grant Thornton was selected by the Auditor Panel for reappointment on a three-year contract from 2025/26 with an optional 12-month extension.

Each year, alongside an opinion on the financial statements, the External Auditor undertakes an assessment of the Trust's arrangements for securing value for money, which includes opinions on governance and on 'improving economy, efficiency and effectiveness'. The report for 2024/25 was presented to the Audit and Assurance Committee in June 2025 and outlined the following opinion:

Financial Sustainability

One significant weakness in arrangements identified and a key recommendation made in respect of the Trust's efficiency savings plan.

Governance

No significant weakness in arrangements identified but two improvement recommendations have been made.

Improving economy, efficiency and effectiveness

One significant weakness in arrangements identified and a key recommendation made in relation to agency spend.

The Audit and Assurance Committee received updates during the year on progress in implementing the recommendations.

The 2025/26 report on value for money concluded as follows:

Financial Sustainability

Significant weakness in arrangements identified and a key recommendation made relating to the Trust's financial position and delivery of recurrent savings.

Governance

Our work did not identify any areas where we considered that key or improvement recommendations were required. We have closed two prior year improvement recommendations.

Improving economy, efficiency and effectiveness

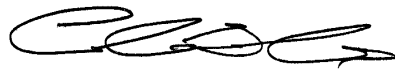
We have updated the prior year key recommendation in respect of bank and agency spend and have identified a significant weakness in arrangements in respect of Urgent and Emergency Care (UEC) performance. We have closed the prior year improvement recommendation.

As described above, the Board and the Financial Recovery Board will oversee the financial and urgency and emergency care improvement plans throughout 2026/27. The Audit and Assurance Committee will monitor implementation of the External Auditor's recommendations.

25. Conclusion

This Annual Governance Statement has identified financial governance underpinning financial delivery as a significant internal control issue. The Board is overseeing the development of an improvement plan for 2026/27, which will be approved and monitored by NHS England.

Signed:



Chief Executive

Date:

6 August 2026

DRAFT

Remuneration and Staff Report

Remuneration Report

The purpose of this report is to provide transparency and accountability relating to the remuneration of the Trust's senior managers.

The following disclosures are made in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual.

Pension related benefits have been calculated in line with the 2025/26 Group Accounting Manual.

Remuneration Policy

The remuneration of executive directors is determined by the Remuneration Committee with reference to national guidance, pay awards made to other staff groups through national awards, benchmarking data and intelligence from independent specialists in pay and labour market research. Executive director contract terms and conditions and remuneration are aligned with NHS England guidance and established pay ranges for acute NHS trusts.

No performance related pay, long-term performance related pay or bonuses were paid to the directors in 2025/26 or 2024/25.

The Trust's executive directors included the following joint roles. In each case the other relevant Trust or Trusts contributed to the remuneration:

- Acting Chief Executive Officer with Wye Valley NHS Trust.
- Interim Chief Finance Officer with Wye Valley NHS Trust.
- Foundation Group Chief Executive with the four trusts of the Foundation Group.

The Trust has complied with the Very Senior Managers Pay Framework. No national approval for a pay case was required during the year.

Performance Appraisal

Performance appraisals of each executive director are undertaken annually to review performance against objectives set at the start of the year and to agree objectives for the coming year, aligned to the Trust's strategic objectives. Progress is regularly reviewed.

Remuneration Committee

The Remuneration Committee is chaired by the Trust Chair and its membership comprises all the non-executive directors, with associate membership of the associate non-executive directors. The Acting Chief Executive Officer and Chief People Officer routinely attended meetings to support the Committee's deliberations and are absent when a conflict of interest arises.

The Remuneration Committee met four times during the year and considered the following matters:

- Very Senior Manager pay award in line with NHS England recommendations.
- Appointment of a Chief Nursing Officer (interim and substantive).
- Appointment of a substantive Chief Operating Officer.
- Appointment of a substantive Chief Digital and Information Officer.
- Appointment of a Deputy Managing Director
- Appointment of an Interim Chief Finance Officer
- Outcome of the annual Fit and Proper Person Test

Appointment Process

The executive appointment process includes the following:

- Open advertising.
- Stakeholder interviews.
- Final panel interview comprising executive and non-executive Board members.
- Decision by the Remuneration Committee.

Diversity within our Board, as within our workforce, is a priority for the Trust and part of Board appointment processes and succession planning.

Succession Planning

The approach to succession planning and talent management is developed and overseen at Foundation Group level to share best practice, align processes and identify opportunities for joint development. This recognises the need to increase diversity within the Trust’s Board and senior leadership teams and comprises the following:

Talent Management					
Attracting	Identifying	Developing	Engaging	Retaining	Deploying
Critical Enablers					
Inclusivity	Skilled support	Protected development	Pipeline visibility	Alignment to demand	
Identifying readiness and Gaps through Performance Appraisal					
Ready Now		Ready Soon		Long-Term Ready	

Chair and Non-Executive Director Remuneration

The Secretary of State for Health sets and reviews the level of remuneration payable to the chair and non-executive directors of NHS trusts. The Chair and Non-Executive Directors are not entitled to a pension provision as part of their remuneration.

Remuneration tables (subject to audit)

Executive Director Remuneration 2025/26

Name	Job title (and period of office if relevant)	Salary & fees (in bands of £5k)		All taxable benefits (nearest £100)	All pension-related benefits (bands of £2.5k)		Total (bands of £5k)	
		£000s		£s	£000s		£000s	
Glen Burley	Group Chief Executive (excludes pay from SWFT, WVT and GEH)	50	55	3,200	10.0	12.5	65	70
Joanna Newton	Chief Strategy & Sustainability Officer (to 27 June 2025)	35	40	0	0.0	2.5	35	40
Neil Cook	Chief Finance Officer	175	180	0	65.0	67.5	245	250
Katie Osmond	Interim Chief Finance Officer (from 12 January 2026) (excludes pay from WVT)	20	25	0	2.5	5.0	25	30
Sarah Shingler	Chief Nursing Officer (to 7th September 2025)	70	75	200	17.5	20	90	95
Hayley Flavell	Chief Nursing Officer (Interim Chief Nursing Officer from 4 September to 7 October 2025)	95	100	0	0.0	2.5	95	100
Stephen Collman	Acting Chief Executive (until 31 March 2026)	165	170	0	82.5	85	250	255
Julian Berlet	Chief Clinical Strategy Officer	220	225	0	35.0	37.5	255	260
Juliette Walton	Chief Medical Officer	215	220	0	57.5	60	275	280
Ali Koeltgen	Chief People Officer	135	140	0	42.5	45	180	185
Rebecca Brown	Chief Digital Information Officer (Interim Chief Digital Information Officer until 31 January 2026)	135	140	100	40.0	42.5	175	180
Chris Douglas	Chief Operating Officer (Interim Chief Operating Officer until 31 January 2026)	145	150	0	130.0	132.5	275	280

Note 1. Glen Burley is seconded from South Warwickshire University NHS Foundation Trust on a shared appointment with SWFT, Wye Valley and George Eliot NHS Trust for a proportion of his time and the remuneration identified above reflects this. G Burley's full salary was within the range £295k to £300k.

Note 2. Neil Cook had the same title and role throughout the year, but he ceased to be a Board member on 6 January 2026. The remuneration above includes £42,546.67 for the period 6 January 2026 to 31 March 2026.

Note 3. Sarah Shingler ceased being a member of the Board on 3 September 2025 but was remunerated until 7 September 2025.

Note 4. Katie Osmond was Interim Chief Finance Officer from 12 January 2026. Katie is seconded from Wye Valley Trust on a shared appointment for a proportion of her time and the remuneration identified above reflects this. K Osmond's full salary was within the range £40k to £45k for the period 12 January 2026 to 31 March 2026.

Note 5. Julian Berlet's remuneration for Chief Clinical Strategy Officer was agreed during the current financial year. Julian was appointed substantive Chief Clinical Strategy Officer in March 2025 and as a result, payments related to 24/25 were processed this financial year (The full salary for 2024/2025 was within the range £215k to £220k). The total remuneration package also includes medical elements. Remuneration split is set out below:

Basic Pay as Chief Clinical Strategy Officer	£177,854
Medical Elements	£44,150
Total Remuneration reported above	<u>£222,004</u>

Payments related to 2024/2025 £532

Note 6. Juliette Walton's remuneration for Chief Medical Officer was agreed during the current financial year. Jules was appointed substantive Chief Medical Officer in March 2025 and as a result, payments related to 24/25 were processed this financial year. The total remuneration package also includes medical elements. Remuneration split is set out below:

Basic Pay as Chief Medical Officer	£190,664
Medical Elements	£28,000
Total Remuneration reported above	<u>£218,664</u>

Payments related to 2024/2025 £1,568

Note 7. Stephen Collman was acting Chief Executive under a shared appointment with Wye Valley Trust for 2025/26. Remuneration relating to the additional responsibilities undertaken at WVT have been recharged to this organisation and is therefore excluded from this table. The costs are an additional £65k to £70k. The full annual salary was within the range £235k to £240K. The remuneration recharged is based on a percentage of 30%. Pension benefits have not been apportioned and therefore include the full pension entitlement.

Note 8. All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.

Executive Director Remuneration 2024/25

		Salary & fees (in bands of £5k)		All taxable benefits (nearest £100)	All pension-related benefits (bands of £2.5k)		Total (bands of £5k)	
Name	Job title (and period of office if relevant)	£000s		£s	£000s		£000s	
Richard Haynes	Director of Communications & Engagement	120	125	0	22.5	25	140	145
Glen Burley	Chief Executive (excludes SWFT, WVT and GEH)	145	150	0			145	150
Helen Lewis (known as Vikki)	Chief Digital Officer (to 20.10.24)	80	85	0	2.5	5	85	90
Joanna Newton	Chief Strategy Officer to 30.09.24, Chief Strategy & Sustainability Officer from 01.10.24	135	140	100	37.5	40	175	180
Neil Cook	Chief Finance Officer	170	175	100	22.5	25	195	200
Helen Lancaster	Chief Operating Officer (to 03.02.25)	165	170	200	105.0	107.5	270	275
Sarah Shingler	Chief Nursing Officer	165	170	400			165	170
Stephen Collman	Managing Director	210	215	0	195.0	197.5	405	410
Julian Berlet	Interim Chief Medical Officer to 20.02.25, Chief Clinical Strategy Officer from 21.02.25.	220	225	0	147.5	150	370	375
Juliette Walton	Interim Chief Medical Officer to 20.02.25, Chief Clinical Strategy Officer from 21.02.25.	210	215	0	122.5	125	335	340
Ali Koeltgen	Chief People Officer	130	135	200	135.0	137.5	270	275
Rebecca Brown	Acting Chief Digital Officer from 21.10.24	55	60	100	27.5	30	85	90
Chris Douglas	Acting Chief Operating Officer from 06.11.24, Interim Chief Operating Officer from 04.02.25	55	60	0	90.0	92.5	145	150

Non-Executive Director Remuneration 2025/26 (subject to audit)

Name	Job title (and period of office if relevant)	Salary & fees (bands of £5k)		All taxable benefits (to nearest £100)	Total (bands of £5k)	
		£000s		£s	£000s	
Russell Hardy	Chair (excludes SWFT, WVT and GEH) (to 31.03.26)	35	40	0	35	40
Julie Moore	Non-Executive Director	10	15	0	10	15
Colin Horwath	Non-Executive Director	10	15	0	10	15
Tony Bramley	Non-Executive Director	10	15	0	10	15
Karen Martin	Non-Executive Director	10	15	100	10	15
Simon Murphy	Non-Executive Director/Deputy Chair	20	25	0	20	25
Susan Sinclair	Associate Non-Executive Director	10	15	0	10	15
Michelle Lynch	Associate Non-Executive Director	10	15	0	10	15
Catherine Driscoll	Associate Non-Executive Director	10	15	0	10	15
Alex Moran	Associate Non-Executive Director (to 31.01.26)	10	15	0	10	15

Note 1. Russell Hardy is seconded from South Warwickshire University NHS Foundation Trust on a shared appointment with SWFT, Wye Valley and George Eliot NHS Trust for a proportion of his time and the remuneration identified above reflects this. Russell Hardy's full salary was within the range £90k to £95k.

Note 2. All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.

Non-Executive Director Remuneration 2024/25

Name	Job title (and period of office if relevant)	Salary & fees (bands of £5k)		All taxable benefits (to nearest £100)	Total (bands of £5k)	
		£000s		£s	£000s	
Julie Moore	Non-Executive Director	10	15	0	10	15
Colin Horwath	Non-Executive Director	10	15	0	10	15
Richard Oosterom	Associate Non-Executive Director (until 30.06.24)	0	5	0	0	5
Simon Murphy	Non-Executive Director/Deputy Chair	20	25	0	20	25
Susan Sinclair	Associate Non-Executive Director	15	20	0	15	20
Tony Bramley	Non-Executive Director	10	15	100	10	15
Karen Martin	Non-Executive Director	10	15	100	10	15
Michelle Lynch	Associate Non-Executive Director	10	15	0	10	15
Russell Hardy MBE	Chair (excludes SWFT, WVT and GEH)	40	45	0	40	45
Catherine Driscoll	Associate Non-Executive Director (from 01.08.24)	5	10	0	5	10
Alex Moran	Associate Non-Executive Director (from 01.08.24)	5	10	0	5	10

Pensions table 2025/26 (subject to audit)

	Real increase in pension at pension age (bands of £2,500)	Real increase in Lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2026 £000	Cash Equivalent Transfer Value at 01 April 2025 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Sarah Shingler	0-2.5	0-0	0-5	0-0	20	0	11	0
Joanna Newton	0-0	0-0	0-0	0-0	0	334	0	0
Neil Cook	2.5-5	2.5-5	70-75	170-175	1,715	1,610	83	0
Stephen Collman	5-7.5	2.5-5	90-95	230-235	2,098	1,977	95	0
Julian Berlet	2.5-5	0-2.5	60-65	155-160	1,481	1,413	46	0
Juliette Walton	2.5-5	2.5-5	50-55	125-130	1,121	1,042	57	0
Ali Koeltgen	2.5-5	0-2.5	30-35	70-75	662	608	36	0
Rebecca Brown	2.5-5	0-0	30-35	0-0	463	422	27	0
Chris Douglas	5-7.5	10-12.5	30-35	75-80	626	502	106	0
Hayley Flavell	0-0	0-0	55-60	140-145	1,277	1,533	0	0
Katie Osmond	2.5-5	0-2.5	45-50	110-115	951	43	874	0

Note 1: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant on 31 March 2026.

