

3. Expectation 1: Right Staff

3.2 Safety performance metrics

Narrative

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



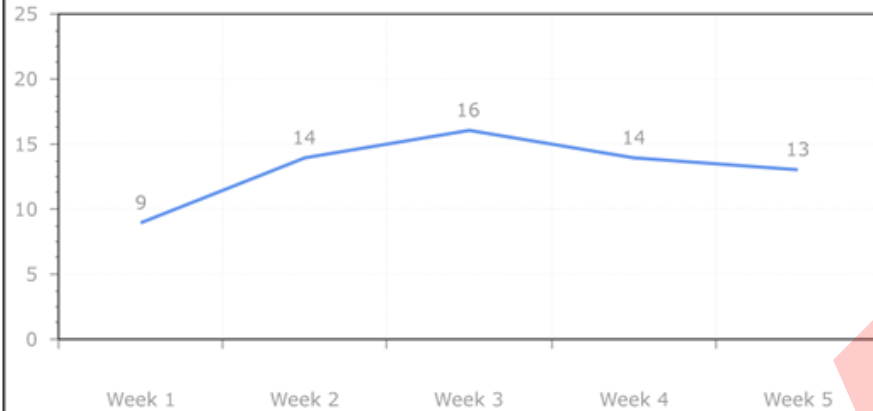
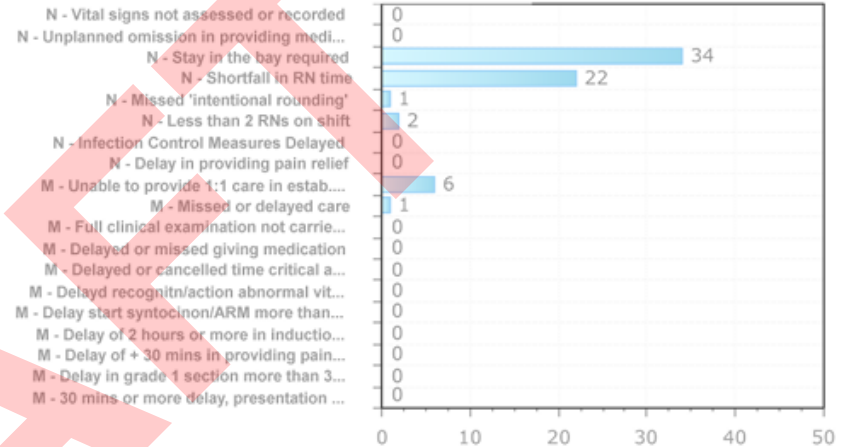
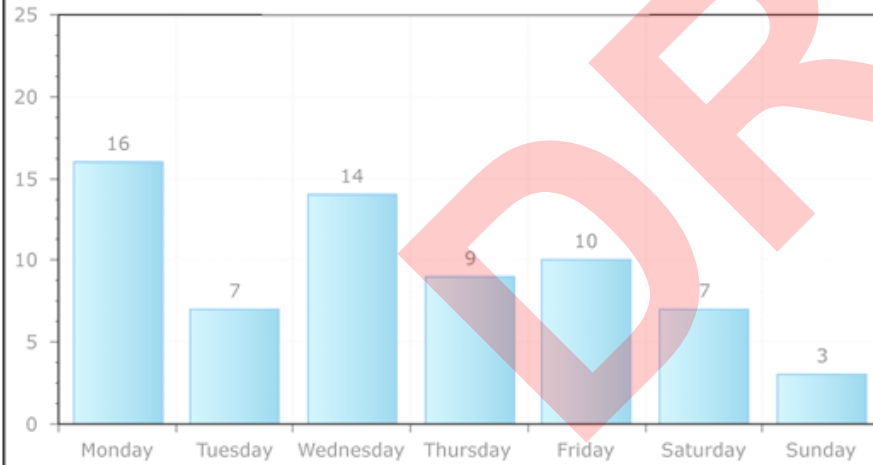
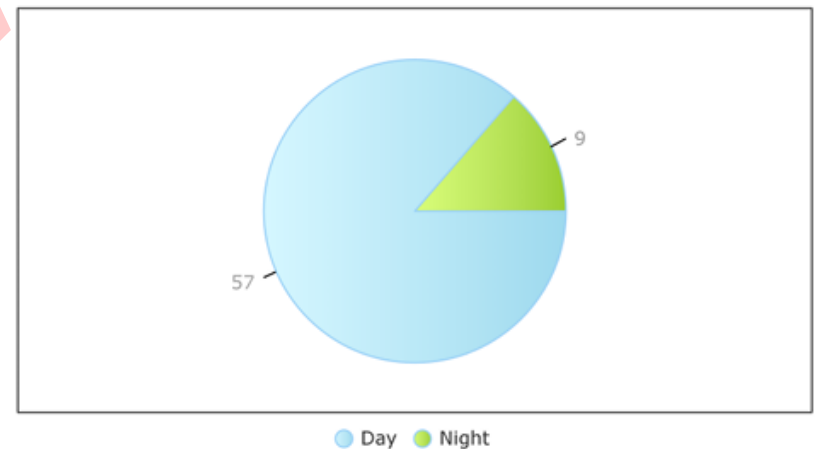


Flag Type: -

Start Date: 01/07/2026

End Date: 31/07/2026

Flag Status: Open Or Resolved

WAHT excluding Medics**Total Flags Over Time****Flags by Type****Total Flags by Day of Week****Flags by Shift Type**

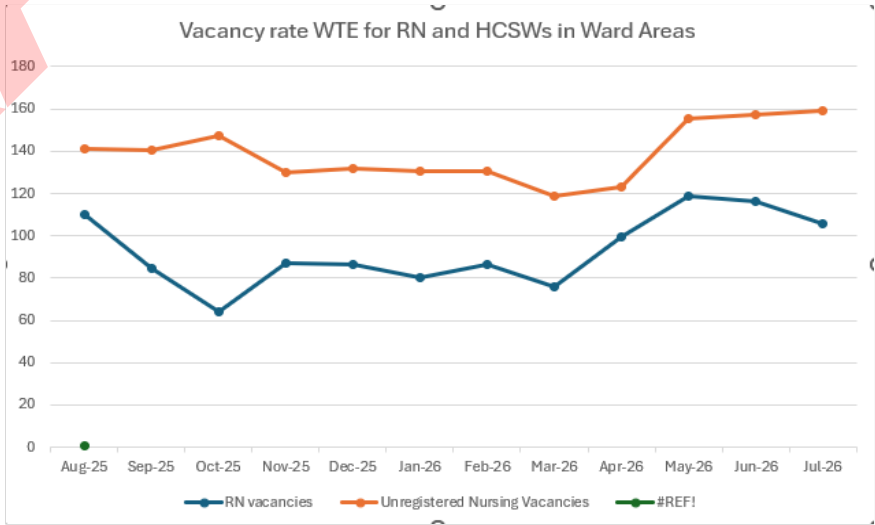
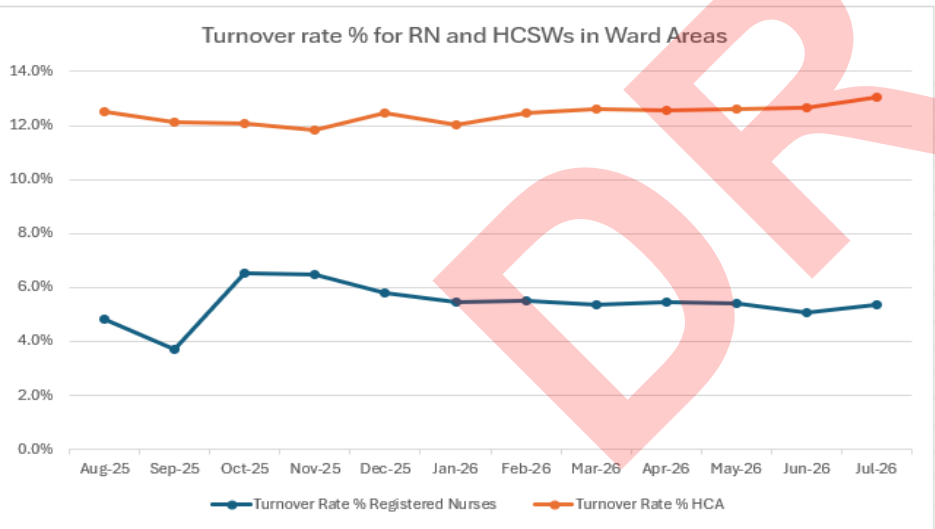
Narrative

- July 2026 saw 80 (from 104 in June) red flags raised; 34 (64) were for stay in the bay, 22 (28) shortfall in RN time, 1 missed intentional rounding, 6 unable to provide 1:1 care, (on review these were all posted by nursing as unable to provide ETOC and miscoded), 2 x less than 2 RNs on shift. In relation to these last 2 flags relating to less than 2 RNs, both related to ward 16 and both are marked as 'resolved' with narrative added by the ward manager as to what mitigation was put in place to increase numbers. As planned, July has seen a revision of the staffing escalation meeting to incorporate red flag review across care groups with the aim to increase visibility, review and outcoming. This has been shown to be beneficial with only 12 flags (out of 80) 15% of flags remaining open at the end of the month compared to 61/104 (58%) in June 2026.
- Monitoring and reporting of red flags raised via safe care will continue to be a focus in 2026 and has been added to both NWAG reporting and the CEA ward accreditation process. This has been supported by additional training for Matrons, Ward Managers and ward staff via the Work force bitesize teaching in May 26.

3. Expectation 1: Right Staff

3.5 Vacant posts (Nursing)

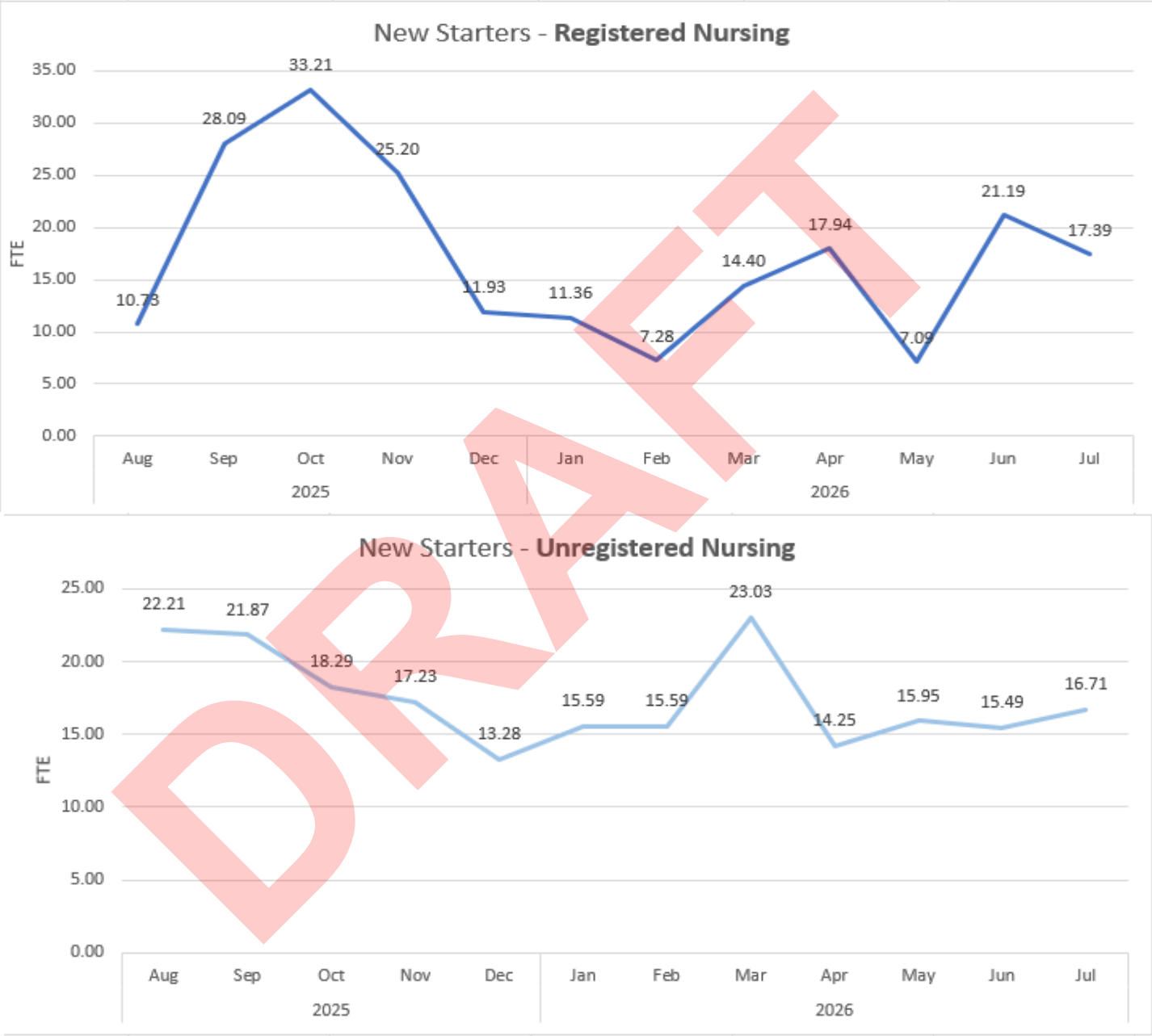
Month	Vacancy Rate % Adult Nurse	Vacancy Rate % HCA	Adult Registered Nursing Vacancies (WTE)	Unregistered Nursing Vacancies (WTE)	Total Nursing Vacancies
Jul-26	4.46%	13.05%	105.87	159.10	264.97↓
Jun-26	4.91%	12.9%	116.45	157.24	273.69↓
May - 26	5.02%	12.77%	118.96	155.6	274.56
Apr-26	4.26%	10.49%	99.7	123.31	223.01
Mar - 26	3.28%	10.08%	76.11	118.5	194.61
Feb - 26	3.47%	11.11%	80.58	130.51	211.09
Jan – 26	3.44%	11.14%	79.96	130.76	210.72



Narrative

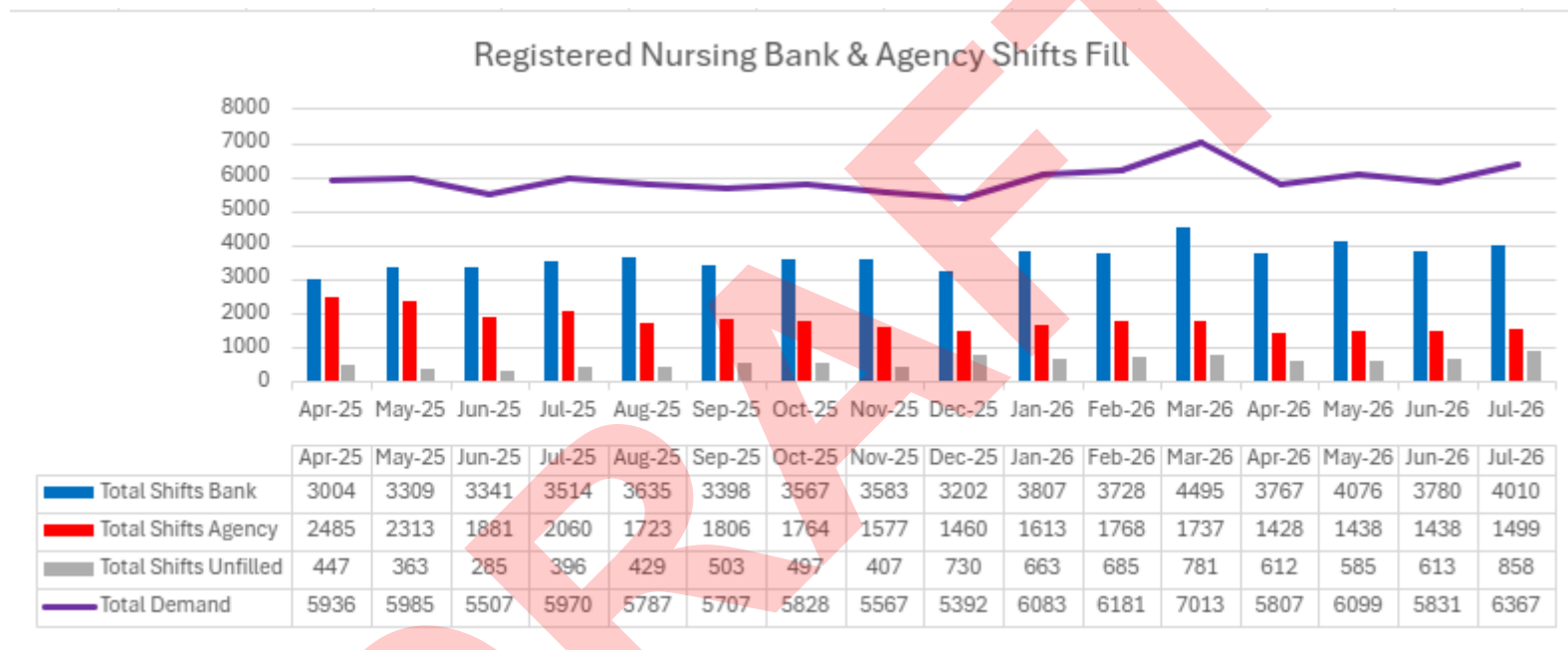
- RN vacancies for July 2026 are currently at 105.87 WTE (4.46%) a reduction of 11 WTE from June 2026. Looking to the future pipeline a further Newly Qualified recruitment event took place on May 16th 2026, with 113 candidates being interviewed. 27 offers have already been made and a further 4 vacancies / mat leaves with candidates awaiting informal visits to areas with a view to offer.
- HCA vacancies remain a focus for ongoing work across divisions / workforce and HR jobs team. Interviews took place on July 31st with 24 offers being made.
- July's vacancy has risen by 2 WTE from June (157 to 159 WTE) despite an unchanged funded establishment. This is not congruent with the starters and leavers information. In month, we had 16 recorded new starters and only 6 leavers. Discussions have taken place with workforce informatics and drivers including leavers on the last day of the month and staff reducing hours have been explored and ruled out as a cause for this lack of congruence. HR workforce team will look into this in the coming month and an update will be provided on the next staffing paper

3. Expectation 2: 3.6 Right Skills



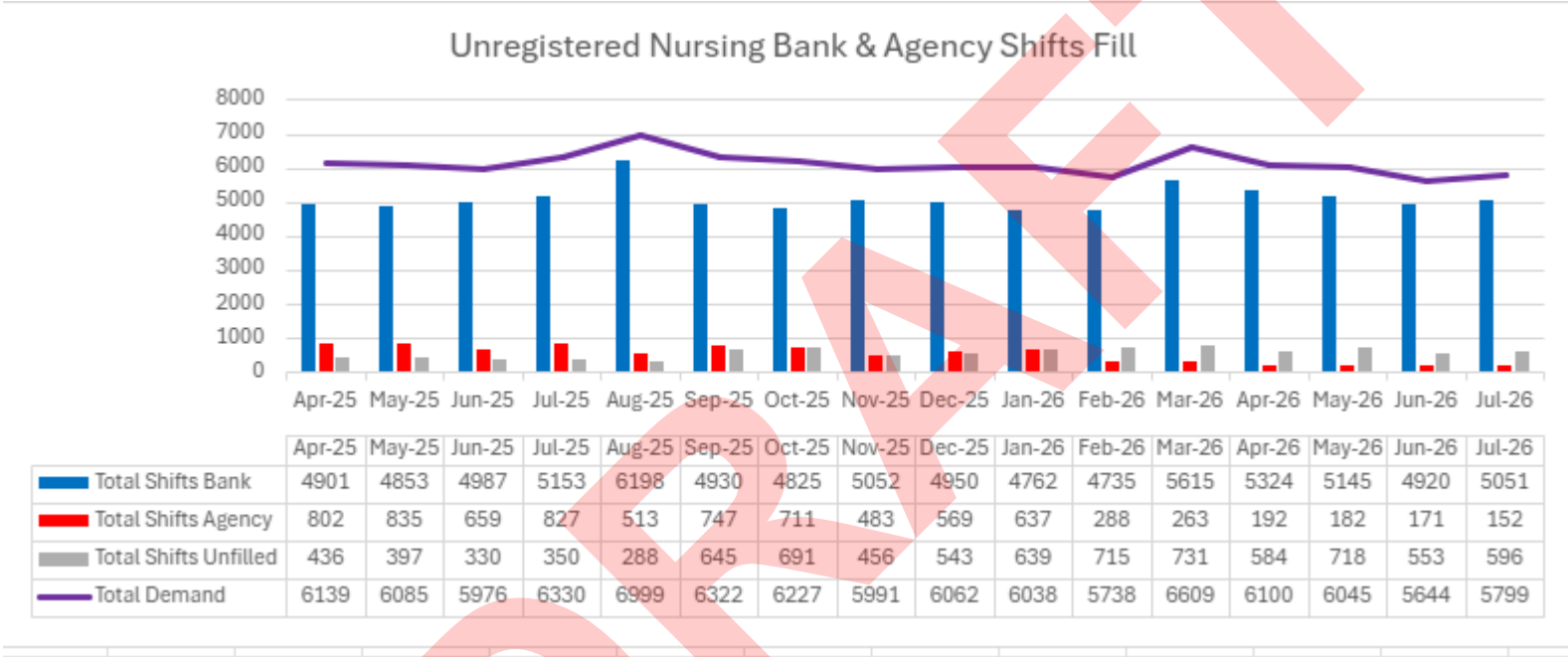
3. Expectation 3: Right Places

3.7 Effective Employment (Registered Temporary Staffing)



3.Expectation 3: Right Places

3.7 Effective Employment (Unregistered Temporary Staffing)



Narrative

- The safer staffing escalation meetings continued twice daily Mon-Fri throughout July 2026 to include the break glass for the removal of HCSW agency cascade in February 2026 across all departments / wards
- Temporary staffing usage increased in July across both registered and unregistered workforce groups. Registered staff usage increased from 265.77 WTE in June to 277.46 WTE, while HCA usage rose from 254.39 WTE to 263.44 WTE. The increase in NHSP-coded shifts is primarily attributable to rising sickness absence and vacancies within both staff groups. Furthermore, the funded registered nursing establishment increased by 16 WTE during the period.
- As per NHSE targets WAHT removed agency HCSW from automatic cascade on Feb 9th 2026 with use being restricted to a 'break glass' process. In line with this the safer staffing escalation meeting has been increased to twice daily with a handover to the on-call team incorporated to ensure safe staffing and escalation points. **Agency HCSW usage fell further in month to 5.57 WTE** total usage (from 6.2 in June).
- Price cap** (agency nursing and midwifery) compliance **98.1% compliant** – 31 shifts in total 15 related to OH contact and 16 chemo this is improved picture from June were 97% complaint this is attributable to a reduction in the number of OH shifts used.

Additional Capacity used / open in July 2026:

Ward	Month	Registered		Unregistered		Registered	Unregistered
		Hours	Cost	Hours	Cost	WTE	WTE
Worcestershire Heart Centre	July	0	0	0	0	0	
Discharge Lounge WRH	July	6	£250.79	372	£7,312.28	0.16	2.3
Discharge Lounge AGH	July	293	£6,221.00	334	£6,251.58	1.8	2.1
AMA	July	1,028	£30,095.00	690	£14,040.00	6.3	4.2
PDU	July			23	£419.33	0.0	0.1
Ward 12 flip bays	July	420	£13,681.15	224	£5,174.79	2.6	1.4
ASA	July	966	£26,711.06	644	£11,228.31	5.9	4.0
Medical SDEC WRH	July	610	£21,087.78	449	£11,573.99	3.8	2.8
	July Totals	3,323	£98,046.78	2,736	£56,000.28	20.56	16.9

3.8 Temporary staffing reduction in use

Following the removal of agency Healthcare Support Workers (HCSWs) from the ward-based cascade in February 2026, Nursing & Midwifery have commenced a phased reduction in the use of agency Registered Nurses (RNs). This process began in June 2026 following agreement at the Nursing, Midwifery and AHP Workforce action Group (NWAG) and has been guided by Care Group recommendations, taking into account agency usage, patient safety, and quality considerations.

The areas transitioned to date are outlined below. The programme will be temporarily paused during August to support the implementation of the planned reduction in bank rates from 1 September 2026. Progression of the agency RN reduction programme will be reviewed and reconsidered in mid-September.

	Division	Ward	Switch Off Date	Jan-26		Feb-26		Mar-26		Apr-26		May-26		Jun-26		Jul-26	
				Agency Hours	%	Agency Hours	%	Agency Hours	%	Agency Hours	%	Agency Hours	%	Agency Hours	%	Agency Hours	%
1	DiagnosticsandSpecialties	Endoscopy - WRH	Jun-26														
2	Family Health Care Group	Neonatal Unit	Jun-26			47	15.6%	11	3.3%								
3	MedicineandEmergency	Cardiac Cath Lab	Jun-26														
4	MedicineandEmergency	Diabetes Nursing	Jun-26														
5	MedicineandEmergency	Discharge Lounge WRH	Jun-26														
6	MedicineandEmergency	Worcestershire Heart Centre	Jun-26	86	18.7%	5	1.3%										
7	MedicineandEmergency	Medical Day Case WRH	Jun-26														
8	MedicineandEmergency	Minor Injuries Unit - KTC	Jun-26														
9	MedicineandEmergency	SPA	Jun-26														
10	Surgical Care Group	Orthopaedic centre	Jun-26														
11	Surgical Care Group	Linden Suite	Jun-26														
12	Surgical Care Group	Hawthorn	Jun-26														
1	DiagnosticsandSpecialties	Laurel 2 Oncology	Jul-26	150	11.5%	28	3.1%	46	3.8%	98	6.7%	150	11.5%	75	6.4%	33	2.3%
2	DiagnosticsandSpecialties	Laurel 3 Haem Ward	Jul-26	197	13.3%	121	9.8%	160	10.9%	154	13.3%	184	16.3%	52	5.8%	63	5.2%
3	MedicineandEmergency	Aconbury 3 Renal	Jul-26	212	19.9%	1,035	40.3%	771	29.6%	449	19.7%	150	11.0%	132	9.0%	81	6.2%
4	MedicineandEmergency	Aconbury 1 Cardiology and CCU	Jul-26	109	9.2%	92	7.9%	126	8.0%	40	3.3%	80	8.6%	58	5.6%	17	1.8%
5	MedicineandEmergency	Discharge Lounge Alex	Jul-26	52	10.2%	52	11.7%	18	3.8%	36	7.9%	72	11.3%	83	13.0%	30	4.6%
6	MedicineandEmergency	Discharge Lounge WRH	Jul-26														
7	Surgical Care Group	Ward 16 Elective Orthopaedics	Jul-26	63	16.3%	12	2.3%	52	6.6%	29	5.1%	82	11.8%	46	8.0%	92	10.9%
8	Surgical Care Group	Ward 17 Urology	Jul-26	162	14.4%	127	16.2%	155	13.5%	196	18.5%	259	20.3%	201	14.1%	115	8.4%
9	Surgical Care Group	Ward 14 Surgery	Jul-26	173	11.5%	81	9.5%	65	5.8%	104	6.4%	40	2.6%	63	6.8%	58	6.4%
10	Surgical Care Group	UIU	Jul-26			27	10.5%	22	7.0%	37	11.8%	40	8.1%			9	1.5%

The proposed reduction in bank rates to bottom of band across all AFC banding in Nursing, Midwifery and AHP was subject to a Quality impact Assessment which has been requested by and submitted to the CNO. The Quality impact assessment (QIA) can be found in **appendix 2**.