Note 2: Joanna Newton has already drawn down pension benefits; therefore, no CETV is applicable.

Note 3. Stephen Collman is under a shared appointment with Wye Valley Trust. Pension benefits have not been apportioned and therefore include the full pension benefits.

Note 4. Katie Osmond is seconded from Wye Valley Trust on a shared appointment. Pension benefits have not been apportioned and therefore includes the full pension benefits.

Note 5. The following directors are not included in the Directors' Pensions Benefits table: Glen Burley chose not to be covered by the pension arrangements during the reporting year. He retains an NHS pension and as he is not adding any more contributions his CETV balance will remain intact until drawn down.

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Pension Benefits

Pension-related benefits represent the value accrued during the financial year through participation in the NHS Pension Scheme. This includes benefits arising from service in previous roles within the Trust prior to an individual's appointment as a Very Senior Manager (Board Member).

The amount is calculated by taking the full pension due to the Director upon retirement if they were to retire on 31 March 2026 and deducting the equivalent value from the amount due on 31 March 2025. This includes lump sum and annual pension entitlement and uses a factor of 20 for grossing up purposes in accordance with the HMRC method (derived from section 229 of the Finance Act 2004).

Where no figures are calculated for 2025/26 the Director was either not a director at the beginning of the year or is not a member of the NHS Pension Scheme.

Calculation of Pension Benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension benefits, grossed up using a factor of 20, less any contributions made by the individual. This calculation excludes increases due to inflation and any changes resulting from a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

No additional benefits will become receivable by the individuals if they retire early.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member as a particular point in time.

The CETV is a payment made by a pension scheme, arrangement to secure pension benefits in another pension scheme or when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme and any contingent spouse's pension payable from the Scheme, not just their service in a senior capacity to which the disclosure applies.

The Real Increase in CETV does not include the effects of inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Trust employees are covered by the provisions of the NHS Pension Scheme, which is a defined contribution scheme and provides pensions related to final salary. No payments are made to any other pension scheme on behalf of executive directors.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the Scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The table above details the current pension benefits of the Trust’s senior managers. Where the executive director in post on 31 March 2025 is not a member of the NHS Pension Scheme, there are no pension benefits to be disclosed.

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of non-executives.

Exit Packages (subject to audit)

Exit packages might include redundancies or other departures. No exit packages were agreed during the year.

Compensations for loss of office and payments to past directors (subject to audit)

No compensation payments were made for loss of office nor payments made to past directors in 2025/26.

Fair Pay Disclosures (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation to the median, 25th and 75th percentile remuneration values. These are disclosed in the table below for 2025/26 and the prior year. The table also discloses the remuneration for the highest paid director and remuneration of the median, 75th and 25th percentile employees.

	Pay Ratio		
	25 th percentile	Median	75 th percentile
2025/26	8.1:1	5.7:1	4.5:1
2024/25	8.7:1	6.1:1	4.8:1

The purpose of the ratios is to demonstrate the range of remuneration within the Trust by expressing the remuneration of the highest paid director as a multiple of the remuneration of the median, 25th and 75th percentiles.

The prior-year pay ratios have been updated following the correction of an error in the reported highest-paid director’s remuneration in the 2024/25 Annual Report.

The pay ratios have decreased compared to the previous year, reflecting increases in employee pay across the wider workforce that have outpaced movements in senior remuneration.

The banded remuneration of the highest paid director in the financial year 2025-26 was £222,536 (2024-25, £223,200). The relationship to the remuneration of the Trust’s workforce is disclosed in the below table.

	Total Remuneration			
	2025/26	% Change	2024/25	% Change
Highest Pay Director	222,536	0%	223,200	5%
Minimum	15,643	52%	10,324	0%
Median	39,043	7%	36,483	6%
75 th percentile	49,387	7%	46,148	0%
25 th percentile	27,476	7%	25,674	5%
Average Remuneration	51,244	7%	47,756	7%

The total remuneration has been disclosed within the fair pay calculations; this is the same as the salary component, meaning these have not been split out.

Salaries paid by the Trust on a full-time equivalent basis varied between £15,643 and £273,756 per annum.

In 2025/26 3 employees received remuneration in excess of the highest paid director. In 2024/25, 12 employees received remuneration in excess of the highest paid director.

The annualised salary of £273,756 is for a consultant who worked shifts through NHSP compared to the highest paid director of £222,536.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The remuneration calculations also cover staff engaged on a bank and agency basis as well as substantive posts.

Non-executive directors are excluded from the scope of the fair pay disclosures in 2025/26. They were included in the disclosures in prior years.

Staff Report

People Dashboard

Key people metrics on 31 March 2026 compared to last year were as follows.

Metric	31 March 2025		31 March 2026	
	Staff	Senior Managers*	Staff	Senior Managers*
Numbers (headcount)	8,058	20	8,257	18
Gender %	20% male; 80% female	50% male; 50% female	21% male; 79% female	39% male; 61% female
Sickness absence	5.53% (cumulative)	n/a	5.44% (cumulative)	n/a
Turnover	9.15%	n/a	7.43%	n/a
Staff Survey engagement	6.82	n/a	6.84	n/a

*Senior Managers are defined as board members, both voting and non-voting

Staff numbers and costs analysis (subject to audit)

The average number of Full Time Equivalent (FTE) staff during the year was 7,133.98. This is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

The workforce profile on 31 March 2026 compared with previous years was as follows:

Full Time Equivalent (FTE) Staff Numbers							
Staff Group	Sub Staff Group	March -21	March -22	March -23	March -24	March -25	March -26
Medical and Dental	n/a	676	689	738	792	854	913
Ambulance Staff	Registered Ambulance Staff	2	1	2	2	2	7
Administration and Estates	n/a	1048	1065	990	1081	1146	1121
Healthcare Assistants and Other Support Staff	n/a	1088	1016	1186	1323	1368	1413
Nursing, Midwifery and Health Visiting Staff	NMC Registered Nurses, Midwives and Health Visitors	1857	1921	1990	2144	2348	2445
	Nursing Associates and support to NMC Registered Nurses, Midwives and Health Visitors	71	138	147	166	139	126
Nursing, Midwifery and Health Visiting Learners	Un-registered Nursing Learners	51			1	3	3

Healthcare Scientists	Qualified Healthcare Science and Public Health Scientific Staff	170	165	180	176	187	208
	Support to Qualified Healthcare Science and Public Health Scientific Staff	106	108	111	121	126	113
Scientific, Therapeutic and Technical Staff	Qualified Allied Health Professionals	437	436	428	439	491	505
	Qualified Other Scientific, Therapeutic & Technical	151	161	160	162	171	177
	Support to Qualified Allied Health Professionals	106	108	112	126	140	130
	Support to Qualified Other Scientific, Therapeutic & Technical	66	75	40	43	58	59
Grand Total		5827	5881	6084	6577	7032	7219

Assignment status of our on-payroll staff as of 31 March 2026 (subject to audit):

Assignment Category	31 March 2025		31 March 2026	
	FTE	Headcount	FTE	Headcount
Fixed Term/Temporary/Locum	598.93	635	629.83	673
Permanent	6,433.32	7,423	6,588.85	7,584
Grand Total	7,032.25	8,058	7,218.68	8,257

The Trust contracts with NHS Professionals as sole provider of Bank and Agency staff. As of 31 March 2026, the following substantive and temporary staff actually worked during the month (Source: Worked from Finance ADI):

Type Breakdown	31 March 2025	31 March 2026
Agency	275.14	162.53
Bank	535.51	667.90
Substantive (worked)	6,920.52	7,061.82
Grand Total	7,731.17	7,892.25

Staff Costs during 2025/26 compared with the previous year were as follows. (subject to audit)

Staff Cost 2025/26	Permanent £'000	Other £'000	Total £'000	2024/25 Total
Salaries and Wages	341,695	0	341,695	315,461
Social Security Costs	46,184	3,593	49,777	36,995
Apprenticeship Levy	1,783	77	1,860	1,693
NHS Pension Costs	68,945	2,093	71,038	64,836
Other Pension Costs	67	0	67	79
Temporary Staff	0	68,082	68,082	78,510
Less: recoveries in respect of outward secondments (where treated net)	0	0	0	0
Total Staff Costs	458,674	73,845	532,519	497,574

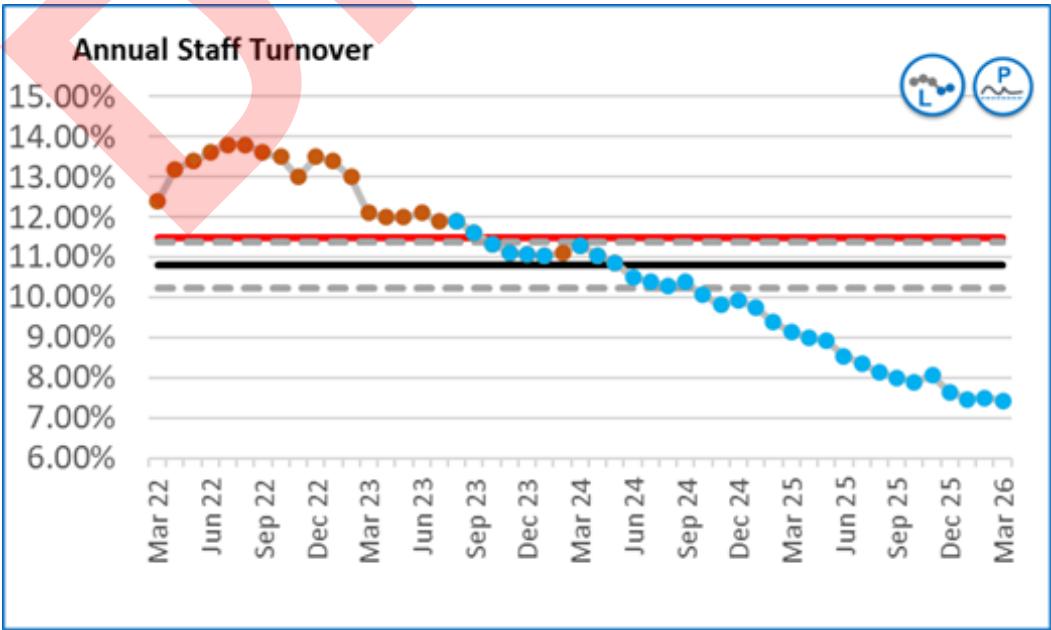
This shows a 7% increase in staffing costs over the year, reflecting:

- An increase in the FTE workforce overall.
- An increase in the FTE workforce in every staff group except administration and clerical.
- An increase in the temporary FTE workforce overall but a reduction in agency workforce.
- Increases in national pay awards.

Staff Turnover

The Trust’s staff survey data is captured as part of [NHS workforce statistics](#); this is an official NHS England statistics publication complying with the UK Statistics Authority’s Code of Practice.

Our annual staff turnover has been steadily improving and, at 7.43% for the year, meets the target of 11.5% and, compared to 9.15% the previous year shows an improving trajectory. This also benchmarks well with other trusts at quartile 1 (best) on the Model Hospital rates for December 2025.



Equality, Diversity and Inclusion

As an NHS provider we are committed to ensuring that our services are accessible to, and meet the diverse needs of, all our patients and visitors. We work in partnership with colleagues in other NHS organisations, voluntary and community groups and our key stakeholders to enable us to plan and deliver our services in a way which best meets the needs of everyone in the communities we serve.

We are an equal opportunities employer committed to fair and equitable treatment of all our staff and all job applicants. We are opposed to any form of negative discriminatory or unfair treatment in all aspects of employment.

We are committed to the elimination of discrimination and ensure our workforce is given the necessary training to support this.

We have a framework of policies and processes in place to support us to achieve this.

Policies	Training	People and Teams
Equality, Diversity and Inclusion Flexible Working Family Leave Freedom to Speak Up Sickness Absence, health & Wellbeing Reasonable Adjustments Dignity at Work Supporting Colleagues who are Transgender, Non-Binary or Gender Non-Conforming	Recruitment and selection Recruitment champion Mandatory EDI Freedom to Speak Up: Speak Up, Listen Up Unconscious Bias	Freedom to Speak Up Guardian Freedom to Speak Up Champions Staff Networks Reciprocal mentoring
Objectives and Commitments	Reporting and Action Plans	Collaboration
Board member annual EDI objectives Inclusive Leadership Pledge	Gender Pay Gap WRES WDES EDS 22 High Impact Improvement Actions	Foundation Group: benchmarking, shared learning, collaboration Integrated Care System: Culture and Inclusion Strategy 2024-29

The NHS High Impact Equality Diversity and Inclusion (EDI) Improvement plan sets out targeted actions to address the direct and indirect prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The EDI Improvement Plan supports the long-term Workforce Plan by improving the culture of workplaces and the experiences of the workforce.

To support the achievement of strategic EDI outcomes for patients and employees, NHS trusts are expected to do the following:

- Address discrimination, enabling staff to use the full range of their skills and experience to deliver the best possible patient care.
- Increase accountability of all leaders to embed inclusive leadership and promote equal opportunities and fairness of outcomes in line with the NHS Constitution and the Equality Act 2010.

- Improve EDI within the NHS workforce, enhancing the NHS's reputation as a model employer and an anchor institution, and thereby continuing to attract diverse talents to our workforce.
- Make opportunities for progression equitable, facilitating social mobility in the communities we serve.

The Trust's progress on these areas was reported to the Trust Board when it met with the other three members of the Foundation Group, which enabled information sharing, learning and benchmarking.