Health Care Scientists

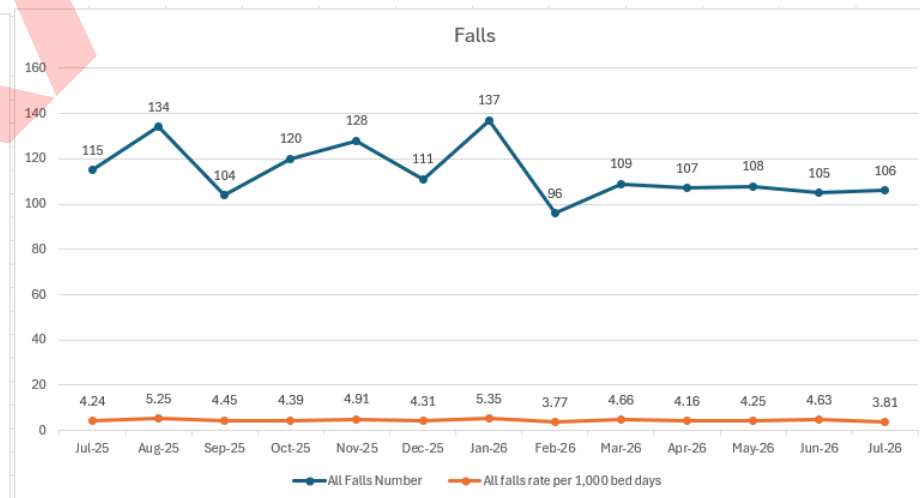
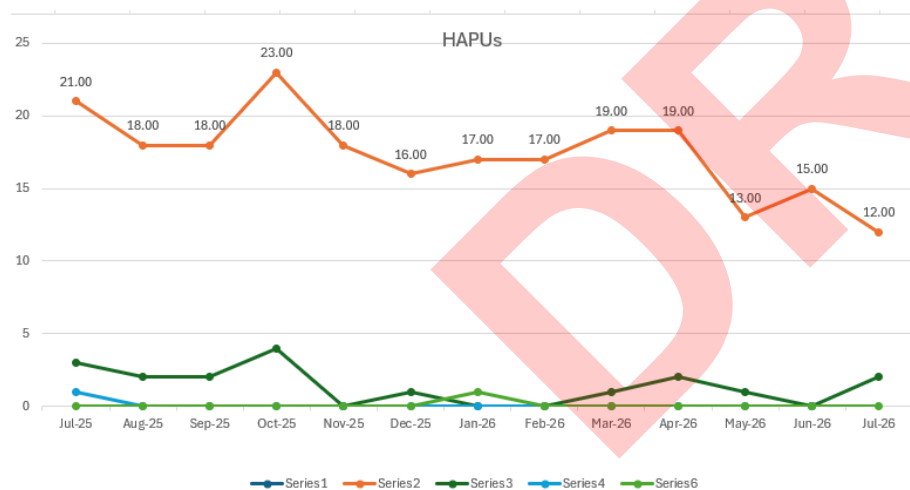
As part of work being undertaken via Agency Program board, Nursing has taken on the support of temporary staffing reduction in Health Care Scientists.

In the financial year 25/26 agency usage in this professional group was seen to reduce by 69% from month 1 to month 12. This represents a 3,500 hrs. per month reduction in usage and was accompanied by a 900 hr. per month increase in bank usage.

Moving forwards monthly updates will be shared with relevant ACOOs to allow further improvements to be made and increase overall visibility in this staff group.

4, Measure and Improve

4.1 Patient outcomes



Narrative

- The total number of falls is stable from last month (106). While Hospital acquired pressure ulcers (HAPUs) are also static at 14 in month.
- Unable to draw parallels to falls and HAPUs to safer staffing metrics at this current time – however a dashboard showing information at ward level – cross referenced with CHPPD at the same level will be included in next month's paper to afford greater triangulation
- There are initiatives taking place across WAHT in relation to falls and patient safety, including the introduction of roles which are intended to focus on education and assessments to proactively reduce the number of Nurse Sensitive Indicators.

Critical Incident

- The Trust declared a critical incident on the 30th of June 2026 which was subsequently stood down on the 2nd of July 2026.
- Additional financial costs were escalated from divisions to finance and collated with overall additional nursing and midwifery costs for the 2 days reported as £3,535 due to additional staffing and use of NTL rates to provide senior clinical cover in A&E's.

APPENDIX

CHPPD per ward – July 2026



Care Hours Per
Patient Day August 1

Quality impact assessment – proposed reduction in bank rates



Bank rates to
bottom of band Sur

DRAFT

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	8 th September 2026
Title of Report:	Midwifery Safe Staffing Report Q1
Lead Executive Director:	Chief Nursing Officer
Author:	Becky Fox -Deputy Director of Midwifery Justine Jeffery - Director of Midwifery
Reporting Route:	Divisional Governance/QGC/Trust Board
Enclosures included with this report:	
Purpose of report:	☒ Assurance ☐ Approval ☐ Information
Brief Description of Report Purpose	
The purpose of this report is to provide assurance that midwifery staffing is monitored in line with national guidance and to note actions taken to mitigate any shortfalls.	
Recommended Actions required by Board or Committee	
The Board is invited to: Note the content of the report and receive assurance that our midwifery safe staffing levels remain in line with NICE guidance – “Safe Midwifery Staffing for Maternity Settings”.	
Executive Director Opinion¹	
The report offers assurance to the Board that there are robust processes in place to monitor midwifery staffing levels in line with national guidance and that appropriate actions are taken to mitigate the risk when staffing gaps occur.	

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

Introduction/Background

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

Safe staffing is monitored monthly by the following actions:

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

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

The summary of the Quarter One workforce KPIs are as follows:

Metrics	Target	Current position (MW)	Current position (MSW/MCAs)
Sickness rate	4%	5.34%	9.09%
Turnover rate (rolling)	11.5%	3.47%	12.21%
Vacancy rate (MW)	7%	3.17%	12.36%
Maternity Leave	-	5.21%	1.69%
Midwife to birth ratio (in post)	1:24	1:18.3	N/A
1:1 care in labour	100%	Achieved	N/A
Shift leader SN	100%	Achieved	N/A

Issues and options

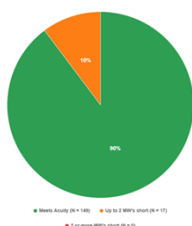
Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 85.20% of the expected intervals on average in the quarter. Therefore, the data presented is reliable. The diagram below presents when staffing met or did not meet the acuity.

April

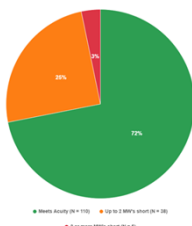
Acuity Summary



*Data % is rounded to nearest whole number

May

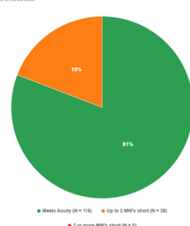
Acuity Summary



*Data % is rounded to nearest whole number

June

Acuity Summary



*Data % is rounded to nearest whole number

Safe staffing levels were maintained on all shifts throughout quarter one following mitigation. The mitigations taken are presented in the diagram below and demonstrate the frequency (n=11) of when staff are reallocated from other areas of the inpatient service. There were 2 recorded reports of staff members not being able to take breaks, 1 instance of escalation to the Manager on Call, 1 occasion when a Community Midwife was redeployed to support the Unit and 35 episodes of staff being redeployed internally.

April

Number of Management Actions
01/04/2026 to 30/04/2026

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

*The % is rounded to nearest whole number

May

Number of Management Actions
01/05/2026 to 31/05/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	18	82%
MA2	Redeploy staff from community	1	5%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	2	9%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	1	5%
MA11	Maternity Unit on Divert	0	0%
TOTAL		22	

*The % is rounded to nearest whole number

June

Number of Management Actions
01/06/2026 to 30/06/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	6	100%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	0	0%
MA11	Maternity Unit on Divert	0	0%
TOTAL		6	

*The % is rounded to nearest whole number

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

NICE recommended red flags are reported in the acuity app and are presented below.

April

Number of Red Flags recorded
01/04/2026 to 30/04/2026

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

*The % is rounded to nearest whole number

May

Number of Red Flags recorded
01/05/2026 to 31/05/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	1	50%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	50%
RF10	Delivery Suite Co-ordinator is not supernumerary	0	0%
TOTAL		2	

*The % is rounded to nearest whole number

June

Number of Red Flags recorded
01/06/2026 to 30/06/2026

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

*The % is rounded to nearest whole number

There were only 2 red flags reported over the quarter – one delayed time critical activity and one occasion when the team were unable to provide one to one care whilst they awaited staff to be deployed.

Meadow Birth Centre

In quarter one, the completion rate for the acuity app for the birth centre was at 75.09%. We are continuing to see more consistent level of activity on MBC. There were 2 recorded red flags for delayed or cancelled time critical activity occurring on 29th May and 18th June. There is no qualitative data for these red flags and acuity is represented as green for the shifts.

Intrapartum & Non-Birthing Categories
01/04/2026 to 30/06/2026

Categories	Number in Categories	Percentage
Cat I	144	57%
Cat II	28	11%
Cat PN	74	29%
Cat X	8	3%
TOTAL	254	

*The % is rounded to nearest whole number

Staffing incidents

There were two staffing incidents reported via Datix, both pertaining to Triage and

Medication Incidents

There were 13 no harm incidents

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

Monitoring the midwife to birth ratio

The average ratio for Quarter One was 1:18.3. The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Maternity SitRep

The maternity SitRep continues to be completed twice per day. The report is submitted to the capacity hub, directorate and divisional leads and is shared with the Chief Nurse and

deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing.

National Maternity SitRep

The new national sitrep has now been launched and is completed daily. It is to be submitted by 11.00 every day.

Unify Data

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

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	87.75%	100%	n/a	n/a
Antenatal Ward/Triage	94%	94.5%	87.58	98%
Delivery Suite	94%	96%	97%	100%
Postnatal Ward	91.5%	88%	84%	90%
Meadow Birth Centre	82%	75%	72%	98.5%

Daily staff safety huddle

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

Vacancy

There are 2 unfilled Specialist Midwifery roles in Fetal Medicine & a Sonography Lead. A Business case to recruit substantively into Maternity Leave has been approved.

Sickness

The average sickness absence rates in Quarter One is 5.34% for midwives and 9.09% for non-registered staff (MCAs and MSWs). Regular deep dives continue with good assurance noted. Return to work interviews continue to be monitored with support from HR.

The following actions remain in place:

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

Turnover

The rolling turnover rate is at 3.47% for Midwives which is an improved position

Maternity Leave

Maternity Leave for Midwives is at 5.21% for the Quarter. Maternity Leave for support for MCA/MSWs is 1.69%. To support rota fill we have secured substantive funding for 8.8WTE midwives to cover maternity leave.

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- SitRep report completed three times per day
- Monthly 'drop - in' sessions led by the DoM/DDoM – these are being reviewed to improve attendance and, in the future, will be individualised for each area e.g. Community Midwives, Delivery Suite, Postnatal Ward etc
- Safety Champion walkabouts continue
- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

Risk Register –staffing

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

Conclusion

To maintain safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts.

There were two reports of a staff member not being able to take a break; three episodes of delayed time critical treatment and 1:1 care in labour prior to escalation.

There was no harm caused from the reported staffing incidents in Triage.

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

The average vacancy rate for the quarter is 3.32% for MWs and 12.36% for MCA's. New starters are supported by either the Preceptorship Midwife or Recruitment and Retention Midwife and interviews and assessment centres will continue in July to fill all vacancies.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	8 September 2026
Title of Report:	2025-26 National Cost Collection – Post Submission Report
Lead Executive Director:	Katie Osmond - Chief Finance Officer
Author:	Rachel Lei – Head of SLR and Costing
Reporting Route:	
Enclosures included with this report:	NCC Board paper - Post-Submission 2025-26
Purpose of report:	☒ Assurance ☐ Approval ☐ Information
Brief Description of Report Purpose	
This report provides assurance to the Trust Board on the 2025-26 National Cost Collection post-submission position. It summarises submission delivery, reconciliation to audited accounts, year-on-year cost and activity movements, key data quality and operational challenges, and the forward Costing, PLICS and EVO development roadmap. The Board is asked to pay particular attention to pages 7-9, which demonstrate material variation against draft NCC moving averages and provide directorate and HRG-level examples of variance and opportunity. These areas should be used to support focused follow-up with Care Groups, working with the Costing Team, to validate the drivers of variation and identify practical improvement actions.	
Recommended Actions required by Board or Committee	
The Board is asked to: - Note that the 2025-26 National Cost Collection submission was delivered on time and has been reviewed in line with NHS Improvement guidance. - Receive assurance on the post-submission position, including the reconciliation, material movements, assumptions and key challenges highlighted in the report. - Review pages 7-9 in detail, noting the significant positive and negative variances against NCC averages and the directorate/HRG areas demonstrating potential opportunities. - Support Care Groups to work with the Costing Team, Finance, BI/Informatics and operational teams to validate the reasons for variation, including service complexity, activity mix, allocation methodology and data quality. - Request that Care Groups translate the identified variance and opportunity areas into targeted work streams, feeding these into regular costing review cycles, PLICS development and wider service improvement plans.	
Executive Director Opinion¹	
The continued use of costing data is a valuable tool in supporting overall financial recovery and aligning with the productivity agenda. Supported by Finance, Care Groups should maximise the use of data to inform discussions, identify opportunities for improvement and strengthen decision-making across the Trust.	

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.

2025-26 National Costing Collection Reports

Summary of Results

Key Message:

The 2025–26 submission has been successfully delivered through the collective efforts of finance, informatics, operational and support services, reflecting strong organisational commitment to the national costing agenda.

- Submission delivered on time in line with NHS England requirements
- Stronger service engagement and increased Financial Management involvement, improving validation and ownership
- Built on 2024–25 foundations, with further improvements to costing methodology and data quality
- Delivery maintained through effective cross-team working and strong team resilience
- Ongoing focus on strengthening cross-organisational collaboration, including Estates, to support improving floor plan accuracy, allocation quality and overall costing robustness

Reconciliation of national costs to the audited annual accounts

Positive = adverse/increase

Description	24/25	25/26	Movement
Operating expenses from consolidated accounts	789,427,000	854,083,610	64,656,610
Other operating income (all)	-38,323,074	-41,820,250	-3,497,175
Accounting adjustments			
Finance income	-2,030,312	-1,975,886	54,426
Finance expenses (including unwinding of discounts)	14,994,231	15,144,083	149,853
PDC dividend expense	4,846,491	4,279,008	-567,483
Other gains/(losses) including sale of assets	713,945	230,063	-483,882
Impairments net of (reversals)	-1,404,347	-34,741,991	-33,337,644
Depreciation related to donated or government granted non-current assets (cash or non cash)	-157,532	-210,669	-53,137
Donations/grants of physical assets and or cash for the purchase of capital assets - all	375,635	829,753	454,118
Final Accounts - FAQ Adjustment 1 - Consistency with financial reporting (UKGAAP)	0	6,130,000	6,130,000
Pre Costing Software Subtotal	768,442,036	801,947,721	33,505,685
Services provided to or by another NHS provider			
Clinical and support services supplied to or received from other organisations (P2P)	-9,096,196	-8,585,985	510,211
Services excluded from the National Cost Collection			
Home delivery of drugs and supplies: cost of drugs and administration costs	-9,858,823	-13,410,273	-3,551,450
Cost of non NHS Patients-Private patients, overseas visitors & other non-NHS patients	-2,440,884	-2,580,851	-139,967
Total National Cost Collection Quantum	747,046,133	777,370,612	30,324,479

- Pre-costing position increased to £801.9m (+£33.5m), driven by underlying expenditure growth and updated accounting treatments
- Movement partially offset by impairments (-£33.3m), with increased other operating income (£3.5m) providing a partial mitigation
- Total National Cost Collection increased by c.£30.3m year-on-year, reflecting growth in the underlying cost base and reinforcing the need for strengthened cost control

Note 1:

The IFRS 16 accounting adjustment for PFI has been incorporated following consultation with the NHS England Costing team; this adjustment was not included in the 2024-25 submission.