Board leadership	Fair and inclusive recruitment	Pay gaps
• Annual EDI objective for every Board member • The Trust is acting as anchor organisation	• Recruitment champion training • Essential criteria interview guarantee scheme	• Gender pay gap action plan • Developing an action plan to address race and disability pay gaps
Health inequalities in the workforce	Programme for international staff	Address bullying, discrimination, harassment, physical violence
• People Strategy • Staff Survey actions • Leadership & management development programmes • Health and Wellbeing conversations	• Pastoral Care • Staff networks • international staff charter • Students Integration Programme	• FTSU Guardian and champions • Speak Up, Listen Up training • Sexual safety policy & charter in place • Safe Learning Charter

Staff with Disabilities and Long-Term Conditions

Workforce by Disability	Total Headcount Mar 24	Total Headcount Mar 25	Total Headcount Mar 26	Total % Mar 26
No	7,057	7,478	7,571	91.69
Not Declared	141	137	122	1.48
Prefer Not to Answer	35	32	35	0.42
Unspecified	14	15	34	0.41
Yes	299	396	495	5.99
Grand Total	7,546	8,058	8,257	100

Support for colleagues with disabilities and long-term conditions includes the following:

- The Trust's Recruitment and Selection Policy requires a guaranteed interview for applicants with disability who meet the essential person specification criteria for the role, in line with the DWP Disability Confident Employer scheme.
- For senior posts (band 8a and above) selection processes must include a dedicated Recruitment Champion who has received Inclusive Recruitment Training to ensure inclusive practice within all stages of selection.
- The Inclusive Recruiting Managers toolkit includes unconscious bias training.
- The Sickness Absence, Health and Wellbeing Policy describes the approach that may need to be taken where an employee becomes disabled during their employment, including making reasonable adjustments to support return to work.
- A Health and Wellbeing Passport launched in September 2023 in partnership with the Staff Disability Network supports colleagues to undertake their role effectively within a

supportive environment. It can be used by any member of staff who feels that they need support at work in relation to their wellbeing.

- Health and wellbeing offer, which includes:
 - Occupational health service
 - Staff psychological wellbeing service
 - Counselling Service
 - Mental Health First Aiders
 - Stress Management toolkit for employees and managers
 - Free health checks for all staff
 - Monthly wellbeing webinars
 - Stress awareness drop-in sessions
- Diverse Ability Working Network (DAWN) (see below).

Health and safety at work

Risks to the health and safety of our staff at work are overseen by the Health and Safety Committee, which meets monthly and reports to the Executive Risk Management Committee. Sub-committees and groups reporting to the Committee cover areas such as security and water, electrical, ventilation and fire safety. Key matters considered during the year included:

- Health and safety incidents
- Fire safety
- Security
- Violence and aggression incidents

Staff Wellbeing

A Wellbeing Hub on the staff intranet draws together all the information about the Trust's wellbeing offer to staff.



Key elements of this offer are:

- Occupational health service
- Staff psychological wellbeing service
- Counselling Service
- Mental Health First Aiders
- Stress Management toolkit
- Free health checks
- Monthly wellbeing webinars
- Stress awareness drop-in sessions
- Wellbeing and relaxation rooms
- Health and wellbeing passport
- Financial wellbeing hub
- Neurodiversity Hub

Human Capital Management

To attract and retain our workforce we need to support staff to stay safe, well and fulfilled at work. As well as supporting their safety and wellbeing, ensuring our staff can progress and develop in their careers is an essential element of this.

The Trust's Education Academy includes a range of opportunities available for staff from all professional groups. These include:

- Apprenticeships
- Coaching and mentoring
- Reciprocal mentoring
- Fellowships
- Professional Nurse/Midwife Advocates
- Career frameworks for different staff groups
- Leadership programmes
- Leadership management and development
- Team engagement development

Employee consultation and participation

The Trust maintains regular communication with its staff in a number of ways, including:

- Weekly emailed newsletters
- Staff intranet containing up to date information and daily news.
- Monthly 'Exec Live' Teams Session for all staff.
- Monthly Leaders Briefings
- Quarterly Foundation Group Leaders Briefings
- Monthly Trust Board meetings – live streamed and recordings published.

During 2025/26 the Trust consulted with staff on the development and implementation of strategies and plans including:

- Trust Strategy
- Ambulance handover improvements.
- Divisional structure
- Outpatient services strategy
- UEC/unplanned flow improvements

One of the main ways in which the Trust engages with its staff is through the staff networks; details of each of these are as follows:

Staff Networks	
Diverse Ability Working Network (DAWN)	
Aims and purpose:	
• Support a fairer and more diverse Trust for everyone. • Tackle issues for under-represented and disadvantaged groups and individuals. • Share experiences and facilitate learning and development. • Help shape and deliver organisational strategy and policy. • Provide training and guidance to aid an understanding of disability. • Listen to the voices of disabled colleagues.	

- Improve workforce data.

EmBRACE Network

Active network of colleagues and allies working together to help create a culture where all staff and patients - regardless of their race or ethnicity - feel supported, cared for and are treated with dignity, kindness and respect. Key areas of focus:

- Support and Advocacy.
- Training and Education.
- Inclusive Recruitment and Retention.
- Launch of Anti-Racism Charter
- Support to International Staff and Students

Faith and Spirituality Network

Objectives:

- Assist in formulating new and reviewing existing policies and procedures
- Support the Trust to attract, recruit and retain staff of all faiths and none.
- Provide learning and development opportunities within the Trust's training and education offer.
- Encourage Trust volunteers with a faith or belief, to be part of the Network.
- Build resilient and positive partnerships with faith groups and leaders across the County.

LGBTQ+ Network

Purpose:

- To influence and support the Trust Board to tackle the key barriers to healthcare for LGBTQ+ patients, whilst also promoting a more diverse and inclusive workplace.
- Safe space for colleagues to share experiences and ideas to improve staff and patient experience.
- Supporting staff and answering questions.
- Reviewing and creating policies to shape the way the Trust supports LGBTQ+ patients and staff.
- Working with fellow Staff Networks to foster an intersectional approach for our communities.

Women's Network

Aims:

- Create a supportive and inclusive environment for all women and those who identify as women.
- Share experiences and champion positive change.
- Promote equality and raise awareness of the challenges women may face in their daily lives.
- Break down barriers to healthcare
- Create a workplace where all women feel valued and empowered.
- Collaboration with all staff networks to foster an equitable culture for all women.

Armed Forces Network

Network of veterans, reservists, military spouses and staff with an interest in the armed forces. Aims:

- To support the aims of the Armed Forces Covenant.
- Maintain 'Gold standard' Armed Forces Covenant accreditation.
- Support patients, families and staff with links to the armed forces.
- Help to maintain our 'Veteran Accreditation' standard.

Trade Union Relationships

In the NHS, 'Staff Side' is a term for the interface with various trade unions and recognised professional bodies. These bodies have locally accredited representatives and working together they are termed 'Staff Side'. The role of Staff Side is to ensure a collective approach to issues such as terms and conditions of employment and receiving advice and guidance from the various unions and organisations. They consider concerns raised by staff members and consult and negotiate with Trust

managers through the Joint Negotiating Consulting Committee (JNCC) where staff side and management come together to discuss matters arising.

Staff side plays a vital role in looking after employee interests and has an excellent working relationship with the Trust.

Expenditure on consultancy

The Trust spent £234,000 on consultancy during 2025/26 compared to £284,000 the previous year. This equates to 0.028% per cent of the Trust's turnover in 2025/26.

Off Payroll Engagements

Off payroll engagements relate to individuals employed by the Trust but not remunerated via the organisation's payroll function. Typically, this would relate to self-employed individuals or those contracted via agencies. The Department of Health requires NHS bodies to report any off-payroll engagements as of 31 March 2026, for more than £245 per day*

Table 1: length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2026, for more than £245 per day :	Number of Engagements
Number of existing engagements as at 31 March 2026	7
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	3
No. that have existed for between two and three years at time of reporting	1
No. that have existed for between three and four years at time of reporting	1
No. that have existed for four or more years at the time of reporting	2

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:

Table 2: off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:	Number of Engagements
Number of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	6
of which:	
Number not subject to off-payroll legislation	
Number subject to off-payroll legislation and determined as in-scope of IR35(1)	
Number subject to off-payroll legislation and determined as out of scope of IR35(1)	6
Number of engagements reassessed for compliance or assurance purposes during the year	2
of which:	
Number of engagements that saw a change to IR35 status following review	2

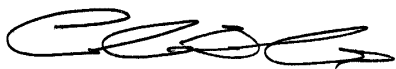
The six engagements reported above all relate to engagements outside of IR35 and therefore the Trust have not been required to introduce contractual clauses.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

Table 3: off-payroll board member/senior official engagements

Off-payroll engagements of board members, and/or senior officers with significant financial responsibility between 1 April 2025 and 31 March 2026	Number of Engagements
Number of off-payroll engagements of board members, and/or senior officials with significant responsibility, during the financial year (1)	0
Number of individuals that have been deemed 'board members and/or senior official's with significant financial responsibility' during the financial year, including both off-payroll and on-payroll engagements.	22

Signed:



Chief Executive Officer

Date:

6 August 2026

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Trust Board
14 July 2026 at 1:00pm
Via Microsoft Teams and live streamed on YouTube
Part 1 in Public

Board Members Present (voting)			
Frances Martin, Chair	FM	Simon Murphy, Non-Executive Director/Deputy Chair	SM
Sir Glen Burley, Chief Executive Officer	GB	Colin Horwath, Non-executive Director	CH
Dame Julie Moore, Non-Executive Director	JM	Stephen Collman, Managing Director	SC
Jules Walton, Chief Medical Officer	JW	Hayley Flavell, Chief Nursing Officer	HF
Katie Osmond, Chief Finance Officer	KO	Tony Bramley, Non-Executive Director	TB
Karen Martin, Non-Executive Director	KM		
Board Members Present (non-voting)			
Ali Koeltgen, Chief People Officer	AK	Rebecca Brown, Chief Digital Information Officer	RB
Chris Douglas, Chief Operating Officer	CD	Catherine Driscoll, Associate Non-Executive Director	CDr
Michelle Lynch, Associate Non-Executive Director	ML	Sue Sinclair, Associate Non-Executive Director	SSi
Attending			
Rebecca Fox, Deputy Director of Midwifery	RF	Gweny Scott, Company Secretary	GS
Richard Haynes, Director of Communications & Engagement	RH	Jo Wells, Deputy Company Secretary	JWe
Apologies			
Julian Berlet, Chief Clinical Strategy Officer	JB	Justine Jeffery, Director of Midwifery	JJ

Ref	Item	Lead	Purpose	Format
1	Welcome and Apologies for Absence	FM	Information	Verbal
FM welcomed everyone to the July Board meeting. A comprehensive Board workshop had been held earlier in the day, covering a range of topics of importance to the people of Worcestershire. On behalf of colleagues across the Foundation Group, FM congratulated GB, who had been knighted in His Majesty the King's Birthday Honours, and thanked him for his significant service, leadership and continuing national contribution to the NHS.				
2	Declarations of Interest	FM	Information	Verbal
SM declared that his wife was the manager of the Adult Safeguarding Board in Worcestershire, which was relevant to the Safeguarding Annual Report later on the agenda. The Chair explained that declarations of interest supported openness and transparency and did not prevent a member from taking part in a discussion; where a commercial conflict existed, the member concerned would be recused. No commercial conflict was identified in this case.				
3	Minutes and Actions Arising	FM	Approval	Report 1
The minutes of the Trust Board meeting held on 9 June 2026 were approved as an accurate record. There were no outstanding actions arising from the previous meeting.				
3.1	Foundation Group Strategy Committee Annual Report	GB	Information	Report 2
GB introduced the report, reminding the Board that the Foundation Group Strategy Committee was a committee in common across the four trusts in the Group. It was the forum through which the organisations connected on a number of levels and, in particular, shared best practice in support of the shared objectives and "big moves" set out in the Group strategy. The report set out the Committee's work over the past year. The Board noted the report.				
4	Chief Executive Officer's Report	GB	Information	Report 3
GB presented the report and highlighted the following:				

- The two recent national maternity reports had been considered during the morning workshop, and the Trust would bring more of its response into the public domain as this developed. The key challenge was to balance responding to the reports with maintaining a high-level Board view of the governance and risks across all specialties.
- An agreement had been reached with the BMA Resident Doctors Committee and the dispute was moving into implementation. This would require an increase in national training numbers, to which the Trust would respond, and a better, more standardised contract for locally employed doctors.
- A new NHS oversight framework applied for the year. As an organisation in receipt of deficit support funding, the Trust remained subject to the financial override and could not achieve higher than segment 3; its aim was to move into segment 3 during the course of the year.
- Lord Mann's review of antisemitism and other forms of racism included a number of immediate actions for the NHS, considered in more detail later on the agenda.
- The first Advanced Foundation Trust had been authorised nationally, and two organisations were shortly to be announced as able to hold integrated healthcare organisation contracts covering the whole population health of their locality. As the Trust developed its lead provider role in Worcestershire, this was an ambition to work towards in future.
- NHS Online, a new organisation delivering a virtual form of healthcare, represented a more disruptive model and reinforced the need for the Trust to develop digital channels through which patients could access its services. A review of the Trust's outpatient model pointed to a more digitally enabled future state, while ensuring that patients unable to use digital channels could still access services well.
- The Patient Discharge Unit had been closed, supporting the aim of ensuring that patients were not kept in hospital unnecessarily and that only patients who needed an acute setting were admitted, contributing to improved flow, safety and efficiency.
- The Trust would expand the cardiac catheterisation laboratory in the future.
- Dementia Action Week had been marked, and staff who had attended the Royal Garden Party in recognition of their long service were congratulated.

FM added her thanks for the "going the extra mile" initiatives undertaken by staff and for the closure of the Patient Discharge Unit, which enabled more appropriate care to be provided in other settings. She also referenced the workshop presentation from volunteers providing therapy dogs – initially at one site and now expanding to others – and recognised the non-clinical wellbeing benefits this brought to patients and staff.

The Board noted the report.