Note 2: The breakdown below should be utilised to support SLA review and agreement.

Provider to Provider Items	Value £
Pathology SLA (Net off Income)	1,129,192
Renal Dialysis SLA with Dudley Group	2,147,164
Cardiac Network UHCW	1,171,517
A&E Community MIU	3,421,443
Radiology SLA	716,669
Total	8,585,985

Note 3: Insulin pump consumables have been reclassified from unmatched Device to Home Care to reflect the appropriate costing treatment.

Home Care Service	Value £
Home Oxygen	272,846
Home Care Drugs	10,077,161
Insulin Pumps Consumable	3,060,265
Total	13,410,273

Note 4

Out of Scope Items	Value £
Other Non-NHS Patients	1,707,539
Private Patients	512,815
Overseas Patients	360,497
Total	2,580,851

Activity & Cost Year-on-Year

Feed/Type	2425		2526		% Change	
	Cost	Activity	Cost	Activity	Cost	Activity
Admitted Patient Care	£402,368,324	181,961	£414,760,504	178,763	3.1%	-1.8%
Outpatient	£138,726,216	857,534	£154,179,257	876,948	11.1%	2.3%
Emergency Care	£63,671,074	188,968	£74,776,566	225,926	17.4%	19.6%
Core Total	£604,765,614		£643,716,327			
Specialist Ward Care	£23,528,693		£21,689,095		-7.8%	
Supplement Information	£78,345,718		£74,555,675		-4.8%	
Aggregated Feed						
Cancer MDT	£3,830,983	27,531	£4,514,789	27,918	17.8%	1.4%
Direct Access Pathology Services	£9,395,774	2,805,675	£9,716,498	3,333,983	3.4%	18.8%
Direct Access Diagnostic Imaging	£4,603,261	46,566	£3,985,890	55,452	-13.4%	19.1%
Direct access Plain Film	£3,249,287	65,434	£2,225,089	71,988	-31.5%	10.0%
Audiology	£3,688,457	27,706	£3,451,452	34,912	-6.4%	26.0%
LRSD other	£6,355,686	5,544	£5,655,970	4,546	-11.0%	-18.0%
Screening (Recon pre 2223)	£9,282,661	149,345	£7,859,827	148,603	-15.3%	-0.5%
Total	£747,046,133		£777,370,612		4.1%	

- Overall costs increased by 4.1% year-on-year, reflecting continued pressure on the Trust's cost base.
- Growth is primarily driven by increased core acute activity, particularly Outpatients and Emergency Care.
- Reductions are noted in critical care, while lower Direct Access costs alongside increased activity suggest a shift towards lower-cost pathways.

** LRSD= Legally Restricted Sensitive Data



**Worcestershire
Acute Hospitals**
NHS Trust

Supplement Breakdown

Feed/Type	2425		2526		% Change		2526 Unit Costs
	Cost	Activity (LOS)	Cost	Activity (LOS)	Cost	Activity	
SWC - Specialist Ward Care							
Adult Critical Care	£16,593,099	4,804	£14,092,731	4,602	-15.1%	-4.2%	£3,062
Neonatal Critical Care	£6,935,594	5,722	£7,596,364	5,569	9.5%	-2.7%	£1,364
Specialist Ward Care Total	£23,528,693	10,526	£21,689,095	10,171	-7.8%	-3.4%	
SI - Supplementary Information							
Device	£2,436,748	1,523	£2,768,138	572	13.6%	-62.4%	£4,839
Diagnostic imaging	£12,838,891	86,981	£12,174,616	84,885	-5.2%	-2.4%	£143
Other diagnostic testing	£1,704,548	11,441	£2,809,650	14,018	64.8%	22.5%	£200
High Cost Drugs	£48,345,236	68,528	£47,250,306	75,868	-2.3%	10.7%	£623
Unmatched support services	£13,020,295		£9,552,965		-26.6%		
SI - Supplementary Information Total	£78,345,718		£74,555,675		-4.8%		

Unmatched Items	2526 Cost	2526 Activity
Unmatched Radiology Scans	£3,893,741	44,832
Unmatched Devices	£2,485,108	1,879
Unmatched Pharmacy Issues	£2,795,215	2,559
Unmatched Pathology Tests	£378,900	43,769
Unmatched support services Total	£9,552,965	93,039

- Critical Care costs reduced; however, average costs remain below commissioner funding levels, indicating continued under-recovery.
- Supplementary Information costs reduced overall, although significant variation remains across categories.
- Device movements reflect increased unmatched activity and higher-cost items, including stents.
- Other Diagnostic Testing costs increased following enhanced service engagement, improving costing accuracy and resource attribution.
- Unmatched items highlights ongoing data quality and completeness challenges.

Activity and Resource Allocation

Activity and Resource £000	2425	2526				Movement %
	Total	Admitted Patient Care	Emergency Care	Outpatients	Total	
Blood	2,743	2,039	634	41	2,713	-1.1%
Chemotherapy	4,481	4,992		84	5,076	13.3%
Diagnostic imaging	21,877	8,004	8,755	5,975	22,734	3.9%
Emergency care	49,838		58,630		58,630	17.6%
Other diagnostic testing	174	231		63	293	68.7%
Outpatient care	106,146			122,311	122,311	15.2%
Pathology	18,337	11,376	3,415	5,039	19,830	8.1%
Pharmacy	1,961	9,407		1,585	10,992	460.5%
Radiotherapy	12,972	62		11,215	11,277	-13.1%
Specialist procedure suites	28,814	22,881			22,881	-20.6%
Support services	13,554	5,706	3,001	7,074	15,781	16.4%
Theatre care	83,862	96,782		142	96,924	15.6%
Ward care	260,007	253,281	341	651	254,273	-2.2%
Total	604,766	414,761	74,777	154,179	643,716	6.4%

- The table presents the allocation of activity and costs across Points of Delivery, with total costs increasing by 6.4% to £643.7m, reflecting continued demand pressures across core services.
- Admitted Patient Care remains the largest cost component, highlighting the intensity of inpatient resource utilisation, while Emergency Care and Outpatients continue to drive overall growth.
- Outpatient services consistently account for around 24% of total costs across all settings.
- Emergency Care costs account for approximately 11.6% of total expenditure.
- The proportion of costs across the three Points of Delivery remains broadly in line with the previous year, with inpatient share decreasing slightly from 67% to 64.4%.

- Pharmacy: Significant increase reflects strengthened engagement with services, enabling more accurate attribution of inpatient pharmacy activity and improved alignment of costs to the appropriate care setting.
- Other Diagnostic Testing: Cost increase (+68.7%) is driven by activity growth, including a c.24% increase in cardiology imaging, with enhanced service engagement supporting improved costing accuracy and more robust resource allocation.

This breakdown provides further detail on the core feeds presented in the previous slide, supporting understanding of cost drivers and resource allocation, while reinforcing the importance of continued service engagement to improve costing accuracy.

Division Year-on-Year Costs & Activities

Divison	Point of Delivery	2024/25			2025/26			Activity Mvmt	Cost Mvmt	Unit Cost Mvmt
		Activity	Cost	Avg Unit	Activity	Cost	Avg Unit			
Medicine	Elective Inpatient & Daycase	8,539	£10,509,218	£1,231	9,076	£10,329,453	£1,138	6.3%	-1.7%	-7.5%
	Non Elective Inpatient	54,876	£139,357,291	£2,539	53,798	£144,291,575	£2,682	-2.0%	3.5%	5.6%
	Outpatient	239,870	£36,890,878	£154	245,741	£45,974,988	£187	2.4%	24.6%	21.6%
	AE Type 1&3	180,892	£63,219,130	£349	226,483	£75,193,540	£332	25.2%	18.9%	-5.0%
	SDEC Type 5	8,777	£953,369	£109	22,883	£5,284,425	£231			
SCS	Elective Inpatient & Daycase	53,823	£37,550,862	£698	54,706	£37,861,543	£692	1.6%	0.8%	-0.8%
	Non Elective Inpatient	2,803	£10,113,791	£3,608	2,467	£11,146,034	£4,518	-12.0%	10.2%	25.2%
	Outpatient	168,208	£34,859,877	£207	174,166	£39,151,614	£225	3.5%	12.3%	8.5%
Surgery	Elective Inpatient & Daycase	29,305	£65,337,613	£2,230	28,821	£76,303,186	£2,647	-1.7%	16.8%	18.7%
	Non Elective Inpatient	13,954	£76,850,265	£5,507	12,894	£75,556,654	£5,860	-7.6%	-1.7%	6.4%
	Outpatient	229,687	£32,823,299	£143	208,091	£35,062,610	£168	-9.4%	6.8%	17.9%
	SDEC Type 5				6,716	£1,371,276	£204			
W&C	Elective Inpatient & Daycase	3,931	£13,283,731	£3,379	4,031	£14,191,618	£3,521	2.5%	6.8%	4.2%
	Non Elective Inpatient	15,782	£50,757,071	£3,216	14,199	£50,173,891	£3,534	-10.0%	-1.1%	9.9%
	Outpatient	165,427	£29,727,324	£180	176,272	£32,209,039	£183	6.6%	8.3%	1.7%
	SDEC Type 5				6,038	£1,671,069	£277			

- Divisional costs continue to increase across key Points of Delivery, with outpatient activity and costs growing across all divisions, reflecting sustained demand across core services.
- Non-elective inpatient activity has reduced in several areas; however, unit costs have increased, indicating continued pressure on the cost of delivering inpatient care.

- Surgery: Elective costs increased despite reduced activity, indicating higher case complexity and input costs.
- Medicine: SDEC activity and costs increased, partly reflecting a prior year recording change, with activity only captured under A&E from October 2024–25.
- SCS: Cost growth driven by non-elective and outpatient pathways, with rising unit costs indicating continued delivery pressure.
- Women & Children (W&C): Outpatient growth offset by reduced non-elective activity; however, higher unit costs indicate ongoing cost pressure.

Activity Reconciliation

- Activity reconciliation confirms alignment between SUS and costing activity, with differences primarily explained by the removal of Well Babies, Phlebotomy, Direct Access and Healthcare Trust Minor Injury Unit data.

Activity Type	SUS Activity	Adj	Costing Activity	Note
Inpatient Episodes	184,491	4,501	179,990	Well Babies (4.5k)
Outpatient Attendance	955,687	139,353	887,245	Remove phlebotomy (23k) and Dummy DA Diag (116k)
A&E Attendance	270,093	43,610	226,483	Excluded H&CT MIU (43.6k)
Total	1,410,271		1,293,718	

Worcester Acute Hospitals Trust vs National Costing Collection (NCC) Moving Averages



Worcestershire
Acute Hospitals
NHS Trust

As at 6th July 2026

£m	24/25 Total Cost	25/26 Total Cost	25/26 Activity @ NCC Avg	25/26 Var
DC	79.2	85.1	86.2	-1.1
EL	46.4	52.7	51.0	1.7
NEL	234.8	238.8	265.3	-26.5
NES	39.8	38.2	37.8	0.4
CL	59.4	66.3	66.4	-0.2
NCL	43.6	46.9	39.8	7.2
OPROC	37.3	41.0	39.8	1.1
EC	63.4	74.8	75.2	-0.4
ACC	16.6	14.1	12.8	1.3
NCC	6.9	7.6	6.9	0.7
AGG/SI	123.3	112.0	100.1	11.8
Total	750.8	777.4	781.5	-4.1

AGG and SI Breakdown

£m	24/25 Total Cost	25/26 Total Cost	25/26 Activity @ NCC Avg	25/26 Var
AGG	3.3	4.4	3.5	0.9
Audiology	3.7	3.0	2.8	0.2
CMDT	3.8	4.5	2.7	1.9
Devices	8.5	5.3	3.3	2.0
Drugs	62.1	51.8	46.0	5.8
Pathology	9.6	10.1	8.3	1.8
Radiology	23.0	25.1	27.3	-2.3
Screening	9.3	7.9	6.3	1.5
Total	123.3	112.0	100.1	11.8

Specialty costs circa £10m in 2025/26

Service (£m)	24/25 Total Cost	25/26 Total Cost	25/26 Activity @ NCC Avg	25/26 Var
Accident & Emergency	63.4	80.4	79.8	0.7
Trauma & Orthopaedics	63.2	64.5	64.5	-0.0
General Medicine	58.7	55.6	59.7	-4.1
Pharmacy	62.1	51.8	46.0	5.8
General Surgery	48.6	49.1	46.6	2.4
Obstetrics	36.7	37.0	34.2	2.8
Cardiology	35.1	35.9	38.4	-2.4
Oncology	31.4	32.6	33.0	-0.3
Urology	24.9	27.0	26.9	0.1
Radiology	23.0	25.1	27.3	-2.3
Respiratory Medicine	26.2	24.6	25.4	-0.8
Gastroenterology	18.0	20.2	19.5	0.7
Geriatric Medicine	15.1	17.4	20.0	-2.6
Gynaecology	20.8	17.2	17.4	-0.3
Ophthalmology	16.0	16.5	17.7	-1.1
Midwifery Service	14.3	16.3	15.0	1.3
Paediatrics	14.3	16.1	16.9	-0.8
Adult Critical Care	16.6	14.1	12.8	1.3
ENT	10.8	13.6	14.3	-0.7
Vascular Surgery	8.9	13.0	14.8	-1.8
Colorectal Surgery	10.3	10.9	9.6	1.3
Clinical Haematology	10.6	11.1	12.3	-1.2
Pathology	9.6	10.1	8.3	1.8
Stroke Medicine	7.6	10.1	14.4	-4.3
Diabetic Medicine	11.4	9.8	11.0	-1.3

- Material variation is evident between Trust costs and NCC average, concentrated in a limited number of high-impact areas.
- Significant positive and negative variances require review to confirm whether these reflect service complexity, activity mix, allocation methodology or data quality.
- Continued service engagement is required to validate drivers of variation and improve benchmarking accuracy.