5	Integrated Performance Report	SC	Information	Report 4
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SC introduced the report and drew out a number of key points:

Chief Executive/Managing Director Overview (SC)

- The efficiency programme remained a significant focus, in particular the productivity element, which linked to operational performance and to a number of quality and safety indicators.
- Deep dives were underway into urology and dermatology, the specialties having a disproportionate effect on performance, alongside broader work with clinical leadership on Model Hospital, GIRFT and both shorter-term improvements and longer-term structural change.
- SC and FM had met regional colleagues to discuss the Trust's improvement programme, which was coming together and would be shared at public Board at the appropriate time. Significant changes were being delivered each month, beginning with the closure of the Patient Discharge Unit, with further changes planned through to December.
- On corridor care, the Board reaffirmed its commitment that this was an unacceptable way to deliver care. The Trust set itself the objective of eliminating corridor care by the end of December for the Emergency Department and by the end of November for ward and inpatient escalation spaces. Executive colleagues would work with care groups to deliver this, and a progress update would be brought to the public Board in September.

FM apologised to patients and members of the public where the Trust had been unable to provide care in an appropriate environment, and confirmed the Board's commitment to caring for patients only in designated patient areas. She noted that delivery would require significant partnership working with Worcestershire Health and Care NHS Trust, the ICB, general practice, Worcestershire County Council and others, alongside opportunities to provide more care to patients at home.

Quality and Safety (JW and HF)

- Timeliness of access to theatre for patients with a fractured neck of femur remained a concern, and the Trust was an outlier nationally for mortality in this patient group; performance in other quality measures for these patients, such as orthogeriatric review and delirium assessment, was good. Work would remain focused on this area, and an apology was offered to patients who had experienced long waits.
- A sepsis screening module had been commenced through the electronic patient record, a positive step; data would be validated and quality improvement work undertaken. Mortality for patients treated for sepsis remained relatively low compared with national averages.
- Although antimicrobial stewardship was traditionally strong, a slight reduction in the correct choice of antibiotics had been seen in a small number of areas; the care groups were already reviewing the reasons and the action required.
- Complaints performance had improved in May to just under 73%, with June slightly lower. Focused work was underway in the women's and children's and surgery care groups, and further work with associate chief nurses and the complaints team was planned to improve the process.
- A measles outbreak had been managed through early identification, isolation and clear patient pathways, alongside significant vaccination work with public health colleagues for both healthcare workers and the wider population; there had been no measles cases for a number of weeks.
- Corridor care utilisation was now reported within the pack to provide ward-to-board transparency and robust governance, while the Trust remained committed to eliminating its use.

GB emphasised that, while corridor care would be eliminated in the near future, patients currently cared for in those settings were kept safe and supported by staff. SC advised that an executive-led deep dive into the fractured neck of femur pathway, through trauma and orthopaedics and the improvement board, was identifying the root causes and would be presented to the Board shortly.

KM advised that the level of detail provided to the Board on complaints had reduced, which limited the Board's ability to see divisional performance and, more importantly, to assure itself that learning was taken from complaints. It was agreed that a fuller report be brought back to a future Board.

Operational Performance (CD)

- Urgent and emergency care demand had continued to grow into May and June, although May's performance had been delivered well. The recent heat had affected attendances and flow across the region, and there was learning for the Trust in activating its escalation plans during the summer; a regional learning event was likely in the coming weeks.
- Action plans were in place for the national model Emergency Department and national model acute pathways, with a plan being developed for the new model discharge processes, overseen through the urgent and emergency care reset programme.
- A visit to George Eliot Hospital was planned to learn from its improvements in the emergency access standard.
- The Trust was on track to eliminate 52-week waits for all specialties except ENT, maxillofacial, trauma and orthopaedics and neurology by the end of July, with those four specialties following by the end of September. Waiting list numbers had risen despite high numbers of clock stops, and validation and digital opportunities remained a focus.
- Cancer remained a significant focus. For skin, next steps included the rollout of teledermatology with the ICB and expansion of the one-stop service, with additional maxillofacial surgery support expected to improve 62-day performance. In urology, supported by the West Midlands Cancer Alliance, there were significant productivity opportunities to improve cancer performance.

The Board discussed the following:

- Outpatient transformation could be targeted at the more challenged specialties and that, by separating the performance of the two Emergency Departments and the Kidderminster Treatment Centre, it would be clearer that Worcester Royal was the main driver of the overall position and an opportunity for focused improvement.
- Work to review clinical resource at the front door reflected both rising demand and the need to ensure the right resource was in the right place across the whole of the front door, not only the Emergency Department. Work was also underway with primary care on attendance avoidance and patient streaming, and system working.

Workforce (AK)

- Temporary staffing remained one of the Trust's most significant challenges; savings from the agency swap-out scheme had not yet been fully realised and there was sustained pressure on bank usage. The closure of the Patient Discharge Unit would help, and further scrutiny of pay rates was planned, including aligning medical rates to the West Midlands cluster rates and addressing instances where bank rates exceeded agency rates.

- Recruitment to vacancies remained fairly well controlled, with careful skill-mix review in non-clinical areas and establishment reductions ahead of the medium-term plan, although temporary staffing pressures outweighed these gains.
- Sickness absence was 4.94% against a 4% target, influenced by higher absence in estates and facilities and in the family health care group, where over half of absence was related to stress and mental health.
- Job planning remained a significant challenge, with plans in place to improve it, including team job planning.
- Mandatory training compliance had dipped in May following the introduction of the face-to-face safeguarding level 3 training requirement for medical, dental, nursing and midwifery staff, which had increased the number of staff required to attend from 258 to over 3,500; plans were underway to recover the position. This was a national change.

The Board discussed the 68% corporate appraisal compliance rate, the lowest in the Trust. It was agreed that further detail would be presented through the People and Culture Committee.

Finance (KO)

- The report covered the period to the end of May. A year-to-date deficit of £7.3m was reported, £1.7m adverse to the planned deficit of £5.6m, driven principally by the impact of April's industrial action and under-delivery of the cost improvement programme.
- The month 2 position assumed that deficit support funding had been earned; although received in cash in April and May, it was at risk of being retained if the plan was not delivered, representing a further £7m risk to the reported position.
- The cost improvement programme was behind plan, having delivered £3.8m against a planned £5.2m. Fully developed, low-risk schemes had largely delivered, with the shortfall driven by less well-developed schemes; targeted work through July aimed to de-risk the programme, move more schemes into fully developed status and improve productivity.
- The cash position was fragile. Proactive management of creditor payment runs to protect payroll had adversely affected prompt payment performance, with only 47% of invoices paid within 30 days against a 95% target.
- Deficit support funding received in quarter one was expected to be withheld in quarter two. A revenue support application of around £6.5m had been partially approved at around £3.5m, and a further cash support application was being prepared for August.

KO expressed increasing, if cautious, confidence in converting cost-saving opportunities into delivery, citing the closure of the Patient Discharge Unit and the work on bank rates, and a series of larger, more transformational interventions planned over the coming months, supported by continued engagement with clinical care groups and corporate areas.

The Board noted the Integrated Performance Report.

6	QUALITY			
6.1	Quality Governance Committee Escalation Report	JM	Assurance	Report 5

The report was taken as read. The Committee, which typically reported a month in arrears, spent considerable time on childbirth, maternity and obstetrics; matters that were being discussed in detail during the day.

The Board noted the report.

6.2	Infection, Prevention & Control Annual Report	HF	Assurance	Report 6
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HF presented the report, which had been considered by the Quality Governance Committee, and highlighted the following:

- Key achievements included meeting the Clostridium difficile target for the first time in a number of years, and a reduction in NHS monitoring from intense surveillance to enhanced monitoring, reflecting the work of the teams.
- Priorities for 2026/27 were reducing bloodstream infections, improving antimicrobial stewardship, strengthening outbreak preparedness and workforce compliance, and progressing the move from enhanced monitoring to routine oversight.
- Areas of ongoing risk included MRSA, following a number of cases in the previous year, and E. coli. The improved overall position had been recognised by NHS England.
- A full NHS England inspection was planned for 20 August, with feedback to be brought to the public Board in due course.

The Board noted an error reference to governors on page 8 of the report, which was not accurate for the Trust and should be removed; the Chief Nursing Officer agreed to correct this.

The Board scrutinised and noted the report and approved its publication on the Trust's website.				
6.2.1	Infection Prevention & Control Board Assurance Framework	HF	Assurance	Report 7
HF presented the Infection Prevention and Control Board Assurance Framework, which was based on the Health and Social Care Act and had been considered by the Quality Governance Committee. There were no red areas; three areas were fully assured and the remaining domains had mitigations in place, supported by strong ward-to-board assurance and oversight through the Trust's Infection Prevention and Control Committee. - Following the measles outbreak, the framework had been updated to strengthen assurance around staff vaccination. More robust processes were now in place to oversee staff vaccination status, and pre-employment checks were being reviewed with the Chief People Officer's team. - The Trust had worked with public health and local authority colleagues, and feedback from the incident management team, chaired by public health with UKHSA present, had been very complimentary about the Trust's proactive approach. Close working had taken place with occupational health, infection prevention and control, workforce and data teams, supported by a risk assessment of higher and lower risk areas. The Board queried the timelines for moving items assessed as partially compliant to full compliance. HF explained that there was variability, with some items relating to matters such as side-room isolation, and offered to bring a deeper dive to the Quality Governance Committee. FM agreed that the detail should be managed through the Quality Governance Committee and escalated to the Board as necessary. The Board received assurance.				
6.3	Safeguarding Annual Report	HF	Approval	Report 8
HF presented the report, which provided strong assurance on the Trust's safeguarding processes, supported by an independent external audit that had previously reported significant assurance to the Quality Governance and Audit committees. - Positives in 2025/26 included Prevent compliance and level 3 compliance, with some safeguarding training levels identified as an area of risk being worked through. - Priorities for 2026/27 included sustaining safeguarding training compliance above 90%, implementing Martin's Law, strengthening safeguarding systems and the alert process, and continuing multi-agency partnership working. The Board sought stronger assurance wording regarding the presence of an anaesthetist or operating department practitioner for sedated or anaesthetised patients in theatres, so that the report would provide clearer assurance to a member of the public. The Chair agreed that this would be picked up and a response brought back to the Board so that it could be fully assured. The Board received assurance and approved the report.				
6.4	Nursing Safe Staffing Report	HF	Assurance	Report 9
HF presented the report, which had been considered by the Quality Governance Committee, and highlighted the following from May's data: - Safer staffing had been maintained throughout the month, with clear mitigations in place for the British Association of Perinatal Medicine (BAPM) standards in the neonatal units. - Registered nurse vacancies remained just under 6%, supported by internal pipelines including nursing associates and the top-up programme, with learners qualifying in September. A cohort of around 250 newly qualified nurses was expected, exceeding the number of available vacancies, a position reflected nationally. - Agency spend was reducing and was expected to reduce further following the closure of the Patient Discharge Unit. - An independent review of the Trust's use of the Safer Nursing Care Tool methodology, led by NHS England's national lead, was commencing and would be overseen through the Nursing and Midwifery Assurance Committee and the Quality Governance Committee. In discussion, the Board noted the opportunity presented by the number of newly qualified nurses and questioned the level of healthcare support worker vacancies, around 12%, being filled by bank staff, suggesting that over-recruitment and a more flexible				

workforce might reduce agency spend. HF confirmed this was not by design, citing challenges in recruiting and retaining healthcare support workers, and pointed to the band 2 to band 3 changes, robust pipelines and the nursing associate offer.

The Board received assurance.

6.5	Maternity Assurance Overview	HF	Approval	Report 10
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HF presented the overview, the underpinning reports having been through robust governance, and highlighted the following:

- The Trust had achieved 10 out of 10 safety actions for year 7 of the Clinical Negligence Scheme for Trusts (CNST), securing funding of just under £1m, and sat within the top performing zone of the regional heat map.
- Midwifery vacancies were at 0%, with over-recruitment into midwifery posts.
- Key risks included an amber alert for MOS and an emerging risk, both with action plans in place to mitigate.
- For year 8 of the Maternity Incentive Scheme, which was more outcome-focused with fewer safety actions and increased Board accountability, the Trust had offered to act as a pilot and to provide feedback, with oversight through the Quality Governance Committee and the Board.

The recent national maternity reports, including the review of maternity services at Nottingham University Hospitals published in June, had been discussed during the morning workshop and would return to the public Board in due course. FM confirmed that responding to these reports remained a key Board responsibility.

The Board received assurance and approved the report.

7	FINANCE
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There were no separate items under the Finance section.

8	WORKFORCE
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8.1	Lord Mann Review Response	AK	Assurance	Report 11
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AK drew attention to the collective responsibility in responding to the Lord Mann review, published in June, and to the accompanying letter from NHS England setting out what was expected of the Trust.

- Some actions were immediate and straightforward, including the adoption of the definitions of antisemitism and anti-Muslim hostility as forms of racism, which the Trust had already incorporated into its policies.
- Other measures were more complex. Much of the required work was covered by the anti-racism charter and action plan the Trust had signed up to the previous year, but a more detailed gap analysis against the NHS England recommendations would be taken through the People and Culture Committee.
- The Trust would complete the NHS England public questionnaire before the end of July, and the work aligned closely with the Trust's values and staff survey feedback.

The Board discussed the following:

- An update on the anti-racism programme; Work was ongoing across multiple forums, including staff networks, policies and hotspot analysis, and a key next step to reinvigorate the campaign to neighbourhoods and the public about acceptable treatment of NHS staff, aligned to the red card scheme.
- The risk of waiting for a national training rollout and whether the Trust's data indicated specific concerns; Existing mandatory equal-opportunities training and the Kindness into Action training provided a strong grounding while the national training was awaited, and that no data hotspots had been identified.

The Board received assurance and noted the report.

9	GOVERNANCE & RISK
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9.1	Audit and Assurance Committee Escalation Report	CH	Assurance	Report 12
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CH advised that the report covered matters of which the Board was already aware, and confirmed that the interim Head of Internal Audit opinion, providing significant assurance, had been finalised. An unqualified external audit opinion on the financial statements was expected in due course, subject to the resolution of an outstanding technical issue. The external auditors had,

through their value for money work, identified three significant weaknesses, all of which were known to the Board and already being addressed.

The Board noted the report.

9.2	Board Assurance Framework	GS	Assurance	Report 13
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The Board Assurance Framework was presented for its quarterly review, with updates highlighted in red for ease of reference. There were no major changes to scores or significant new elements, the changes largely reflecting new-year assurances and indicators.