Worcester Acute Hospitals Trust vs National Costing Collection (NCC) Directorates Variance Examples

Surgery Directorate	POD	25/26 WAT Activity	25/26 WAT Cost £000	25/26 Activity @ NCC Avg £000	25/26 Var £000	25/26 Var %
General Surgery	Daycase/Elective IP FCEs	11,147	£13,591	£12,811	£781	6.1%
	Non Elective IP FCEs	2,309	£6,652	£6,310	£342	5.4%
	Outpatients	50,421	£7,362	£7,630	£-268	-3.5%
General Surgery Total			£27,605	£26,751	£854	3.2%
Oral Surgery	Daycase/Elective IP FCEs	2,890	£3,135	£3,310	£-175	-5.3%
	Outpatients	17,876	£5,645	£4,129	£1,516	36.7%
Oral Surgery Total			£8,780	£7,439	£1,341	18.0%

W&C Directorate	POD	25/26 WAT Activity	25/26 WAT Cost £000	25/26 Activity @ NCC Avg £000	25/26 Var £000	25/26 Var %
Maternity	Daycase/Elective IP FCEs	54	£351.5	£363.0	£-11.5	-3.2%
	Non Elective IP FCEs	6,621	£35,103.4	£34,617.9	£485.5	1.4%
	Outpatients	45,045	£9,568.1	£7,589.6	£1,978.5	26.1%
	Community Contacts	68,318	£8,284.3	£6,642.4	£1,641.9	24.7%
Maternity Total			£53,307.3	£49,212.9	£4,094.4	8.3%
Neonatal	Non Elective IP FCEs	515	£516.9	£792.6	£-275.7	-34.8%
	Neonatal Cot Days	5,558	£7,596.4	£6,943.4	£652.9	9.4%
Neonatal Total			£8,113.3	£7,736.1	£377.2	4.9%

Medicine Directorate	POD	25/26 WAT Activity	25/26 WAT Cost £000	25/26 Activity @ NCC Avg £000	25/26 Var £000	25/26 Var %
Gastroenterology	Daycase/Elective IP FCEs	10,876	£8,729	£7,556	£1,173	15.5%
	Non Elective IP FCEs	458	£1,285	£1,509	£-223	-14.8%
	Outpatients	10,190	£2,320	£1,772	£548	30.9%
Gastroenterology Total			£12,335	£10,837	£1,497	13.8%
Respiratory Medicine	Daycase/Elective IP FCEs	339	£612	£299	£314	105.1%
	Non Elective IP FCEs	1,614	£4,524	£5,456	£-932	-17.1%
	Outpatients	27,351	£7,795	£6,120	£1,675	27.4%
Respiratory Medicine Total			£12,931	£11,875	£1,057	8.9%

SCS Directorate	POD	25/26 WAT Activity	25/26 WAT Cost £000	25/26 Activity @ NCC Avg £000	25/26 Var £000	25/26 Var %
Oncology	Daycase/Elective IP FCEs	20,876	£6,581	£8,501	£-1,920	-22.6%
	Non Elective IP FCEs	146	£648	£1,246	£-599	-48.0%
	Outpatients	56,666	£18,819	£13,575	£5,244	38.6%
Oncology Total			£26,047	£23,321	£2,726	11.7%
Pathology	Direct Access	3,378,805	£10,174	£8,479	£1,694	20.0%
Critical Care	Adult Critical Care	4,547	£13,804	£12,518	£1,286	10.3%

- Significant directorate cost variances against draft NCC average costs, based on 2025–26 activity levels.
- Highlights areas for further review of cost drivers and costing methodology in line with service delivery models.
- Benchmarking supports identification of efficiency and service improvement opportunities.

Worcester Acute Hospitals Trust vs National Costing Collection (NCC) HRG Directorates HRG Variance Examples



Worcestershire
Acute Hospitals
NHS Trust

Surgery Directorate	HRG	25/26 WAT Activity	25/26 WAT Ave Cost	25/26 Activity @ NCC Avg Ave Cost	Opportunity £000
Dermatology	JC43C-Minor Skin Procedures 19 years and over	3,478	£944	£523	£1,466
General Surgery	FE31Z-Diagnostic Colonoscopy with Biopsy 19 years and over	1,047	£1,112	£1,007	£110
	FE32Z-Diagnostic Colonoscopy 19 years and over	1,677	£901	£827	£123
	FE35Z-Diagnostic Flexible Sigmoidoscopy 19 years and over	731	£420	£347	£53
Oral Surgery	JC43C-Minor Skin Procedures 19 years and over	1,377	£473	£316	£217
	WF01A-Non-Admitted Face-to-Face Attendance Follow-up	3,265	£630	£423	£676
	WF01B-Non-Admitted Face-to-Face Attendance First	3,265	£313	£239	£241

W&C Directorate	HRG	25/26 WAT Activity	25/26 WAT Ave Cost	25/26 Activity @ NCC Avg Ave Cost	Opportunity £000
Maternity	NZ21Z-Ante-Natal Standard Routine Ultrasound Scan	4,516	£310	£179	£594
	WF01A-Non-Admitted Face-to-Face Attendance Follow-up	32,174	£185	£160	£817
	WF01B-Non-Admitted Face-to-Face Attendance First	7,397	£263	£200	£465
Gynaecology	WF01A-Non-Admitted Face-to-Face Attendance Follow-up	5,482	£223	£195	£151
	WF01B-Non-Admitted Face-to-Face Attendance First	6,769	£242	£209	£229
Neonatal	XA01Z-Neonatal Critical Care Intensive Care	237	£4,998	£2,791	£523
	XA02Z-Neonatal Critical Care High Dependency	839	£3,019	£1,755	£1,060

Medicine Directorate	HRG	25/26 WAT Activity	25/26 WAT Ave Cost	25/26 Activity @ NCC Avg Ave Cost	Opportunity £000
Gastroenterology	FE20Z-Therapeutic Endoscopic Upper Gastrointestinal Tract	217	£1,932	£1,015	£199
	FE22Z-Diagnostic Endoscopic Upper Gastrointestinal Tract Pt	1,841	£1,274	£1,098	£325
	WF01B-Non-Admitted Face-to-Face Attendance First	4,131	£316	£216	£412
Respiratory	WF01A-Non-Admitted Face-to-Face Attendance Follow-up	10,422	£240	£176	£669
Stroke	WF01A-Non-Admitted Face-to-Face Attendance Follow-up	598	£462	£274	£112
	WF01B-Non-Admitted Face-to-Face Attendance First	1,199	£730	£327	£484
Cardiology	WF01B-Non-Admitted Face-to-Face Attendance First	21,584	£219	£174	£975
A&E	VB04Z-Emergency Medicine, Category 2 Investigation with Ca	13,901	£841	£705	£1,884
	VB09Z-Emergency Medicine, Category 1 Investigation with Ca	24,799	£267	£211	£1,398

SCS Directorate	HRG	25/26 WAT Activity	25/26 WAT Ave Cost	25/26 Activity @ NCC Avg Ave Cost	Opportunity £000
Oncology	SC22Z-Deliver a Fraction of Treatment on a Megavoltage Macr	1,387	£649	£367	£391
	SC23Z-Deliver a Fraction of Complex Treatment on a Megavolt	2,823	£624	£310	£885
	SC31Z-Deliver a Fraction of Adaptive Radiotherapy on a Megav	16,276	£558	£328	£3,728
Ophthalmology	WF01A-Non-Admitted Face-to-Face Attendance Follow-up	21,481	£197	£135	£1,337
	WF01B-Non-Admitted Face-to-Face Attendance First	11,849	£185	£171	£168
Critical Care	XC03Z-Adult Critical Care 4 Organs Supported	698	£4,034	£3,444	£412
	XC04Z-Adult Critical Care 3 Organs Supported	1,064	£3,495	£3,143	£374
	XC05Z-Adult Critical Care 2 Organs Supported	1,410	£3,323	£2,884	£619

- Examples of HRGs/PODs with costs above draft NCC averages, based on 2025–26 activity levels.
- Provides a more detailed view of cost variation at HRG level, enabling targeted review of specific service areas.
- Supports identification of key cost drivers, benchmarking opportunities and potential areas for efficiency improvement.

Key Challenges Encountered



Data Quality and Completeness

- Ongoing issues with data quality, including implausible episode/ward durations
- Inconsistencies and gaps in date and time recording, reducing confidence in activity capture and cost attribution.

Operational Engagement and Inputs

- Service engagement has improved but requires further strengthening to build confidence in costing outputs.
- Limited availability of up-to-date floor plans continues to constrain the accuracy of estate allocations.

Technical and Resource Constraints

- Periods of instability within the national submission portal during the submission period reduced time available for output improvements
- Continued reliance on some historic costing assumptions reflects constrained capacity within the costing function.

Conclusion & Sign-Off Request



The 2025–26 National Costing Submission has been completed and reviewed in line with NHS Improvement guidance.



The overall position remains broadly consistent with 2024–25, with movements reflecting changes in activity, recording practices and costing methodology.



Key changes reflect improved alignment with national recording standards and increased service engagement, supporting more granular and accurate costing.



All material movements and assumptions have been summarised in this pack to support transparency and audit assurance.



Despite operational and technical limitations, the submission represents the most accurate and robust position achievable at this stage.



Next Step:

Please review and sign off the final submission via the following link:

[National Cost Collection 2026 Chief Finance Officer \(CFO\) sign-off form](#)



Costing, PLICS & EVO Development Roadmap

Short-Term (next 3–6 months)

Build Foundations

- **Further develop the PLICS dashboard** to facilitate service Use
- **Setup costing presentation** for all service managers to educate and drive engagement
- **Identify service champions** to pilot the EVO framework
- **Strengthen data validation** to improve confidence in cost outputs
- **Engage services** to validate cost drivers, models and allocations

Medium-Term (1–2 Years)

Implement & Integrate

- **Expand PLICS use across divisions** to support routine operational and financial management
- Establish **regular costing review cycles** with clinical, operational and finance teams
- **Pilot EVO framework** in priority specialties with identified service champions
- **Enhance integration** of PLICS with activity, workforce and finance data for accurate and timely reporting
- **Improve data quality** and completeness, including floor plans, and service-level inputs
- **Standardise and automate** costing processes to improve efficiency and reduce reliance on manual work

Long-Term (3+ Years)

Embed & Scale

- **Embed PLICS and EVO** as trusted routine decision-support tools for strategy, planning and performance management
- **Drive data-informed decision making** to optimise pathways, productivity and resource allocation
- **Achieve high-quality, complete and standardised data** inputs with strong service ownership and governance
- **Align costing with national developments** and future costing submission (e.g. FDP and evolving frameworks)
- **Embed continuous improvement** in costing processes through automation, innovation and best practice
- **Build a culture of cost awareness** and accountability across all levels of the organisation

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Microsoft Teams
Tuesday 2nd June 2026 at 10:00

Present		
Chair	Karen Martin (KM)	Non-Executive Director
Members		
	Ali Koeltgen (AK)	Chief People Officer
	Colin Horwath (CH)	Non-Executive Director
	Jules Walton (JW)	Chief Medical Officer
	Stephen Collman (SC)	Managing Director
	Chris Douglas (CD)	Chief Operating Officer
	Hayley Flavell (HF)	Chief Nursing Officer
	Sue Sinclair (SS)	Associate Non Executive Director
	Katie Osmond (KO)	Chief Finance Officer
Attendees	Liz Faulkner (LF)	Deputy Chief People Officer
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Rich Luckman (RL)	Assistant Director of People & Culture
	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Rachael Hayter (RH)	Director of AHPs
	Louise Pearson (LP)	Associate Director (Nursing) Workforce and Education
	Justine Jeffery (JJ)	Director of Midwifery
	Richard Haynes (RH)	Director of Communications
	Sue Hayes (SH)	Vice Chair DAWN Network
	Sophie Burt (SB)	Head of Fundraising & Community Development
Apologies	Bianca Edwards	Assistant Director of People & Culture

Chairs Welcome and Apologies for Absence	
KM welcomed all attendees to the meeting and the apologies received were acknowledged above.	
Quorum and Declarations of Interests	
There were no additional Declarations of Interest pertinent to the agenda. Declarations of Interest are available on the Trust's website. KM confirmed that: a) A Quorum of the P&C was present. b) There were no declarations of interest.	
Action Log and Minutes of the previous meeting	
The minutes of the last meeting held on the 7 th April 2026 were reviewed and agreed as a true and accurate record. SS asked for an update on same sex accommodation for transgender people in light of the supreme court ruling. AK advised that the EHRC has published draft guidance which is currently in a 6-week review period. The Trust remains in line with national policy guidance, and the Trust has a clear policy of where and how patients should be placed. HF added that guidance from the CNO of England may be coming out in due course.	