FM welcomed the correlation between the Board Assurance Framework and the matters considered through the Board's agendas.

The Board accepted the Board Assurance Framework.

10	Date of Next Meeting	FM	Information	n/a
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The next Trust Board meeting in public would be held on 8 September 2026.

It was noted that a committee in common with South Warwickshire University NHS Foundation Trust and George Eliot Hospital would be held in August.

11	Any Other Business and Questions from the Public	FM	Information	n/a
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There was no other business, and no questions had been received from the public. The Chair reminded members of the public of the means by which questions and concerns may be raised with the Board, details of which are available on the Trust's website.

The Chair thanked all staff for maintaining safe and effective services during the recent extreme heat, and reminded members of the public of the seasonal public health advice to stay hydrated and out of the sun.

The Board resolved to exclude members of the public from Part II of the meeting as matters under discussion were exempt from disclosure to the public under the Freedom of Information Act.

Report Summary			
Report to	Joint Board – Public	Date of Meeting	2 September 2026
Report Title	Foundation Group Boards Workshop Report form the Meeting held on 5 August 2026	Agenda Item	
Executive/ Non-Executive Lead	Glen Burley, Chief Executive	Report Author(s)	Chelsea Ireland, Foundation Group EA
Report Previously Discussed at and Outcome from the Meeting		N/A	

Purpose of the Report		
The purpose of this report is to provide the Joint Board with an overview of the Foundation Group Boards Workshop meeting held on the 6 May 2026.	For Approval	
	For Discussion	
	For Information	R

Recommendations and Action Required
The Joint Board is asked to receive and note this report.

Impact					
Quality		Research		Workforce	
Equality		Performance	R	Legal	
Finance		Compliance		Carbon/Sustainability	

Relationship to the Board Assurance Framework (BAF) and Risk Register	
Are any existing risks on the BAF/Risk Register affected?	No
Identify the BAF/Risk Register risk ID and description – explain how the risk has been affected – reduced or increased as a consequence of the evidence within the report.	N/A
Do you recommend a new entry to the BAF and/or Risk Register is made as a result of this report? If yes, describe the new risk.	No

Overall Level of Assurance for this Report	
Full Assurance	
Significant Assurance – with minor improvement opportunities	R
Partial Assurance – with improvements required	
No Assurance	

Report to GEH/SWFT Joint Board – 2 September 2026

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

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

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

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

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

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

The latter part of the workshop focused on organisational resilience, culture and future readiness. Boards reviewed the Annual Foundation Group Equality Benchmarking Report, which demonstrated progress in workforce equality and inclusion while recognising ongoing challenges relating to bullying, harassment and the experience of minority staff groups. Cyber security was considered as a significant organisational and patient safety risk, with discussion centred on resilience, assurance arrangements, supplier risk management and the evolving threat landscape. Members also received an update on procurement

transformation, including plans to establish a single Foundation Group procurement function and the implications of the Procurement Act 2023. The workshop concluded with a strategic update covering national NHS developments, future governance reforms, the emergence of NHS Online, prevention priorities and the need to refresh the Foundation Group strategy to reflect an evolving healthcare landscape.

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

Chelsea Ireland
Foundation Group EA

DRAFT

Report to:	Trust Board - Public
Date of Meeting:	8 th September 2026
Title of Report:	Chief Executive Officer's Report
Lead Executive Director:	Chief Executive Officer
Author:	Chief Executive Officer
Reporting Route:	N/A
Enclosures included with this report:	None
Purpose of report:	☐ Assurance ☐ Approval ☒ Information
Brief Description of Report Purpose	
This report provides the Board with an overview of the principal national, regional and local developments since the previous meeting. It sets out the implications for the Trust and the action being taken. Detailed operational performance is reported separately through the Integrated Performance Report. The report is presented for information.	
Recommended Actions required by Board or Committee	
The Board is asked to note the report.	
Executive Director Opinion ¹	
N/A	

1. National Political and Legislative Context

National political leadership changed during the summer. The new Secretary of State for Health and Social Care has identified maternity services and social care reform as immediate priorities. The Health Bill continues its passage through Parliament. Its provisions include the proposed abolition of NHS England, the transfer of functions to the Department of Health and Social Care and Integrated Care Boards, changes to governance arrangements and measures to support a single patient record.

For the Trust, the immediate requirement is continuity of delivery during structural change. National expectations for elective recovery, urgent and emergency care, maternity safety and financial discipline remain in place. The final legislative position and implementation timetable remain uncertain until the Bill completes its parliamentary passage.

The Trust will not make anticipatory governance changes before Royal Assent. Planning will continue on the basis that the core national priorities remain unchanged.

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

2. Maternity and Neonatal Services

The national reviews of maternity services at Nottingham University Hospitals and maternity and neonatal services in England identified recurring concerns about listening to women and families, speaking up, escalation and organisational response. The Government has announced a national maternity and neonatal commissioner. NHS England has also issued a 10 Point Plan of urgent actions for every trust, ahead of a National Action Plan due in December. Under Year 8 of the Maternity Incentive Scheme, assurance rests directly with trust boards following removal of Local Maternity and Neonatal System sign-off.

The findings require the Trust to test not only maternity practice but the wider organisational response to concerns raised by patients, families and staff. Board assurance must be based on evidence of action and impact.

The Chief Nursing Officer and Chief Medical Officer will present a gap analysis against the 10 Point Plan to the Quality Governance Committee during the autumn, followed by a report to the Board. The analysis will identify gaps, owners, timescales and residual risks.

3. Winter 2026/27 and Urgent and Emergency Care

July was reported nationally as the busiest month recorded in Emergency Departments, with 2.49 million attendances in England and 75.4% of patients seen within four hours. NHS England required Integrated Care Boards and providers to complete draft winter plans by the end of August, identify an accountable executive lead and participate in regional stress testing during September. The national expectation is for ambulance handovers within 15 minutes, with none exceeding 45 minutes.

The Trust also experienced its busiest July at the front door. Performance improved, but the principal risk remains the effect of end-to-end flow and capacity constraints on patients, including corridor care and prolonged use of escalation areas. These issues will remain subject to national and regional scrutiny throughout winter.

Our Bed modelling and scheme development are complete. The Chief Operating Officer is the accountable executive lead, and the regional stress test with NHS England Midlands and system partners is scheduled for 10 September. Several schemes depend on affordable transformational change. The winter plan and financial recovery plan will therefore be considered together, with clear evidence of impact, affordability and risk.

4. Elective Care

NHS England published eight minimum standards for patient experience in planned care on 3 July. These cover referral confirmation, communication while waiting, appointment information and rebooking following cancellation. Trust boards must publish a statement during 2026/27 setting out their approach to compliance and repeat this annually. National elective performance weakened over the spring, with 65.8% of patients waiting less than 18 weeks in June against an interim expectation of 70% during 2026/27. Year-long waits increased in every region.

The Trust remains below the England average for the 18-week measure, with further pressure expected from exceptional referral growth. In contrast, 52-week waits reduced month on month and reached the upper quartile nationally. The existing focus on long waits is effective and must be maintained as demand increases.

The Chief Operating Officer will complete a self-assessment against all eight patient experience standards and submit a draft Board statement during the autumn. The statement will set out any gaps, remedial action and delivery dates.

5. Cancer performance

No national cancer waiting time standard was met in the July data. England reported 79.0% against the 28-day Faster Diagnosis Standard, 92.2% against the 31-day standard and 69.9% against the 62-day standard, alongside record referral demand. The Trust is above the England position for diagnosis and below it for 62-day treatment. The principal areas of concern are skin and urology. The performance gap requires continued operational focus and support across organisational boundaries.

Recovery action includes the West Midlands Cancer Alliance programme for urology, mutual aid from Wye Valley Trust and full implementation of teledermatology across every Primary Care Network by the end of September. Delivery and impact will continue to be monitored through the established performance arrangements.

6. Workforce

Resident doctors accepted the Government's pay and conditions offer in June. Mandates for consultants and specialist doctors remain live, and the Agenda for Change review continues. NHS England announced 350 additional postgraduate medical training places on 10 August for starts in February 2027. National NHS staff standards also set expectations for line management, health and wellbeing, violence prevention, sexual safety, tackling racism and flexible working.

For the Trust, the immediate emphasis moves from industrial action contingency to safe implementation, workforce deployment and productivity. Agency use and turnover compare favourably nationally, but establishment growth remains above the planned trajectory. Stress-related absence also requires further examination.

The Chief People Officer and Chief Finance Officer are aligning workforce controls, roster and job-plan assurance, and productivity measures. Reductions must be delivered safely and benefits evidenced. The Trust will also assess its position against the six national staff standards and report gaps and actions through the appropriate committee.

7. Regional Arrangements and Financial Oversight

NHS England Midlands is implementing a revised regional operating model, including winter oversight, stress testing and quarterly executive strategic reviews. NHS Herefordshire and Worcestershire Integrated Care Board is working in a cluster with NHS Coventry and Warwickshire Integrated Care Board, with shared senior leadership and a reduction in running costs. Both remain separate statutory bodies. Provider collaboratives are increasingly taking responsibility for work previously convened by commissioners, including fragile services, community service mapping and shared service models.

The transition may reduce commissioner capacity to convene system work. The Trust will therefore need to take a more active role with Foundation Group and system partners on fragile services, discharge and winter. Financial oversight is also tightening. National deficit support is conditional on in-year delivery, quarter two support has been withheld pending a return to plan, and cash remains dependent on revenue support.

The Trust will prioritise recovery schemes that improve patient flow, workforce deployment and clinical capacity alongside financial performance. System action will be convened directly where required. Financial recovery, quality and operational delivery will be managed as one programme.

8. Cyber Security and Lawful Access To Records

NHS England has asked chairs and chief executives to ensure that boards are assured that cyber security risk is actively managed. The required areas include core controls, access management, unsupported systems and incident recovery. National attention has also focused on unlawful access to patient records.

The Trust must demonstrate effective Board oversight and clear control of access to clinical information. Patient records may be accessed only where there is a current and legitimate work-related reason. Breaches may have legal and professional consequences.

A dedicated cyber security assurance paper will be considered through the Finance and Performance Committee. The requirement for lawful access has been reinforced with all colleagues, and any breach will be managed in line with Trust policy and professional obligations.

9. More From Our Great Teams

- a. The Trust's teams continued to deliver improvements for patients during a period of exceptional demand. At Worcestershire Royal Hospital and the Alexandra Hospital, urgent and emergency care teams improved performance during the busiest July recorded at the Trust's front doors.

b. **A heartfelt thank you to our Interstitial Lung Disease Nursing team**

We get many letters of thanks from our patients or their families, expressing their appreciation of our teams and the care they provide – this recent letter from a patient's daughter captures wonderfully the impact that our teams can have.

'Nancy, Ffion and Lulu,

I wanted to take a moment to say a huge thank you for the care and attention you give my father. From the time spent in the Alexandra Hospital to the phone calls and the in-person appointments the care has been second to none and I think this is based on the following:

- *Treating the patient as a human being, not patronising and listening to what they want and working with that.*
- *Always looking for alternative solutions to either solve a problem or work with my Dad's preferences/resistances.*
- *Taking the time, never feeling rushed.*
- *Taking the time to explain the mechanics of his disease, medication effects, etc. I have learnt something new with every conversation!
It certainly makes it easier for a patient who is older and also probably scared.*
- *Always calling back when you say you will, I have not once had to chase on anything.*
- *Wanting to be kept informed on Dad's progress so you have a holistic view of what is happening to him and jumping in to help when you see it is needed. To realise he needed help after being*
- *ambulanced into hospital again and reaching out to us to make the appointment before I can even get through my to do list is unbelievable. It makes us feel as a family that its not just all on us and that you have him to and you care.*

You are a shining example of exceptional service and care, how a team should work no matter which member we see and what would make the NHS great if we could replicate this across the board.

From the bottom of our hearts, thank you.'

c. **Worcester City Runs**

Good luck to everyone taking on the Worcester City Runs next weekend (Sunday 13 September), especially the 30-plus members of Team Worcestershire Acute who are racing through the historic streets of Worcester while raising money for Worcestershire Acute Hospitals Charity.

Already an incredible £6,993 has already been raised before the runners have even taken to the start line. The funds raised will help enhance hospital life in ways that go above and beyond core NHS services, from bringing comfort to patients and families, to funding innovation and improved care across local hospitals.

Every runner has their own personal reasons for taking part, from hospital staff raising funds for their department to grateful patients wanting to give back for the care they received. Among them, Dr Anna Gregory from Bromsgrove, who is taking on Worcester Half Marathon alongside her husband, Chris, and a team of 17 family members, friends, and colleagues. Together, they are raising funds for Breast Care Services across Worcestershire in gratitude for the care and treatment Anna received during her own breast cancer journey, with a particular focus on enhancing care for patients undergoing chemotherapy.

d. And finally....

We are lucky to have a community of volunteers who are incredibly generous with their time, and who make a real difference every day across our hospitals – but among the most popular are our Therapy Dogs. A surprise presentation was arranged recently for our long serving therapy dog Aero, to mark his ten years (70 years in dog years?) with handler Lesley Fage of providing comfort and a whole heap of joy to our patients, visitors and staff as he looks forward to a well-earned partial retirement. Thank you Aero!



The Board is asked to note the contribution of these teams and the many colleagues across the Trust who continue to hold operational recovery, quality, workforce discipline and financial delivery together. The challenges remain significant, but these examples show what focused teams can achieve when the position is clear and action is sustained.

Chief Executive Officer

8 September 2026

Report to:	Trust Board - Public
Date of Meeting:	8 th September 2026
Title of Report:	Winter Plan Progress Update
Lead Executive Director:	Managing Director
Author:	Deputy Chief Operating Officer
Reporting Route:	N/A
Enclosures included with this report:	Presentation – WAHT Winter Planning Approach
Purpose of report:	☐ Assurance ☐ Approval ☒ Information
Brief Description of Report Purpose	
The presentation, supported by a verbal update, will provide the Board with an overview of progress against Worcestershire Acute Hospitals' 2026/27 Winter Plan. It will outline key milestones and timelines, the approach to plan testing, and give a brief overview of schemes currently being developed and assessed. The key objective of this years plan is to continue to deliver key emergency and urgent care performance standards, reduce average length of stay and minimise the use of corridor care and escalation beds outside of our core bed base, whilst maintaining our elective activity. The update will summarise the key focus areas being progressed through cross care group/system wide schemes to ensure optimal outcomes for our patients and our colleagues.	
Recommended Actions required by Board or Committee	
The Board is asked to take note.	
Executive Director Opinion¹	
N/A	

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

Winter 2026/27

Worcestershire Acute Hospitals NHS Trust
Our approach to winter planning



Our winter intent

Worcestershire Acute Hospitals NHS Trust | Winter 2026/27

● Focus on admission alternatives, work with system partners to provide pathways that keep patient care closer to home

● Support earlier senior clinical decisions

● Improve access to diagnostics for swifter decision making

● Bring the discharge process forward, working with community colleagues and driving hospital at home pathways

● Escalate safely and consistently when there are challenges/delays

Our approach

Worcestershire Acute Hospitals NHS Trust | Winter 2026/27

NAVIGATE

Direct patients to the right service first time. Focussing on admission alternatives

DIAGNOSE

Provide timely diagnostics and specialist review earlier.

ESCALATE

Coordinate Trust and system wide response to pressure, leading to earlier de-escalation and swifter resolution.

DECIDE

Support earlier senior clinical assessment and decisions.

DISCHARGE

Deliver consistent discharge processes and access to recovery pathways.

Cross-cutting enablers

Worcestershire Acute Hospitals NHS Trust | Winter 2026/27

WORKFORCE

Senior decision-makers and flexible staffing models.

TRANSPORT & PORTERING

Reliable and targeted

SYSTEM CAPACITY

Single Point of Access, community alternatives and rapid transfer. Collaborative response across system providers

SEVEN-DAY SERVICES

Therapy, pharmacy, diagnostics, pathology and ward rounds.

Same Day Care, Frailty Pathway

DIGITAL & OPERATIONAL GRIP

Shared information, daily oversight and consistent rhythm.

INFECTION RESILIENCE

Testing, vaccination, cohorting and outbreak response.

Infection prevention and control

Worcestershire Acute Hospitals NHS Trust | Winter 2026/27



Rapid screening and testing



Daily oversight of patient placement and any
cohorting



Robust/simple out-of-hours guidance



Fit testing and reliable PPE availability



System communication and outbreak
management

Staff wellbeing

Worcestershire Acute Hospitals NHS Trust | Winter 2026/27



Accessible occupational health and psychological support



Self-referral



Visible ward-based engagement



Support for physical and financial wellbeing



Manager training to help support our staff during these periods

Key Timelines

Bed Modelling complete and draft Plan submitted to ICS and NHSE	27th August 2026
Internal executive discussion/review process	2nd September
2026	
Winter plan stress test – system-wide/ICS	3rd September 2026
Winter plan stress test – Regional/NHSE	10th September
2026	

The Winter Plan contains a number of schemes. Schemes will be discussed internally and prioritised.

Prioritisation will focus on:

- 1) Impact
- 2) Outcomes for patients
- 3) Cost effectiveness Vs outcome

Any stress test exercise will be attended by clinical and non clinical colleagues, to work through assumptions prior to finalisation and approval of the full plan by ICS and NHSE. The exercise was undertaken in 2025 successfully and provides further opportunity to explore additional mitigations across the system, collaboratively.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	September 2026
Title of Report:	Green Plan Delivery Update, Strategic Assurance and Future Delivery Model
Lead Executive Director:	Julian Berlet, Chief Clinical Strategy Officer / Board-level Net Zero Lead
Author:	Ollie Schoolcraft, PMO Lead, Green and Sustainability Programme
Reporting Route:	Green Steering Group
Enclosures included with this report:	Appendix 1: Green Plan Workstream Delivery Assessment
Purpose of report:	☒ Assurance ☒ Approval ☐ Information
Brief Description of Report Purpose	
This report provides assurance on delivery against the Trust Green Plan 2025–28, summarises progress and challenges over the previous 12 months, and seeks Board direction on the future priority, investment principles and delivery model required to achieve the Trust’s sustainability ambitions and NHS Net Zero commitments. The paper assesses the current position against the nine Green Plan workstreams, describes the programme reset now being led through the PMO, and outlines options for addressing capacity and specialist capability gaps. It also explains the development of a 12-month delivery plan for the nine workstreams and Care Groups, providing clearer ownership, milestones, reporting and escalation through the Green Steering Group.	
Recommended Actions required by Board or Committee	
The Board is asked to: - Note the current position and provisional assessment of delivery against the nine Green Plan workstreams. - Note the programme stocktake and support completion of the 12-month delivery plan for workstreams and Care Groups. - Reaffirm that achievement of the Green Plan remains a strategic Trust priority. - Support the principle that proportionate investment may be required to secure the capacity, specialist capability and enabling schemes needed to deliver measurable carbon reduction. - Confirm whether carbon-reduction proposals should be considered only where they deliver a direct financial saving, or against broader benefits including statutory alignment, resilience, quality, population health, social value and avoided future cost. - Support the recommendation for the future delivery model of the Green Plan, including the opportunity to recruit an experienced Sustainability Manager employed by the Trust or collaboratively with partner organisations, alongside selective use of specialist external support.	
Executive Director Opinion¹	
The Trust has the foundations required to rebuild delivery, including Executive sponsorship, PMO leadership, clinical leadership, Estates and Facilities expertise and a keen and enthusiastic workforce. Wards and departments	

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

have also developed their own “Green House” pledges, selecting three of the nine Green Plan workstreams and identifying practical commitments intended to drive local change, improvement and efficiency.

Following leadership changes and a period of reduced momentum, the current priority is to re-establish the programme as a coherent and accountable delivery system. The PMO Lead has completed a stocktake and is coordinating a refresh of programme governance and delivery arrangements. The resulting 12-month delivery plan will translate the strategic Green Plan into practical commitments for the nine workstreams and Care Groups, with clearer accountability and escalation through the Green Steering Group.

However, specialist capability for carbon accounting, sustainable travel planning, technical decarbonisation, investment appraisal, benefits quantification and access to external funding is not fully available within the current team. There is an opportunity to address this across partner organisations with appropriate investment principles and an agreed delivery model.

Green Plan Delivery Update, Strategic Assurance and Future Delivery Model

Introduction / Background

The Trust Green Plan Refresh 2025–28 was published in June 2025 and supports the Foundation Group ambition to “Lead the NHS on carbon reduction”. It sets out nine workstreams: Workforce and Leadership; Adaptation; Medicines; Supply Chain and Procurement; Net Zero Clinical Transformation; Food and Nutrition; Digital Transformation; Travel and Transport; and Estates and Facilities. Clinical Divisions and Care Groups form a cross-cutting route for local delivery.

The Trust Annual Report 2025/26 describes governance through the Board-level Net Zero Lead and Green Steering Group and reports total emissions of 14,397 tCO₂e for 2024/25, a 4.6% reduction compared with the 2021/22 baseline. Progress remains behind expectations for NHS England Net Zero targets, and the carbon report is incomplete for important Scope 3 sources, including procurement and staff and patient commuting.

Over the previous 12 months there have been changes in programme leadership and a loss of momentum. Executive SRO arrangements and dedicated PMO support are now in place. A programme stocktake has identified activity across the Trust but also confirmed fragmented delivery, limited visibility of Care Group plans through central governance, and workstream commitments that require translation into actionable deliverables.

The PMO Lead is therefore leading a refresh and the creation of a 12-month delivery plan for the nine workstreams and Care Groups. The plan will sit underneath the three-year Green Plan, link staff-led ideas with clinical, operational and support-service capability, clarify accountable owners and milestones, and provide routine escalation through the Green Steering Group.

1. Delivery against the Green Plan

Appendix 1 provides a provisional PMO desk-based assessment against the commitments and key performance indicators in each workstream. It draws on the Green Plan Refresh 2025–28, the Trust Annual Report 2025/26, the programme stocktake and workload material, and examples of activity identified through available programme documentation. It is not a validated performance return from accountable workstream leads.

Current evidence indicates that overall progress against the nine workstream plans has been limited, fragmented and insufficiently evidenced. There are examples of completed or ongoing activity, including medicines and anaesthetic-gas initiatives, local staff engagement and individual Estates and Facilities

schemes. However, these examples do not demonstrate delivery of the full workstream commitments or achievement of the stated quantitative KPIs.

The main assurance gaps are incomplete or unvalidated KPI baselines, limited quantification of carbon and financial benefits, inconsistent workstream reporting, incomplete Scope 3 information, unclear ownership and gaps in specialist sustainability capability. The provisional RAG ratings in Appendix 1 reflect the strength of evidence currently available and require validation through the 12-month delivery planning process.

2. Progress and change during the previous 12 months

- Leadership transition contributed to a period of reduced programme momentum and continuity.
- Executive SRO arrangements and dedicated PMO support have now been established.
- A comprehensive stocktake has consolidated projects, actions, business-as-usual activity and opportunities.
- The PMO Lead is refreshing governance and developing the 12-month delivery plan for the nine workstreams and Care Groups.
- The Green Champions Network continues to demonstrate a keen and enthusiastic workforce and provides an important route for staff ideas and participation.
- Wards and departments have developed local “Green House” pledges focused on three of the nine workstreams. The next phase must connect these pledges to relevant workstream leads, Care Group plans, enabling services, measures and governance.
- Clinical sustainability leadership continues to support medicines, anaesthetic-gas and greener-care initiatives.
- Estates and Facilities continue to support major energy, waste, infrastructure and travel-related priorities.
- Reported achievements include elimination of desflurane, completion of nitrous oxide manifold decommissioning, LED programmes, boiler refurbishment and approval of theatre-ventilation optimisation.

3. Current delivery strengths and capability gap

The programme benefits from enthusiastic staff, Executive sponsorship, dedicated PMO leadership, an active Clinical Sustainability Lead and support from Estates and Facilities. The Green Champions Network and locally developed Green House pledges provide important routes for frontline participation and improvement ideas. These strengths represent delivery potential rather than evidence that the nine workstream plans are currently on track.

The Trust requires access to expertise in carbon accounting, travel planning, technical decarbonisation, benefits measurement, business-case development and external funding. Addressing this gap is necessary to reduce reliance on repeated professional consultancy commissions and retain organisational knowledge.

4. Future delivery options

Option 1: Continue with current arrangements

Maintain delivery through the Executive SRO, PMO Lead, Clinical Sustainability Lead, Estates and Facilities, workstream leads and Green Champions.

Benefits: No additional recurrent post and minimal immediate cost.

Risks and implications: Specialist gaps remain; progress continues to depend heavily on existing capacity and goodwill; accountability for technical delivery may remain dispersed.

Option 2: Commission specialist support for defined products

Procure targeted external expertise for requirements such as the Green Travel Plan, carbon accounting, technical assessments, funding submissions or decarbonisation plans.

Benefits: Rapid access to particular expertise and clear time-limited outputs.

Risks and implications: Potentially high or repeated consultancy cost; knowledge and capability may remain external; separate commissions may not create whole-programme ownership.

Option 3: Establish experienced sustainability-management capacity

Employ an experienced Sustainability Manager wholly within the Trust or collaboratively with Foundation Group, system or other public-sector partners.

Benefits: Builds retained expertise, long-term ownership and coordination across all workstreams; can reduce reliance on outsourced professional services.

Risks and implications: Requires recurrent funding, a clear role specification and agreement on organisational authority and shared arrangements if jointly appointed.

Option 4: Hybrid model- *Recommended option*

Establish sustainability-management capacity (as above, internally or in collaboration with partners) and commission only highly specialist technical products where required.

Benefits: Balances retained organisational capability with access to specialist skills and is likely to provide the strongest whole-programme continuity.

Risks and implications: Requires recurrent investment plus controlled external expenditure and clear commissioning priorities.

5. Strategic assurance required

Decision area	Assurance or direction requested
Trust priority	Does the Board reaffirm achievement of the Green Plan and the Trust's carbon-reduction commitments as a strategic priority?
Support for delivery costs	Does the Board support proportionate investment in capacity, technical capability and enabling schemes where required to drive measurable CO2 reduction?
Basis for prioritisation	Should carbon-reduction activity proceed only where it generates a direct cost saving, or should decisions also recognise wider statutory, resilience, quality, health, social-value and avoided-cost benefits?
Future delivery model	Does the Board support further development of the preferred delivery model, including dedicated sustainability-management capacity and selective specialist commissioning?

Conclusion

The Trust has a published three-year Green Plan, an engaged workforce and examples of completed or ongoing sustainability activity. However, the current assessment indicates that progress against the nine workstream plans has been limited, fragmented and insufficiently evidenced. The principal challenge is to connect Green House pledges, staff-led initiatives, Care Group priorities, clinical transformation and corporate support services within a single accountable delivery system, while ensuring that activity is measured against the commitments and KPIs in the Green Plan.

The PMO-led refresh and 12-month delivery plan will provide the structure needed to turn strategic commitments into measurable actions, assign ownership and enable reporting and escalation through the Green Steering Group. We believe that will provide the right conditions internally to help deliver progress against our Green Plan.

In the current context of significant work going on across the organisation to improve both operational and financial performance, Board opinion is now invited on the principles with which to progress delivery of the Green Plan and support requested for the recommended option of creating a hybrid model of internal capacity along with cross-organisational expertise.

DRAFT

Appendix 1: Green Plan Workstream Delivery Assessment

Provisional programme assessment pending validation through the 12-month delivery planning process

This appendix is an initial PMO desk-based assessment prepared from the Green Plan Refresh 2025–28, the Trust Annual Report 2025/26, the programme stocktake and workload material, and examples of activity available through programme documentation. It has not yet been validated by accountable workstream leads. The RAG ratings indicate the current strength of evidence against each workstream’s stated commitments and KPIs; they do not represent a confirmed performance return.