The ongoing action log was reviewed and updated accordingly.	
Leading Cultural Change	
HF explained the aim to fully implement the patient safety incident review framework which focusses on system thinking and learning how patient safety incidents happen. Part of this will be embracing the being fair framework to ensure that when there is a patient safety incident, the response is compassionate and there is a sense of psychological safety. This will allow the Trust to truly understand how to make improvements across the organisation. There have been 3 teaching sessions so far, however HF emphasised the this is a significant cultural change and will not be as simple as a teaching session or new posters. The success and improvements need to be measurable and appendix 1 details this. AK added that psychological safety is vital and that feedback from teaching sessions is that staff experience personal fear about what would happen to them or their registration if they make a mistake. Swartz rounds were considered previously however have not been implemented. KM felt the link to the Trust's values should be stronger. KM noted that this will depend on capability and mindset, especially given changes in leadership development. HF explained that there is appetite for this across the organisation, and that there isn't parity at the moment. There is buy-in from senior leaders, but a framework needs to be developed at pace so practitioners making decisions feel supported. CH asked how implementation will be tracked. HF advised that the key metrics in Appendix 1 would indicate whether changes were taking effect and noted that, as Chair of the Patient Safety Incident Review Group, she also had oversight. AK added that wider cultural issues should begin to improve as the work progresses. Managers may feel that no immediate action is being taken when an issue is first raised; however, the initial focus should be on gathering the facts to understand whether the outcome would have been the same regardless of who was involved. This helps determine whether the matter reflects a system issue rather than an individual failing. Immediate suspension does not, in itself, prevent recurrence. SC suggested case studies would be useful. He also noted that system learning needs to be captured quickly to avoid the next person making the same mistake. It was recognised that registered practitioners have a code of conduct that they need to adhere to. The Committee endorsed the work.	
Network Update – DAWN Network	
SH explained the work the Network has assisted with over the last year, including the creation of the neurodiversity hub, the Health & Wellbeing passport, and anti-racism charter. The Neurodiversity hub in particular has been well viewed and used, providing support to both Neurodiverse individuals and their managers. Staff survey results 2025 staff with a disability or long-term condition showed improved engagement, although still struggling with attendance at network meetings. Work on reasonable adjustments is improving and is now closer to the national average. Career progression perceptions also improving. Lived experience remains unequal; there are higher levels of harassment and bullying reported from patients with a long term health condition or disability, as well as greater pressure for staff to attend work when unwell. Bullying and harassment from patients has worsened since the last survey, bullying linked to managers is lower than the national average but higher than that of other Trust staff. The Network is considering refreshing it's homepage on the intranet to be able to present more information to support managers in mitigating. The Health and Wellbeing passport needs further promoting as it can support with implementing reasonable adjustments, as well as encouraging managers to have meaningful conversations with teams. The Network is also considering sharing lived experiences. SH noted that accountability and responsibilities were unclear when staff raised issues through the Network, including what support the Network could provide. AK advised that individual cases had been raised at some Network meetings and noted the need to maintain an engaging	

space where staff could share experiences, while ensuring those requiring specific support were directed to HR. It was recognised that this may affect attendance at Network meetings, and that clarity was needed on how such issues should be managed when they arise, particularly where the Network may not be the most appropriate forum. Recent accessibility issues were noted, including an incident where a wheelchair user providing advice was unable to access the site to deliver a talk. A review with Estates was suggested, as some access barriers may be addressed through the installation of automatic door openers. Despite the Neurodiversity Hub and the education available for managers, there are ongoing reports of staff struggling with this across the organisation. There are more people reporting neurodiversity but not receiving enough support at work, with some progressing to disciplinary. Tools are there – need to encourage mgrs. To use it. Regarding the flexibility of the Trust's health and wellbeing offer, SH advised that charity-funded support was focused on what would best help the individual, rather than being determined by the organisation. It is part of the appraisal process to be offered a health and wellbeing conversation with a facilitator; however these should also be carried out informally by line managers. SC noted the need for support for neurodiverse colleagues, recognising that stress may present differently for some individuals and could be misinterpreted by others as aggressive behaviour. Coaching was suggested to help staff understand how their responses may be perceived by colleagues and to support effective stress management. SH added that a Neurodiversity forum is held every month for colleagues to receive support and advice. AK suggested incorporating this within general health and wellbeing and then signposting appropriately within the passport.	
People & Culture Updates:	
Chief People Officer Report	
At the time of writing, no industrial action was planned. Resident doctors have since announced strike action for the sixteenth time, and a live BMA ballot is underway for consultants and SAS doctors. Changes to employment rights legislation were noted, alongside the increasingly busy Employment Tribunal landscape nationally. AI was identified as an emerging influence, and an increase in grievances was also reported. The national review and reform of Employment Tribunals suggests a three-tier system, ranging from straightforward breach of contract cases to more complex and nuanced matters, with the highest tier covering significant discrimination cases. It was noted that some cases are now being listed up to two years ahead, creating challenges in maintaining witness recollection and affecting staff health and wellbeing. NHS Staff Standards leadership and management framework more information to be circulated soon. The Staff Standards will focus on the basics of people's experience at work such as access to food and hydration, feeling safe and not subject to assault, harassment or racism.	
Temporary Staffing Reduction Plan	
LF explained that agency usage is reducing however bank usage is increasing. Due to work to reduce agency rates down to price cap (particularly in Nursing), bank rates are now typically higher than agency. KM asked whether the worker receives the same net pay, or whether any higher rate paid by the Trust is offset by NHSP commission and therefore does not directly benefit the worker. LF clarified that the data shows the Trust's payments to the agency but agreed to liaise with NHSP for the data to demonstrate more clearly what the worker is paid. SC explained the Trust is paying more through bank to the person, due to a small transaction fee to NHSP. Additionally, if the rate is higher than agency (Healthcare workers for example), the worker would be getting more money through the Trust's bank than agency. Action: LF to find out.	

LF summarised actions being taken and emphasised need to focus on both reduction in rates and usage. Divisions are working on swap-out and recruitment plans. Closure of unfunded areas where there is no establishment, only bank and agency usage, will also make an impact. Price caps have been implemented for Nursing and Midwifery and AHPs, and this needs to be replicated for Medics. The plan is to take a stepped approach to reduce rates to those of the West Midlands agency cluster. If Divisions do not feel they can reduce rates, they will be asked to provide reasons and then implement action plans. The cost-of-living uplift was not applied to bank rates from April 2026, this is consistent across all staff groups. The next step is to consider reducing rates from the top of band to mid- or lower-band levels. Discussions have also taken place regarding a national bank rate for medical staff, although the national temporary staffing team is due to be disbanded by September. An options appraisal and Quality Impact Assessment will be undertaken to ensure there is no adverse impact on services. KM suggested more definitive deadlines for the actions and LF advised that many will have detailed CPIP schemes with deadlines. Agreed to include in future reports or on/off track indicator. AK acknowledged difficult decisions will need to be made however if not taken, the Trust will continue to pay above agency rates. The NHSP tender ends in March 2027 with an optional extra year. The Trust will review options and consider whether it is feasible to bring bank in-house, given 70/80% are Trust staff and agency has reduced significantly. SC added that bank rates should be high because they fill shifts; however, this is not currently the case and a discussion with NHSP is therefore warranted. If PDU closes, substantive staff would return to their wards, which should reduce temporary staffing usage. It was noted that for HCAs in particular, the Trust's bank rate is higher than agency despite NHSE mandate not to use. It was noted that HCAs are difficult to recruit and retain but agreed it does not make sense for bank rates to be higher than agency. Action – LF to provide further detail on the Quality Impact Assessment at the next meeting. SS noted the increase each month for temporary medical cover and questioned whether there are enough locally employed doctors. JW advised that business cases will be forthcoming from medicine to convert lines to substantive locally employed.	
Sickness Absence	
AK presented the audit report, which provided both moderate and significant assurance. The report confirmed that the policy framework is comprehensive and up to date, and that managers feel well supported in using it; however, it could be made more user-friendly. Some weaknesses were identified in documentation, alongside inconsistency in how the policy is applied. This links to the wider sickness reduction programme and associated deep dives. The importance of managing sickness as effectively and proactively as possible was noted. Workshops are being held to understand how learning on consistency can be shared across the organisation and incorporated into the documentation toolkits provided to managers.	
Additional Updates:	
Job Planning	
Job planning compliance across the organisation was 83% for all doctors as at April. Consultant compliance is now good, although further work is required for SAS grades. The target is 95%, with an interim aim of reaching 85% by the end of this financial year. The plan is to achieve 95% by the end of the next financial year by changing the job planning approach over the next 12 months, starting with teams before moving to individuals. Figures are expected to fluctuate during the next year while the revised process is embedded. The intention is to ensure there is no lapse by proactively completing job plans for the following year. SC added that historic disagreements relating to job plans had been resolved.	
Compliance with Resident Doctor 10 point plan	

Progress continues against the plan, with the quick wins now completed. Expectations regarding parking for on-call doctors remain high. Use of alternative parking such as County Hall, continues to be encouraged, while recognising that other staff groups also work shifts. Positive progress has been made with rota planning, although challenges remain due to late submissions from the Deanery. Resident doctors were considered to be generally satisfied, although further improvement is still required.	
Admin Transformation Progress	
Meetings were established in October last year and the programme wording has been updated to reflect the opportunity to modernise services, reduce duplication and optimise the use of technology. The programme also aims to ensure the workforce is aligned with the 10-year plan and future workforce requirements. Work is underway with Digital, the Chief Operating Officer and AK to reset the programme, refocus its objectives and clarify roles, responsibilities and workstream leads. The last six months have highlighted significant inconsistencies across administrative services, alongside opportunities to make better use of technology. Governance within the People Directorate is also being reviewed, including the establishment of a People Operational Delivery Group. This will ensure the programme is subject to appropriate scrutiny and oversight going forward. In relation to MARS, 40 applications were received and first drafts of settlement agreements have been issued for 13 colleagues. Plans are in place to identify skill-mix opportunities and deliver savings for these 13 posts. The affected colleagues are expected to leave the organisation by the end of August.	
International Staff and Students Integration Programme	
A workforce wellbeing grant of approximately £50,000 was awarded by NHS Charities Together through the innovation grant. The project focuses on internationally educated staff and students, and aims to identify the challenges they experience. Feedback indicated that staff are experiencing difficulties outside work, including understanding the benefits system and visa requirements. It was also noted that some colleagues on wards have established food banks to support them. Support from Citizens Advice is now in place, although uptake has been slow. The offer is being promoted through the usual Trust communications channels, with SH working closely with the EmBRACE Network Chair to undertake walkabouts and raise awareness. The Building Belonging work includes webinars and engagement with staff to understand the topics they would find helpful. The first event is scheduled to take place in June at CHEC. The first report to NHS Charities Together will be submitted next month. Engagement is also taking place with the University of Worcester regarding its role and responsibilities for student welfare. The university will be included in relevant documentation, with information channelled through practice facilitators. It was noted that there are hundreds of internationally educated nurses. Direct written communication, either by email or leaflet, was suggested as a way to reach this group more effectively to inform them of the support available. It was agreed that the term "internationally educated" should be used, recognising that these colleagues are WAHT staff.	
Professional Bodies Report	
The report has previously been presented via QGC and provides an update on NMC and HCPC activity. A robust process is in place for NMC cases, although further work is required with HCPC colleagues. The NMC has identified processing issues over the last 12 years relating to health and character screening. Around 18,000 staff nationally may be affected, with 421 individuals requiring review. Those individuals have been contacted. Although organisations do not know who is affected, the Trust has decided to write to all staff to confirm that support is available should they feel they need it. Action: Include lapses in registration in the next report.	

HF clarified that before making a referral to the NMC, the Trust undertakes its own internal process and would not refer an individual while keeping them on suspension. Where an individual has been dismissed, the Trust will automatically make a referral. The NMC will not usually progress an investigation until the Trust has completed its internal investigation.	
The Future of Freedom to Speak up	
It was noted that the National Guardian's Office is recommended to cease operating from the end of June. A gap analysis has been completed and identified only minor gaps, with the Trust generally in a good position. Information on the public-facing Trust website is out of date, and discussions are taking place with the National Guardian's Office regarding whether contact details should use an individual or generic email address. Quarterly data is currently submitted to the National Guardian's Office; however, it has not yet been confirmed where this information will be submitted in future. Seek assurance at the August committee that outstanding recommendations have been closed.	
Governance:	
People & Culture Risk Register	
There are currently two workforce risks rated 15 or above: • Risk 5625: Medical and dental temporary staffing. The recommendation was to retain the risk at its current rating. • Risk 5692: Job planning. Following the recent ERM request to review all red risks, and given the assurance received from the CMO that the Trust is close to achieving the 95% target, has a clear improvement plan in place, and has addressed historic 12PA+ job plans. LF therefore proposed reducing the risk rating to 3. SC suggested creating one risk for bank staffing, including nursing, and a separate risk for agency staffing. The positive progress on agency use was recognised, while bank staffing was noted as an emerging area requiring greater focus. In relation to job planning, there may be a need to separate SAS doctors from consultants, given the specific concerns relating to job planning this group. HF noted that job profiling may present a financial risk. There may be some funding attached to band 5/6 changes, although the position for 6/7 or 7/8 changes remains unclear. LF agreed that further information was awaited and agreed to draft a risk, noting that it may not reach a rating of 15 or above. It was agreed that Risk 5625 would remain, with an additional bank staffing risk to be added across all staff groups. It was agreed to reduce the job planning risk as proposed, while also reviewing a separate SAS doctor risk. JW noted that any separate SAS doctor risk was unlikely to exceed a rating of 15 due to the smaller size of the group. The updates will be reflected in the next report.	
Any Other Business (AOB)	
Use of charitable funds RH noted that charitable funds are sometimes utilised to support celebrations such as international awareness days and festivals. It was clarified that there are no general funds available for this type of activity. The charity had previously supported staff awards, although this ceased when the Trust joined the Foundation Group. Over the past year, £165,000 has been invested in staff wellbeing through the charity, and feedback was invited on what colleagues would find most valuable.	

AK noted that any support should link clearly to staff experience and the Trust's values, including recognition of the behaviours the organisation wishes to encourage. It was agreed that the £165,000 investment in staff wellbeing should be more widely promoted. SC added that while there are many international awareness days and festivals, not all require charity funding or resource. However, the Trust could still help to publicise relevant events and celebrations. <u>Lessons learned from Measles outbreaks</u> HF noted that recent measles outbreaks had highlighted the need for assurance around some Occupational Health processes and systems. Work is underway with IPC and Occupational Health to ensure clear oversight of staff immunity, following issues identified through measles contact tracing. Agreed to discuss at the next meeting.	
Date of Next Meeting	
The date of the next meeting is Tuesday 4th August, Colab Kidderminster Treatment centre.	