DRAFT

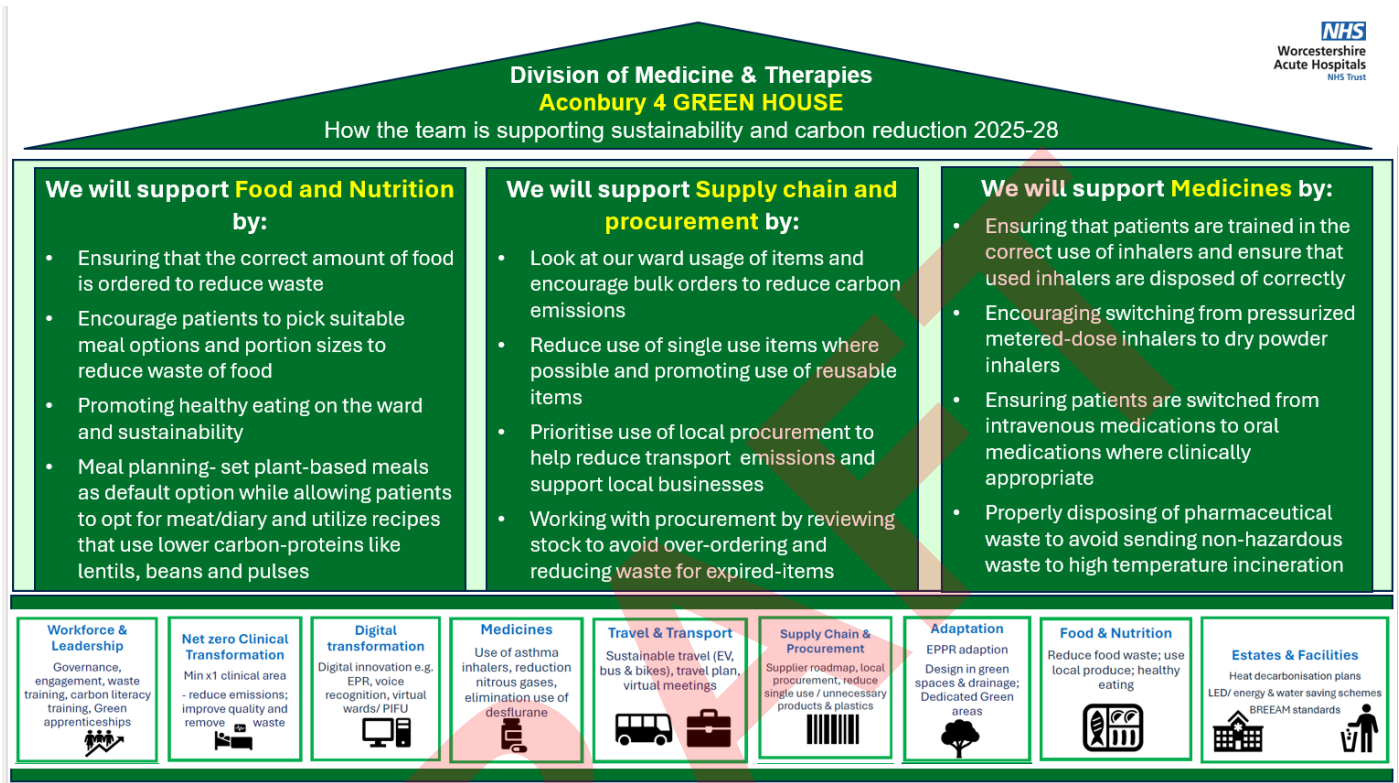
ASSESSMENT SCOPE: Review of delivery and progress over the last 12 months against the “We will” commitments in the Green Plan Refresh 2025–28, to identify gaps and agree a measurable 12-month delivery plan.

RAG: Green = evidence and plan substantially in place; Amber = evidence available but plan, measures, ownership or assurance require confirmation; Red = significant known gaps with no credible agreed route; Not assessed = insufficient evidence pending review with the lead. All ratings remain provisional until validated with accountable workstream leads.

Workstream	Plan lead	Delivery and progress	Outstanding actions / assurance	RAG
1. Workforce and Leadership	Deputy Chief People Officer	Leadership, governance groups, Green Hub, waste e-learning and Carbon Literacy activity are in place. A stocktake has been completed.	Confirm capacity, ownership, dashboard, risk register, training targets and Sustainability Impact Assessment delivery. Lead to confirm focus actions for the next 12 months.	Amber
2. Adaptation	Head of EPRR	Weather protocols, staff alerts and climate-risk arrangements are reported. Other commitments are not yet validated.	Validate the adaptation plan, exercises, cooling assessments and capital-scheme integration. Lead to confirm focus actions for the next 12 months.	Not assessed
3. Medicines	Lead Pharmacist	Nitrous oxide is complete; MDI, ethyl chloride and plastic reduction remain active, with measures and reporting proposed.	Agree priorities, measures and owners; close completed commitments and reset weaker measures.	Green
4. Supply Chain and Procurement	Director of Procurement	Sustainability standards, inventory management, remanufacturing and recycled-paper activity are reported.	Validate supplier performance, inventory rollout and reductions in single use, packaging, waste, cost and carbon. Lead to confirm focus actions for the next 12 months.	Amber
5. Net Zero Clinical Transformation	Clinical Sustainability Lead	Clinical lead and subgroup are in place; gas reduction and greener-pathway activity have progressed.	Confirm subgroup delivery, two to three pathways and measures. Lead to confirm focus actions for the next 12 months.	Amber / Green
6. Food and Nutrition	Director of Estates and Facilities	Healthy and sustainable food activity, reduced single-use items and initial waste measurement are reported.	Validate electronic menus, healthier options and food-waste reduction. Lead to confirm focus actions for the next 12 months.	Amber
7. Digital Transformation	Chief Technology Officer	EPR, patient portal, digital infrastructure and supplier activity support reduced paper, travel and energy use.	Confirm delivery status, owners and measures for paper, travel, energy and environmental benefits. Lead to confirm focus actions for the next 12 months.	Amber
8. Travel and Transport	Director of Estates and Facilities	Beryl Bikes, flexible working and community transport are active; progress on the travel plan, fleet and emissions is unclear.	Validate the travel plan, fleet, EV, courier and commuting commitments. Lead to confirm focus actions for the next 12 months.	Amber / Red
9. Estates and Facilities	Director of Estates and Facilities	LED, boiler, energy and infrastructure schemes have progressed, but delivery against all plan commitments is not consolidated.	Complete the gap analysis; confirm measures, funding, governance and Care Group reporting. Lead to confirm focus actions for the next 12 months.	Amber / Red

Cross-cutting delivery through Care Groups and Clinical Divisions

Wards and departments have developed local “Green House” pledges, with participating areas selecting three of the nine Green Plan workstreams and identifying practical commitments to drive change, improvement and efficiency. The 12-month delivery plan should join the dots between frontline commitments, Care Group priorities and formal workstream plans. Each pledge should be mapped to the relevant workstream, supported by an accountable owner, linked to appropriate corporate or technical expertise, and accompanied by proportionate measures, timescales and escalation routes.



Overall assurance assessment

The available evidence shows activity across the nine workstreams, but overall delivery against the Green Plan is currently limited, fragmented and insufficiently evidenced. The most material assurance gaps are inconsistent KPI baselines, limited measurement of carbon and financial benefits, incomplete Scope 3 information, fragmented accountability, unclear status across a substantial number of actions and specialist capability gaps. This appendix should remain explicitly provisional until accountable workstream leads have validated the evidence, confirmed the RAG ratings and agreed the 12-month delivery plan.

Source documents

- Green Plan Refresh 2025–28, Worcestershire Acute Hospitals NHS Trust, June 2025.
- Trust Annual Report 2025/26, Environmental Matters and TCFD extract supplied for this paper.
- Green Programme stocktake and PMO workload material, July–August 2026.

Worcestershire Acute Hospitals NHS Trust
Trust Key Performance Indicators (KPIs) - up to Jun-26 data

Performance Against Target (Status)

Meeting Target

Not Meeting Target

Activity Performance Only

Over 5% above Target

5% above to 2% below Target

More than 2% below Target to 5% below Target

Over 5% below Target

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

Example

Data Quality Assurance Questions

S - Sign Off and Validation

Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?

T - Timely & Complete

Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?

A - Audit & Accuracy

Are there processes in place for either external or internal audits of the data and how often do these occur (Internal / Out Only)?

R - Robust Systems & Data Capture

Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Overall QR Rating Key

No Assurance

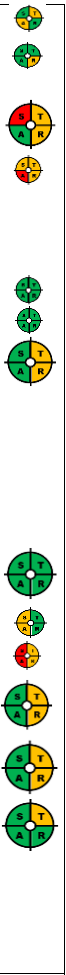
Limited Assurance

Reasonable Assurance

Substantial Assurance

Quality of care, access and outcomes																				Responsible Director		Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Latest Month		Year to Date (v Standard if available)	Latest Available Monthly Position			SPCs		DQ Mark			
																																							Numerator	Denominator			Latest month v benchmark	National or Regional	Pass / Fail	Trend Variation				
Cancer	% of patients told their cancer diagnosis outcome within 28 days (all routes) *NHSE NOF*																			Chief Operating Officer	80%	74.6%	70.0%	75.4%	77.2%	75.9%	74.0%	80.1%	80.4%	75.8%	63.7%	77.2%	72.2%	75.4%	82.3%	83.1%		2,309	2,779	80.2%										
	% of patients receiving their first or subsequent treatment for cancer within 31 days of decision to treat / earliest clinically appropriate date (all routes)																			Chief Operating Officer	96%	87.4%	84.7%	84.4%	79.6%	83.3%	80.8%	83.3%	85.8%	87.3%	82.9%	89.1%	83.1%	84.1%	84.9%	86.4%		475	550	85.1%										
	% of patients receiving their first definitive treatment for cancer within 62 days of referral (all routes) *NHSE NOF*																			Chief Operating Officer	75%	64.5%	57.4%	58.5%	57.3%	65.1%	54.5%	60.2%	61.1%	66.5%	58.4%	57.3%	57.2%	51.8%	44.0%	57.0%		206	362	51.2%										
	% of suspected cancer referrals waiting >62 days																			Chief Operating Officer	Plan	8.6%	10.3%	9.8%	9.8%	11.5%	9.1%	10.4%	9.3%	12.1%	12.2%	11.8%	10.9%	11.1%	13.1%	13.0%	12.1%													
Urgent and Emergency Care	% of ambulance handovers within 45 minutes																			Chief Operating Officer	100%	65.9%	71.7%	80.8%	84.2%	81.4%	65.8%	65.2%	74.8%	72.7%	59.6%	75.1%	83.4%	87.1%	86.4%	79.3%	79.4%		3,237	4,076	83.1%									
	% of patients seen within 4 hours (any type) *NHSE NOF*																			Chief Operating Officer	76%	60.9%	65.1%	66.1%	66.5%	64.5%	63.0%	62.4%	62.7%	59.9%	62.9%	67.1%	71.5%	69.6%	71.9%	68.5%	69.3%		15,483	22,353	69.8%									
	% of patients seen within 4 hours (type 1)																			Chief Operating Officer		44.5%	49.3%	50.9%	50.8%	49.5%	47.7%	48.0%	49.1%	47.1%	49.4%	54.8%	59.6%	56.6%	60.1%	55.4%	55.7%		8,541	15,327	57.0%									
	% of patients spending more than 12 hours in A&E *NHSE NOF*																			Chief Operating Officer		13.0%	10.8%	10.1%	8.9%	10.3%	12.3%	12.9%	11.9%	12.3%	13.2%	10.7%	7.5%	11.6%	11.6%	13.5%	12.3%		1,889	15,371	12.3%									
Elective care	Referral to Treatment - % of open pathways waiting < 18 weeks *NHSE NOF*																			Chief Operating Officer	92%	59.3%	59.8%	59.9%	59.1%	58.5%	59.3%	58.9%	57.5%	57.9%	57.3%	58.7%	62.6%	62.3%	62.5%	62.9%	61.7%		36,375	58,986										
	Referral to Treatment - % of non-admitted pathways waiting < 18 weeks for their first outpatient appointment																			Chief Operating Officer	72%	63.1%	63.1%	62.2%	59.1%	58.5%	58.8%	58.4%	57.4%	57.5%	58.8%	60.7%	65.6%	67.6%	67.2%	66.3%	65.1%													
	Referral to Treatment - % of open pathways waiting > 52 weeks *NHSE NOF*																			Chief Operating Officer	0%	1.65%	1.66%	1.72%	1.66%	1.57%	1.49%	1.51%	1.34%	1.24%	1.32%	1.42%	1.37%	1.45%	1.37%	1.04%	0.99%		575	58,986										
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List																			Chief Operating Officer	0	21	24	22	18	18	25	47	22	5	4	4	6	5	8	3	4													
	Outpatient Activity - New attendances (volume v plan)																			Chief Operating Officer	Plan	104%	105%	105%	100%	95%	100%	97%	106%	98%	107%	104%	117%	104%	100%	101%	98%		23,777	24,292	101%									
	Total Outpatient Activity (volume v plan)																			Chief Operating Officer	Plan	107%	106%	105%	103%	97%	102%	100%	105%	97%	107%	102%	113%	107%	102%	101%	100%		69,079	69,051	2%									
	Total Elective Activity (volume v plan)																			Chief Operating Officer	Plan	106%	108%	98%	98%	98%	96%	97%	100%	95%	101%	97%	104%	102%	109%	105%	101%		9,200	9,087	104%									
	Elective - Theatre utilisation (%) - Capped																			Chief Operating Officer	85%	83%	84%	84%	83%	83%	83%	82%	84%	81%	84%	85%	85%	87%	86%	86%	86%				86%		82%	May-26						
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)																			Chief Operating Officer		40	37	55	50	21	46	32	36	50	40	61	42	44	44	65	37				190		22,029	Q1 26/27						
Waiting Times - Diagnostic Waits >6 weeks *NHSE NOF*																			Chief Operating Officer	<15%	16.8%	16.2%	21.0%	24.9%	26.4%	24.9%	28.1%	27.4%	29.6%	27.6%	21.7%	24.5%	27.6%	29.5%	28.6%	30.6%		4,906	16,026											
Maternity	% of women who have been booked to see a midwife by 9 weeks and 6 days of pregnancy																			Chief Nursing Officer	90%	37%	37%	42%	47%	42%	49%	54%	55%	56%	50%	66%	65%	66%	66%	64%	67%		345	514	66%									
	Rate of pregnant women with a delayed planned induction per 1,000 deliveries *NHSE NOF*																			Chief Nursing Officer														1.8		10.7														
	Maternity Activity (Deliveries)																			Chief Nursing Officer		384	403	420	432	419	450	441	373	402	372	388	383	374	412	389	413				1,588									
Outpatient transformation	Missed outpatient appointments (DNAs) rate																			Chief Operating Officer	<4%	4.5%	4.7%	5.0%	5.2%	4.9%	5.1%	5.2%	4.8%	5.0%	5.1%	4.6%	4.5%	4.6%	4.8%	4.8%	4.9%		3,461	70,777	4.8%									
	Outpatient - % OPD Slot Utilisation (All slot types)																			Chief Operating Officer	90%	89%	90%	90%	89%	89%	89%	89%	90%	88%	88%	90%	90%	90%	89%	90%	89.5%		38,472	42,974	90%									
	Outpatient Activity - Follow Up attendances (volume v plan)																			Chief Operating Officer	Plan	109%	108%	105%	105%	98%	103%	102%	104%	97%	107%	101%	111%	108%	104%	101%	101%		45,302	44,759	103%									
	Outpatients Activity - Virtual Total (% of total OP activity)																			Chief Operating Officer	25%	18%	18%	17%	17%	18%	18%	18%	18%	19%	19%	18%	18%	18%	19%	18%	19%		12,905	68,955	19%									
Prevention long term conditions	% of inpatients making a supported quit attempt with an in house tobacco dependence treatment service *NHSE NOF*																			Chief Nursing Officer				32.7%			28.8%			24.0%			23.4%			TBC		750	3,200											
	Maternity - Women who were smokers at time of delivery (SATOD)																			Chief Nursing Officer		3.9%	6.5%	5.7%	4.4%	5.0%	4.4%	4.1%	4.0%	3.2%	3.5%	2.1%	2.3%	4.5%	4.6%	3.1%	4.4%		18	413	4.2%									

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	<92%	96%	96%	95%	94%	93%	94%	94.5%	94.6%	93.4%	96.3%	95.5%	95.3%	95.0%	94.7%	96.2%	96.3%	774	804	96%			95%	Jun-26					
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	0	55	62	46	60	52	55	53	56	61	58	38	64	50	50	50	52			202			4,935	Jun-26					
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	4.5	7.71	7.40	7.33	7.02	6.73	7.09	7.24	6.93	6.58	6.88	7.11	7.01	7.12	6.62	6.61	6.83	22290	3263	6.8			4.4	Feb to Jan					
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	2.5	3.1	3.1	3.3	2.5	3.6	3.4	3.16	3.7	3.63	3.29	3.84	3.4	3.96	3.9	4.04	3.60	1877	521	3.88			3.1	Feb to Jan					
	Medically fit for discharge - Acute	Chief Operating Officer	5%	12%	14%	16%	15%	15%	12%	12%	12%	11%	14%	16%	16%	15%	15%	14%	15%	117	773	15%			23.1%	Dec					
	% of patients to acquire a new grade 3 or 4 pressure ulcer *NHSE NOF*	Chief Nursing Officer		Placeholder - to be updated after publication of Q1 26/27 NOF																											
	Number of patients cared for in corridors (ED only) *NHSE NOF*	Chief Nursing Officer															1,723	1,895	2,041			5,659									
	30 day readmission rate band *NHSE NOF*	Chief Medical Officer		Most recent publication of banding is 24/25. WAHT had a rate of 13.3 and a banding of B1 (Significantly lower than the national average at the 99.8% level)																											
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	5%	4.65%	4.87%	4.62%	4.73%	4.67%	4.69%	4.44%	4.84%	4.86%	5.01%	4.84%	6.73%	7.32%	7.19%	6.70%	6.22%	650	10450	6.9%			14.7%	24/25					
	Mortality SHMI - Rolling 12 months *NHSE NOF*	Chief Medical Officer	100	110.71	110.55	111.77	111.51	111.51	112.19	111.00	110.04	107.99	108.05	107.75										As expected							
	Number of MRSA Bacteraemia cases *NHSE NOF*	Chief Nursing Officer	0	1	0	0	1	1	2	0	0	0	0	0	0	0	0	0	1			1									
	Number of E-Coli cases	Chief Nursing Officer	102	6	4	6	3	4	5	15	14	12	8	7	10	7	7	13	10			37									
	Rate of E-Coli *NHSE NOF*	Chief Nursing Officer		0.96			1.01			1.06			1.11			TBC															
	Number of external reportable >AD+1 clostridium difficile cases	Chief Nursing Officer	102	4	8	11	10	11	14	12	8	14	5	10	8	9	8	6	9			30									
	Rate of c-difficile *NHSE NOF*	Chief Nursing Officer		1.01			0.93			0.83			0.88			TBC															
	Rate of inpatient falls that cause harm (Hip Fracture only) *NHSE NOF*	Chief Nursing Officer		Placeholder - to be updated after publication of Q1 26/27 NOF																											
	% of safety incidents resulting in harm * NHSE NOF*	Chief Nursing Officer		Placeholder - to be updated after publication of Q1 26/27 NOF																											
	Number of falls with moderate harm and above	Chief Nursing Officer		3	4	4	4	3	4	1	1	1	2	5	4	4	4	7	3			18									
	VTE Risk Assessments	Chief Medical Officer	95%	91%	91%	91%	91%	92%	93%	93%	91%	92%	93%	94%	94%	93%	92%	95%	96%	12,640	13,151	94%									
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	80%	47.5%	57.1%	57.9%	65.2%	67.3%	77.8%	62.5%	68.7%	66.7%	79.0%	68.3%	48.1%	81.1%	68.8%	60.9%	65.5%	29	19	69%									
	Complaints resolved within policy timeframe	Chief Nursing Officer	85%	64%	69%	78%	54%	79%	67%	63%	65%	64%	56%	64%	63%	57%	73%	65%	67%	68	102	66%									
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	95%	84%	81%	85%	84%	80%	80%	82%	81%	82%	84%	93%	89%	85%	87%	84%	82%	4,465	5,467	84%			79%	May-26					
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	95%	96%	96%	96%	96%	95%	96%	97%	95%	95%	96%	94%	94%	94%	94%	93%	95%	9,261	9,756	94%			95%						
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	95%	98%	93%	96%	97%	96%	97%	94%	94%	95%	97%	95%	97%	96%	92%	97%	96%	151	157	95%			92%						
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	20%	13%	25%	16%	24%	19%	18%	16%	15%	12%	17%	16%	21%	18%	17%	17%	32%	5,467	17,134	21%									
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	30%	32%	36%	35%	36%	31%	31%	38%	33%	32%	23%	37%	55%	53%	52%	52%	74%	9,756	13,204	58%									
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	30%	26%	21%	11%	23%	18%	14%	14%	17%	10%	11%	18%	18%	10%	11%	13%	17%	157	934	13.0%									
	CQC inpatient survey satisfaction rate * NHSE NOF*	Chief Nursing Officer		From Adult Inpatient Survey 2024 - 2.00 (somewhat better than expected or as expected)																											
	NHS staff survey advocacy rate *NHSE NOF*	Chief Nursing Officer		6.60 (2025)																											
	NHS Staff Survey raising concerns sub-score *NHSE NOF*	Chief Nursing Officer		6.47 (2025)																											
	Breadth and depth of clinical audit outliers * NHSE NOF*	Chief Nursing Officer		Placeholder - to be updated after publication of Q1 26/27 NOF																											



People		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Latest Month		Year to Date	Latest Available Monthly Position			SPCs		DQ Mark
																				Numerator	Denominator		Latest month v benchmark	National or Regional	Pass / Fail	Trend Variation		
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	6%	6.6%	4.8%	5.3%	4.6%	3.2%	4.6%	3.6%	4.1%	2.9%	3.4%	2.9%	1.6%	2.4%	2.7%	2.9%	2.7%			2.7%						
	Appraisals - Non-medical	Chief People Officer	90%	83.0%	84.0%	84.0%	83.0%	82.0%	82.0%	83.0%	84.0%	85.0%	84.0%	83.0%	83.0%	84.0%	83.0%	83.0%	83.0%	6,614	5,527	83.3%						
	Appraisals - Medical	Chief People Officer	90%	96.0%	96.0%	94.0%	94.0%	94.0%	93.0%	96.0%	95.0%	96.0%	94.0%	94.0%	94.0%	92.0%	93.0%	91.0%	92.0%	646	593	92.0%						
	Mandatory Training	Chief People Officer	90%	90.0%	90.0%	91.0%	91.0%	90.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	89.0%	90.0%	83.0%	87.0%	87.0%	78,629	90,517	86.8%						
	Sickness absence rate *NHSE NOF*	Chief People Officer	4.5%	5.1%	4.8%	4.7%	5.2%	5.5%	5.5%	5.7%	5.6%	5.9%	5.8%	5.7%	5.4%	5.0%	4.9%	5.3%	5.6%	12,665	224,837	5.2%						
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	12%	9.0%	8.9%	8.6%	8.4%	8.1%	8.0%	7.9%	8.1%	7.7%	7.5%	7.5%	7.4%	7.6%	7.5%	7.4%	7.6%	493	6,533	7.5%						
	Vacancy Rate	Chief People Officer	8%	7.2%	7.4%	7.3%	7.6%	7.1%	6.8%	6.2%	6.6%	6.6%	6.9%	6.7%	6.5%	7.3%	8.1%	7.8%	7.8%	616	7,262	7.7%						
	NHS staff survey engagement theme score *NHSE NOF*	Chief People Officer		6.84 (2025)																								
	National education and training survey satisfaction rate *NHSE NOF*	Chief People Officer		76.74% (2025)																								
	NHS staff standards score *NHSE NOF*	Chief People Officer		Placeholder - to be updated after publication of Q1 26/27 NOF																								
	Healthcare worker flu vaccination rate *NHSE NOF*	Chief People Officer									42.6%																	
	Temporary staffing cost relative band *NHSE NOF*	Chief People Officer		Placeholder - to be updated after publication of Q1 26/27 NOF																								

Finance and Use of Resources																				Latest Month		Year to Date	Latest Available Monthly Position		SPCs		DQ Mark
																				Numerator	Denominator		Latest month v benchmark	Latest month v benchmark	Pass/Fail	Trend Variation	
	I&E - Surplus/(Deficit) (£k) *NHSE NOF*	Chief Finance Officer	≥0	-£3,631	-£3,063	-£2,149	-£339	-£2,292	-£745	£2,773	-£4,741	-£2,037	-£6,266	£3,417	£7,056	-£2,695	-£4,563	-£2,097	£5,626	£25,530							
	I&E - Margin (%)	Chief Finance Officer	≥0%	-5.7%	-4.8%	-3.3%	-0.5%	-3.6%	-1.1%	-5.7%	-7.2%	-3.0%	-9.9%	4.8%	7.0%	-3.9%	-6.8%	-3.0%	-8.4%	-9.4%							
	I&E - Variance from plan (£k)	Chief Finance Officer	≥0	-£221	-£68	£141	£199	-£40	£23	-£12	-£6,148	-£3,559	-£8,366	£1,725	£4,310	£630	£1,028	-£505	£2,176	£4,338							
	I&E - Variance from Plan (%) *NHSE NOF*	Chief Finance Officer	≥0%	6.0%	2.0%	-6.0%	-38.0%	2.0%	-3.0%	0.0%	-437.0%	-234.0%	-398.0%	102.0%	157.0%	31.0%	29.0%	32.0%	63.0%	20.0%							
	CPIP - Variance from plan (£k)	Chief Finance Officer	≥0	-£593	£147	-£152	-£563	-£2,833	-£489	£2,346	-£4,574	-£4,190	-£4,411	-£2,654	£1,404	£591	£770	-£373	£1,456	£3,193							
	Agency - expenditure (£k)	Chief Finance Officer	N/A	-£2,294	-£1,983	-£2,215	-£1,988	-£1,275	-£1,404	-£1,501	-£1,825	-£1,234	-£1,460	-£1,186	£1,186	£1,043	£1,173	-£1,272	£1,193	£4,682							
	Agency - expenditure as % of total pay	Chief Finance Officer	N/A	5.5%	4.8%	5.3%	4.6%	3.2%	3.4%	3.6%	4.2%	2.9%	3.4%	2.8%	1.6%	2.4%	2.7%	2.9%	2.7%	2.7%							
	Capital - Variance to plan (£k)	Chief Finance Officer	≥0	£664	£328	-£378	£1,420	£11	£1,489	-£1,204	-£2,069	-£2,122	-£1,544	-£991	£4,866	-£3,612	-£3,063	-£2,448	£2,028								
	Cash - Balance at end of month (£m)	Chief Finance Officer	As Per Plan	£21.887m	£21.443m	£17.673m	£18.698m	£15.859m	£6.160m	£6.39m	£4.638m	£4.478m	£10.678m	£10.143m	£7.388m	£4	£15	£2	£3								
	BPCC - Invoices paid <30 days (% value £k)	Chief Finance Officer	≥95%	92%	94%	94%	92%	90%	91%	90%	98%	90%	82%	75%	72%	79%	62%	48%	57%								
	BPCC - Invoices paid <30 days (% volume)	Chief Finance Officer	≥95%	91%	94%	91%	82%	90%	92%	94%	96%	89%	83%	71%	67%	60%	47%	49%	53%								
	Relative cost difference (National Cost Collection Index) *NHSE NOF*		Chief Finance Officer		103.5 (24/25 publication)																						

Productivity and Innovation																				Latest Month		Year to Date	Latest Available Monthly Position		SPCs	
		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Numerator	Denominator		Latest month v benchmark	Latest month v benchmark	Pass / Fail	Trend Variation
Productivity Innovation	Implied productivity growth *NHSE NOF*		Chief Finance Office	Placeholder - to be updated after publication of Q1 26/27 NOF																						
	% of clinical trials set up within 90 days *NHSE NOF*		Chief Medical Officer														100%									
	Data Quality Maturity Index *NHSE NOF*		Chief Digital Officer		94.2%	94.8%	95.0%	94.9%	96.2%	96.2%	96.0%	95.8%	96.1%	95.1%	95.0%	95.1%	96.2%									