DRAFT

Escalation and Assurance Report

Report from: Audit and Assurance Committee
 Date of meeting: 9 July 2026
 Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation

None

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

Item/Topic	Internal Audit Progress Report
Rating rationale	- Two draft reports, on the Data Security and Protection Toolkit and NHS pre-employment checks, had been finalised and would be presented at the next meeting. The DSPT opinion had improved from the previous year and included four low-level recommendations. - Five actions due at the start of the financial year had been implemented. Benchmarking confirmed strong arrangements for action tracking, although overall performance was affected by the timeliness of lower-priority actions. - Internal Audit and management were continuing to ensure that agreed actions were specific, deliverable, evidenced and completed promptly, with transparent acceptance of risk where action was not proposed.
Outcome	The Committee noted the report and the positive action-tracking position.
Item/Topic	External Audit Value For Money Recommendations: Next Steps
Rating rationale	The purpose of the report was to provide more focus on the management actions included within the annual Auditor reports presented alongside the Annual Accounts at a previous meeting. The Auditor confirmed that the management actions in response to recommendations were viewed as appropriate and proposed an interim review of improvements in January. The Committee considered the role of both the Financial Recovery Board (FRB) and Trust Board in monitoring progress. It was agreed that there was merit in a regular stocktake on this and associated matters, including the Undertakings and the NHS Oversight Framework (NOF)
Outcome	The Committee accepted the report and agreed the following actions: - Schedule a regular report to the Trust Board of progress on the VFM recommendations, Undertakings and NOF. - Schedule thematic reviews of VFM improvements in the Committee's annual workplan. - Schedule an interim review of VFM progress by External Audit in January 2027.
Item/Topic	Counter Fraud Progress Report
Rating rationale	Delivery of the annual plan was progressing well. There had recently been two positive prosecutions from legacy cases. Two new referrals were in the early stages of investigation. No significant matters were identified for escalation at this stage.
Outcome	The update was noted.
Item/Topic	Group Procurement Services: Financial Sustainability and VFM
Rating rationale	The Committee received an update on procurement transformation across the Foundation Group. Work continued to focus on improving value for money through enhanced category management, contract management, data analytics and collaborative procurement activity. The business case for a shared procurement service was supported by the Trust Management Board and was progressing through partner organisations, with the Trust proposed as host.
Outcome	The Committee welcomed the progress reported to date, including the use of clinical expertise to support standardisation and value realisation, and supported continued focus on automation, resilience and service sustainability.

Assurance Rating Key

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 9 July 2026
Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	Fit and Proper Persons Test (FPPT) Compliance Report
Rating rationale	The annual report provided assurance that the Trust was fully compliant with its policy in 2025/26 and submission to NHSE within the required timescale. A local audit identified some minor opportunities for improvement in the presentation of evidence and actions were planned. A review by the Internal Auditor the previous year provided significant assurance that the Trust's policy and processes were compliant with the national framework. The low priority recommendations for improvement had been implemented.
Outcome	The Committee accepted the report.
Item/Topic	Board Assurance Framework
Rating rationale	The BAF had been updated with a heat map and the Board-approved risk appetite statement. The document and process continued to develop. Workforce risks would be reviewed by the People and Culture Committee, and digital and cyber risks had been reviewed through digital governance. The Committee requested further assurance on how risk management is translated from ward to Board level through operational and divisional governance arrangements.
Outcome	Action: Add an item to the Committee work plan on ward-to-Board risk management.
Item/Topic	Annual Review of Audit and Assurance Committee Effectiveness
Rating rationale	The annual review concluded that the Committee remained broadly compliant with its terms of reference. A number of opportunities for further development were identified for implementation during 2026/27. The terms of reference were updated to reflect the most recent version of the HFMA guidance.
Outcome	Recommendations for further development of Committee effectiveness were agreed.

To Note: Items received for information or approval	
Item/Topic	External Audit Update
Summary	Discussions with the External Auditor regarding the accounting treatment of a lease arrangement were ongoing. Further work was being undertaken to finalise the accounting entries and understand any impact on prior year accounts. A further report would be brought to the Board when the position was confirmed.
Outcome	The update was noted.

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	8 September 2026
Title of Report:	Annual Review of Audit and Assurance Committee Effectiveness
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Company Secretary
Reporting Route:	Audit and Assurance Committee
Enclosures included with this report:	Draft Revised Committee Terms of Reference
Purpose of report:	☒ Assurance ☒ Approval ☐ Information
Brief Description of Report Purpose	
An annual review of the effectiveness of the Audit Committee is considered good governance and best practice to ensure the Committee is meeting its terms of reference, including in particular, its duties and responsibilities with regard to the oversight of a robust system of governance, risk management and control. In addition to guidance and tools provided by the Healthcare Financial Management Association (HFMA), the report is informed by a set of measures and a member survey focused on Committee impact. This report should be read alongside the Annual Governance Statement which is part of the Annual Report 2025/26.	
Recommended Actions required by Board or Committee	
The Trust Board is asked to: - Take assurance from the report that the Committee met its terms of reference in 2026/27 and that further developments to improve the effectiveness of the Committee in 2026/27 are planned. - Approve the proposed changes to the Committee terms of reference.	
Executive Director Opinion¹	
The report was reviewed and approved by the Audit and Assurance Committee at its last meeting in July.	

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

Annual Review of Audit Committee Effectiveness 2025/26

Contents

1. Introduction	1
2. Meeting the Terms of Reference	1
3. Oversight of the system of governance, risk management and control	3
4. Performance and Effectiveness of External Audit	7
5. Performance and Effectiveness of Internal Audit.....	7
6. Impact of the Audit Committee	8
7. Conclusions and recommendations.....	11

1. Introduction

This report summarises the work of the Audit Committee during 2025-26 in discharging its duties as set out in its terms of reference.

The report should be read in conjunction with the Annual Governance Statement, which is part of the Trust's Annual Report.

The following documents are available as appendices to the report.

- Review of compliance with terms of reference
- Committee attendance record
- Committee Process and Effectiveness Checklists (HFMA)
- Record of Committee reporting
- Draft Revised Committee Terms of Reference

2. Meeting the Terms of Reference

a) Terms of Reference Compliance Review

The terms of reference are substantially aligned with the model published by the Healthcare Financial Management Association (HFMA).

The documentation appended to this report demonstrates that the Committee met its terms of reference in full, with the following exceptions.

Term	Compliance	Comment	Action
As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committees must not undertake the Committee's role.	Partial	The Committee has agreed to strengthen this area on 2026/27	See below
The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance, risk	Partial	Limited focus in this area	Strengthen focus on other assurance functions and linkages with other committees and avoid overlap/duplication.

management and assurance of the organisation, to include IT security and information governance.			
These will include, but will not be limited to, understanding the implications of working in an Integrated System, ensuring arrangements are aligned and any impact on the Trust's governance arrangements. Also any reviews by NHS England, Department of Health and Social Care arm's length bodies, Regulators/Inspectors (eg Care Quality Commission (CQC), NHS Resolution, etc), NHSCFA and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies,).	Partial	Much of this falls within the scope of the Quality Committee	
In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee/Quality Assurance Committee/Quality Committee/Quality Governance Committee and the Risk, Health and Safety Board/Executive Risk Committee/Executive Risk Management Committee.	Not Met	See above	Schedule reviews of the work of the other Board committees
In reviewing the work of the Clinical Governance Committee/Quality Assurance Committee/Quality Committee/Quality Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function including that the quality account presents accurate data and meets the reporting requirements as prescribed nationally.	Not Met	Not met in year as above. Note that the expectations of the committee in relation to the quality account have changed, as expressed in the HFMA handbook	Revise this term in relation to the quality account, in accordance with updated HFMA handbook
It may also request specific reports from individual functions within the organisation (eg clinical audit, ICT, compliance reviews and accreditation reports) as they may be appropriate to the overall arrangements.	Partial	None in-year	Schedule local assurance reports on key internal control matters or areas of concern outside the internal audit plan

b) Committee Meeting Attendance

The record shows good attendance from all members, a quorum at each meeting and good attendance and engagement from managers and auditors in line with the terms of reference.

c) HFMA Process Checklist and Effectiveness Checklist

Completion of the checklists has highlighted opportunities for improvement in similar areas to the terms of reference compliance review:

- Linkages with and assurance from other Board committees.
- Oversight of assurance from sources other than the auditors and local counter fraud specialist.

d) Terms of Reference Revisions

Proposed revisions to the Terms of Reference are set out in the attached Appendix.

In addition to changes recommended in the review of compliance above, the following changes are proposed in line with the up to date HFMA model:

- More explicit confirmation that the Head of Internal Audit, External Audit representative and Local Counter Fraud Specialist (LCFS) have direct and unrestricted access to the Committee Chair and/or Committee as required.
- Updated terminology regarding internal audit.
- Extending the private meeting provision to include the LCFS alongside the internal and external auditors.
- Additional wording about the requirement for an annual committee effectiveness review.

3. Oversight of the system of governance, risk management and control

a) Committee Work Programme

An annual work programme was set at the start of the year based on the audit cycle, annual report and accounts, internal audit cycle and other key responsibilities within the Terms of Reference.

The work programme covered the following areas:

- Annual Accounts and Report
- Annual Governance Statement
- External Audit updates and annual report
- Work of the Internal Auditor in delivering the annual plan.
- Work of the LCFS, both planned and reactive.
- Financial governance matters:
 - Single tender waivers
 - Losses and special payments
 - Contract management
 - Accounting policies
 - Non-compliance with Standing Financial Instructions (SFI)
- Governance and regulatory matters:
 - Managing conflicts of interest
 - Fit and Proper Person Test (FPPT)

- Process for Raising concerns (freedom to speak up)
- Annual review of compliance with Terms of Reference
- Provider Capability Assessment
- Local Security Management Annual Report
- Emergency Planning, Resilience and Response Annual Report
- Risk management:
 - BAF process, format and controls
- Other Assurance reports:
 - UEC Capital Project Value for Money (VFM) Review (independent)
 - Independent opinion on accounting treatment of carpark
 - Management response to External Audit VFM recommendations
 - EPR Benefits Realisation

b) System of Risk Management

The Trust's system of risk management is described in detail in the Annual Governance Statement, which was reviewed in draft by the Committee after the end of the financial year and is included in the final Annual Report presented to the Committee in June 2026.

Each year, the Internal Audit Plan includes a review of risk management, with a particular focus on the Board Assurance Framework (BAF), as a core review pertinent to the Head of Internal Audit opinion. The outcome of each of the annual audits from 2022/23 is set out in section 6 of this report.

The BAF format and approach were revised in-year, with each strategic risk aligned to relevant annual strategic objectives and Trust priorities. The Audit Committee received regular reports on the new BAF during the second half of the year following these revisions.

c) Internal Audit

The work of the Internal Auditor during the year is described in detail in the Annual Governance Statement. The outcome of each review from the 2025/26 Internal Audit Plan is set out below. Each report included management responses to the review recommendations. The Committee reviewed the responses and where it was not satisfied that these were sufficiently robust or realistic in terms of timescales, amendments were requested. Where appropriate, a detailed update on progress of management actions was requested. The Internal Auditor tracked completion of recommendations and provided a regular report, focused in particular on high and medium priority actions (see below).

Possible ratings:

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

Review	Rating / Opinion
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

Handover and Transfer of Care (joint with H&CT)	Limited assurance
Fire Safety Enforcement Notice Action Plan	Substantial assurance
Board Assurance Framework	Moderate assurance
Absence Management	Significant assurance
Data Protection and Security Toolkit (DPST)	Risk: low Confidence: high

d) Other Assurance: Management and Independent Assurance Reports

In addition to routine governance matters and reports from the Auditor and LFCS, the Committee received management reports on four areas:

- UEC Capital Project Value for Money (VFM) Review

The Committee reviewed an independent assessment of the VFM of the UEC capital project, which completed in 2023/24.

- Independent Opinion on accounting treatment of car park

The report was commissioned as a source of assurance on the accounting treatment for the proposed carpark solution.

- Management response to External Audit VFM recommendations

The Committee reviewed progress against the previous year's recommendations and undertook a more detailed review of the management response to recommendations included in the 2024/25 Audit report.

- EPR Benefits Realisation

The Committee considered the benefits derived to date from the phased programme, noting substantial validated cost savings and positive staff feedback about quality benefits.

e) Governance: Other Committees with Assurance Functions

- Quality Governance Committee

During the year the Quality Governance Committee increased its focus on divisional risk and adopted the escalation and assurance report format to enhance the focus on assurance in its reports to the Trust Board, directing attention to priority areas, which will support future internal audit planning.

- PFI Exit Committee

The committee was established at the end of 2024/25 to oversee the hand-back of the Worcester Royal Hospital PFI contract to the Trust, which will end in 2031. The Committee developed its approach during 2025/26, with support from external advisors and colleagues from the Foundation Group and Wye Valley NHS Trust, which is 2 years ahead of the Trust in its expiry programme.

Escalation and assurance reports from the Committee were presented to the Trust Board in private during the year due to the focus on third parties and commercial contracts. These reports will become increasingly important over time and will align with a planned Board Assurance Framework risk.

- Executive Risk Management Committee

The Committee has a detailed focus on individual high and very high risks and the quality of risk management within the divisions.

- Financial Recovery Board

The FRB membership comprises all Board members and is not therefore truly a Board committee; however, this important forum provides a regular opportunity for more detailed scrutiny of and assurance about the delivery of the annual financial plan.

- Relationships with other Assurance Committees

There is cross membership between the Audit and Assurance Committee and all of the above committees, with the exception of the Executive Risk Management Committee, in which case the link is provided by the Company Secretary and Managing Director.

Where appropriate, internal audit reports are referred by the Audit Committee to other relevant Board assurance committees for more detailed oversight.

f) Financial Reporting Systems

The Committee's assurance on the reliability and quality of the Trust's financial reporting systems comprised the following:

- Internal Audit Review

Reviews of financial controls are included in every annual internal audit plan with a different focus each year. These are key sources of assurance for the Head of Internal Audit Opinion. The 2025/26 reviews included financial ledger, procurement/contract management and payroll (expenses), all of which were rated significant assurance.

- Counter Fraud Annual Report

The report includes an assessment of the Trust's compliance with the Counter Fraud Functional Standard. In 2025/26 the overall rating was green.

During the year, the LCFS undertook proactive exercises in the following areas, which informed the Trust's fraud risk assessment:

- Staff working elsewhere
- National fraud initiative conflict of interest matches

- External Audit:

The External Auditor highlights any areas of significant weakness in financial sustainability, governance or economy, efficiency and effectiveness. The number of weaknesses identified has varied each year since 2022/23, highlighting sustained issues in some areas.

- Financial governance reports:

Reports providing assurance on key areas of financial governance are scheduled throughout the year. In 2025/26, these included:

- **Contract management:** Two reports during the year provided assurance on work in progress to improve the central management of contract expiry, which improved the ability to plan and identify opportunities for savings efficiencies cross Trust or Group.
- **Single tender waivers:** Regular reports assured the Committee that the controls in place were robust and continued to develop.
- **Losses and special payments:** The reports provided assurance regarding the controls in place to reduce losses, including bad debts, lost patient property and expired pharmacy stock.

- **Review of Financial Statements**

The Committee performed a detailed review of the unaudited financial statements and the draft Annual Governance Statement.

No significant issues related to the financial statements were highlighted prior to the audit.

No major weaknesses in governance systems were highlighted in the Annual Governance Statement.

4. Performance and Effectiveness of External Audit

The Auditor discussed the audit plan with the Committee at an early stage before the start of the Audit.

There were reportedly positive relationships between the Auditor and management/the finance team.

The Committee received regular updates from the External Auditor on progress of all stages of the audit.

The External Auditor also provided additional information to the Committee on sector benchmarking and sector developments, which added value.

5. Performance and Effectiveness of Internal Audit

- **Delivery of the Internal Audit Annual Plan**

The annual Internal Audit Plan comprises mandatory reviews of topics that are core to the annual Head of Internal Audit Opinion and prioritised risk-based reviews of areas recommended by the Executive Team and agreed by the Committee.

The Committee received regular updates on delivery of the Internal Audit Plan, including performance on agreed KPIs for both the Internal Auditor and Trust management. The plan was complete by year-end, enabling presentation of the Head of Internal Audit Opinion in May 2026.

- **Recommendation Tracking**

Recommendations made by the Internal Auditor are ranked according to priority. Implementation of agreed recommendations was closely tracked and the position was regularly reported to the Committee during the year, with any due date revisions highlighted.

The reports provided assurance that management took internal audit and the need for assurance seriously and that actions were implemented in a timely way, reducing the duration of the Trust's exposure to risk.

The improvements achieved in 2024/25 in the timely implementation of recommendations continued in 2025/26, with 100% closed on time.

- **Committee Review of Internal Audit Effectiveness**

The Committee discussed the effectiveness of internal audit in private during the year.

6. Impact of the Audit Committee

As well as considering whether the Committee met its terms of reference and standards of best practice in 2025/26, this report considers the Committee's effectiveness in terms of its impact. Following Committee agreement, two sources of information were used as part of this assessment:

- a) Key measures, with annual comparators where available, providing a picture of the Committee's impact or influence on its areas of oversight over time
- b) Committee member survey.

Details of these two sources are provided below.

DRAFT

Audit Committee Impact Metrics

Indicator	2022/23	2023/24	2024/25	2025/26	Comment
External Audit: No. of financial sustainability weaknesses	One	Two	One	One	Improvement after deterioration at year two
External Audit: No. of governance weaknesses	None	None	None	None	Consistent
External Audit: No. of improving economy, efficiency & effectiveness	Two	Two	One	Two	Varied weaknesses identified
Head of Internal Audit Annual Opinion	Moderate assurance can be given as weaknesses in the design, and/or inconsistent application of some controls, put the achievement of aspects of some of the organisation's objectives at risk in some of the areas reviewed.	I am providing an opinion of Limited assurance that there are weaknesses in design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.	I am providing a final opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.	I am providing a final opinion of 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.	Improvement in last two years
Internal Audit: Key Financial Controls/ Core financial systems	Significant	Significant	Significant	Significant	Consistent
Internal Audit: BAF & Risk Management	Full	Limited	Significant	Moderate	Variable, reflecting changes in corporate governance leads and developments in approach
Internal Audit: Data security & protection toolkit	n/a	n/a	Risk: moderate Confidence: high	Risk: low Confidence: high	Improvement from year one to two
Internal Audit: Complaints	n/a	Limited assurance	Moderate assurance	n/a	Improvement between reviews

Internal Audit: Implementation of management actions	42% of recommendations overdue	94% of recommendations implemented on time	94% of recommendations implemented on time	100% implementation on time	Significant improvement over the 4 years
LCFS: Counter fraud functional standard return	10/13 green 3/13 amber	11/13 green 02/13 amber	11/13 green 02/13 amber	11/13 green 02/13 amber Overall: green	Consistent, with some improvements over time
Number of counter fraud referrals	4	Not reported as an annual figure	11	18	Growth over time

DRAFT

Audit Committee Member Survey

Following consideration by the Committee earlier in the year, the Chair agreed a series of questions to include in a survey of Committee members with a view to assessing the impact of the Committee. The same survey was implemented at the Trust's partner trust, Wye Valley NHS Trust, which will provide opportunities for benchmarking and sharing.

Summary

Committee members answered 'agree' or 'strongly agree' in response to the following questions:

- The Committee has added value to the Trust
- The Committee sought development and improvement of its own structure and approach
- There is evidence of tangible improvements to practice or compliance as a result of the work of the Committee
- The internal audit and counter fraud plans covered all the highest priority areas

There was a mixed response (strongly agree, agree or not sure) to the following questions:

- Where internal audits provided limited assurance, the Committee ensured it followed up on progress
- Progress reports on areas with limited assurance showed improvement
- The Committee received sufficient assurance from other sources on lower priority areas
- The outcome of independent audit and reviews have resulted in significant improvements to internal controls
- Areas reviewed annually by the Committee have shown improvement

There was a mixed response (agree, not sure or disagree) to the following questions:

- Managers were positive and transparent in responses to independent audits and reviews
- The Committee engaged well with the other Committees of the Trust Board

Key strengths/positives are highlighted as follows:

- Committee challenge and follow-up.
- Improvements in internal audit recommendation completion rate.
- Improvements in contract management

Areas highlighted as opportunities for the Committee to be more effective:

- Visibility of and detail on progress and improvements in audited areas
- Gaps in assurance/audit plan due to audit capacity
- Engagement with other Board committees

Suggested Committee Objectives

- Interact more effectively with the other Board committees
- Strengthen challenge of management responses to recommendations
- Provide more space for priority issues (agenda/audit plan)
- Increase visibility of the implementation of recommended changes.

7. Conclusions and recommendations

The report demonstrates good overall compliance with the terms of reference and current NHS guidance, with some areas for improvement to strengthen the Committee's oversight of the Trust's governance arrangements and internal controls.

Through its work during the year, the Committee was assured that:

- the Trust's system of risk management is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks.

- the assurance framework is fit for purpose and that the assurances and the reliability and integrity of the sources of assurance are sufficiently comprehensive to support the Board's decisions and declarations.
- there are no outstanding areas of significant duplication or omission in the Trust's systems of governance that have come to the Committee's attention.

Recommended actions

1.	Update terms of reference to align with updated HFMA model
2.	Add to annual work programme reviews of the effectiveness of: • Quality Committee • People and Culture Committee
3.	Refer audit reports to relevant Board committee for ongoing oversight and review committee responses
4.	Schedule follow-up management reports to the Committee on areas with lower levels of independent assurance as required
5.	Allow more time on meeting agendas to consider management responses to audit recommendations, enabling more opportunity for challenge.
6.	Add to annual work programme an agreed schedule of local assurance reports on key internal control matters or areas of concern.
7.	Share learning from this review with Foundation Group partner trusts and invite learning from their identified areas of good practice.
8.	Add a mid-year update on progress of these changes.

Worcestershire Acute Hospitals NHS Trust

Audit and Assurance Committee

TERMS OF REFERENCE

Remit	The Committee is established by the Trust Board (hereafter referred to as the Board), in accordance with the Trust's Standing Orders, as an Audit and Assurance Committee in relation to providing assurance to the Board, specifically in relation to internal controls, risk management and the Trust's overarching governance framework.
Accountability Arrangements and Authority	The Committee is accountable to the Board in accordance with the following paragraphs of the Standing Orders: - The Trust shall establish a Committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate. The Committee has the full support of the Board and the Board has authorised the Committee to: - investigate any activity within its Terms of Reference. - seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Committee. - to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
Responsibilities	<u>Governance, Risk Management and Internal Control</u> The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy and effectiveness of: - all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board. - the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of disclosure statements. - the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence. - the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHS Counter Fraud Authority (NHSCFA). In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and

managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committees must not undertake the Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets ~~public sector~~Global Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable/Accounting Officer and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between Internal and External Auditors to optimise the use of audit resources.
- ensure a robust system is in place to follow up internal audit, external audit, value for money and any other audit reports presented to the Committee, based on agreed management action plans.
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- monitor the effectiveness of internal audit by carrying out an annual effectiveness review.

External Audit

The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors, and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of External Audit, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate).
- discussion and agreement with External Audit, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy.
- discussion with External Audit of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all External Audit reports, including reports to those charged with governance and any work undertaken outside the annual audit plan, together with the appropriateness of management responses and also recommend the annual audit letter to the Board.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- Ensuring that the External Audit tenure of appointment conforms with the code of governance regarding rotation of key audit personnel and the provider as a whole.
- The Committee shall ensure the cost effectiveness of External Audit.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance, risk management and assurance of the organisation, to include IT security and information governance.

These will include, but will not be limited to, understanding the implications of working in an Integrated System, ensuring arrangements are aligned and any impact on the Trust's governance arrangements. Also any reviews by NHS England, Department of Health and Social Care arm's length bodies, Regulators/Inspectors (eg Care Quality Commission (CQC), NHS Resolution, etc), NHSCFA and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).

In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee and the Executive Risk Committee/Executive Risk Management Committee.

In reviewing the work of the Quality Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and the robustness of processes behind the quality accounts.

~~including that the quality account presents accurate data and meets the reporting requirements as prescribed nationally.~~

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and shall review the outcomes of counter fraud, bribery and corruption work that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist, it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

It may also request specific reports from individual functions within the organisation (eg clinical audit, ICT, compliance reviews and accreditation reports) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- changes in, and compliance with, accounting policies, practices and estimation techniques.
- Changes in, and compliance with guidance issued by NHS England.
- unadjusted misstatements in the financial statements.
- significant judgements in preparation of the financial statements.
- significant adjustments resulting from the audit.
- Letter of representation.
- Explanations for significant variances.
- Qualitative aspects of financial reporting.
- The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.
- The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Suspension of Board Standing Orders

The Committee shall review every Board decision to suspend the Board Standing Orders.

System for Raising Concerns

The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise, (in confidence,) concerns about possible improprieties in any area of the organisation, including (financial, clinical, safety or workforce matters.) The Committee shall seek assurance and ensure—that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance Regulatory Compliance

The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test.

	<u>Conflicts of Interest</u> The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective. <u>This will include</u>ing receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.
Membership / Attendance	The Members of the Committee are: • Not less than three Non-Executive Directors. • One of the members shall have recent and relevant financial experience. • A Non-Executive Director maybe coopted to attend a meeting to ensure the quorum of two Non-Executive members is met. The Chairperson of the Trust shall not be a member of the Committee. The Chief Finance Officer, Trust Company Secretary and appropriate Internal Auditor, External Auditor and Local Counter Fraud Specialist representatives shall normally attend meetings. At least once a year the Committee will meet privately with External Audit, and Internal Audit and the Local Counter Fraud Specialist, either separately or together, and may do so more frequently where required. <u>The Head of Internal Audit, External Audit representative and Local Counter Fraud Specialist shall have direct and unrestricted access to the Committee Chair and/or Committee when required. This access is intended to support timely escalation of significant governance, risk, control, audit and counter fraud matters.</u> The Chief Executive, Managing Director, Chief Officers and other Managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Chief Executive will attend at least annually, to discuss the process for assurance that supports the Annual Governance Statement and also when the Committee considers the annual accounts. The Managing Director will attend when the Committee considers the draft internal audit work plan. In exceptional circumstances, deputies may be nominated to attend prior to the meeting, with the Chair's approval. The Chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. The Audit Committee, supported by the Chief People Officer, will ensure that all members are suitably trained and have continuing appropriate training to enable them to be effective.
Chair	The Chair of the Committee shall be appointed by the Board from amongst the Non-Executive Directors.

	The Vice Chair or Senior Independent Director should not Chair the Audit Committee. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the Chair.
Quorum	A quorum shall be two Non-Executive members, to include the member with significant, recent and relevant financial experience/ Chair of the Committee (who will be a voting Non-Executive Director).
Reporting Arrangements	The Minutes of Audit Committee meetings shall be formally recorded and the approved Minutes will be made available for review by submitted to the Board. Following each meeting, the Committee Chair will submit a formal report on the proceedings of the meeting, drawing the Board's attention to any issues that require disclosure to the full Board, or require executive action, to the next meeting of the Board. The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts. <u>The Committee shall undertake an annual effectiveness review. The outcome of the review will be reported to the Committee and Board and will inform any proposed amendments to these Terms of Reference.</u>
Frequency of Meeting	The Committee will hold scheduled meetings not less than four times a year. The External Auditor or Head of Internal Audit may require a meeting if they consider that one is necessary. Therefore and the Committee Chair may convene additional meetings as necessary. <u>An annual work programme will be maintained to ensure that meeting dates and agendas are planned around the audit cycle, annual report and accounts, Annual Governance Statement, governance reporting, risk and assurance cycles, counter fraud reporting and other key responsibilities within these Terms of Reference.</u>
Administration	The Trust Secretary will provide appropriate support to the Committee Chair and Committee members which will include: • Advising the Committee on pertinent areas relating to governance and risk management arrangements. • Supporting the Chief Executive as Accountable Officer on issues in relation to internal controls, governance and risk management particularly providing assurance on such systems through the drafting of the Annual Governance Statement. • The development of an annual programme of work for the Committee to approve.

	The Committee shall be supported by a nominated Executive Assistant/Board Administrator, whose duties will include: • Preparation of agenda in consultation with the Committee Chair and Chief Finance Officer. • Collation and publishing reports / presentations at least 5 working days in advance of the meeting. • Taking the Minutes, ensuring they are an accurate reflection of the business of the meeting and keeping an accurate record of matters arising and issues to be carried forward. • Ensuring the Minutes and actions are circulated to the Committee Chair for review within 5 working days of the meeting and circulated to the other members for information within 10 working days. • Keeping a record of matters arising and seeking updates on action points ready for the next meeting.
Date Approved	WVT Committee on 12 December 2024 Foundation Group Boards on 5 February 2025 By Audit Committee on: 9 July 2026 By Trust Board on:
Date Review	To be reviewed annually. These Terms of Reference will be reviewed annually, and more frequently if required. The annual review will take account of the Committee's effectiveness review, changes to national guidance, changes to Trust governance arrangements and any learning arising from internal audit, external audit, counter fraud or Board assurance processes.