Worcestershire Acute Hospitals NHS Trust

Trust Key Performance Indicators (KPIs) - up to Jun-26 data

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

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

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

Example

Data Quality Assurance Questions

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

NHS Worcestershire Acute Hospitals NHS Trust

Quality of care, access and outcomes		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Latest Month Numerator	Latest Month Denominator	Year to Date (v Standard if available)	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/Fail	SPCs: Trend Variation	DQ Mark
Cancer	% of patients told their cancer diagnosis outcome within 28 days (all routes) ***NHSE NOF***	Chief Operating Officer	**80%**	74.6%	70.0%	75.4%	77.2%	75.9%	74.0%	80.1%	80.4%	75.8%	63.7%	77.2%	72.2%	75.4%	82.3%	83.1%	82.5%		2,479	3,005	80.9%		79.3%	Jul-26			
	% of patients receiving their first or subsequent treatment for cancer within 31 days of decision to treat / earliest clinically appropriate date (all routes)	Chief Operating Officer	**96%**	87.4%	84.7%	84.4%	79.6%	83.3%	80.8%	83.3%	85.8%	87.3%	82.9%	89.1%	83.1%	84.1%	84.9%	86.4%	87.0%		521	599	85.6%		92.5%				
	% of patients receiving their first definitive treatment for cancer within 62 days of referral (all routes) ***NHSE NOF***	Chief Operating Officer	**75%**	64.5%	57.4%	58.5%	57.3%	65.1%	54.5%	60.2%	61.1%	66.5%	58.4%	57.3%	57.2%	51.8%	44.0%	57.0%	53.0%		204	385	51.7%		71.2%				
	% of suspected cancer referrals waiting >62 days	Chief Operating Officer	**Plan**	8.6%	10.3%	9.8%	9.8%	11.5%	9.1%	10.4%	9.3%	12.1%	12.2%	11.8%	10.9%	11.1%	13.1%	12.7%	10.5%	10.9%									
Urgent and Emergency Care	% of ambulance handovers within 45 minutes	Chief Operating Officer	**100%**	65.9%	71.7%	80.8%	84.2%	81.4%	65.8%	65.2%	74.8%	72.7%	59.6%	75.1%	83.4%	87.1%	86.4%	79.3%	79.4%	71.7%	2,878	4,012	80.8%						
	% of patients seen within 4 hours (any type) ***NHSE NOF***	Chief Operating Officer	**76%**	60.9%	65.1%	66.1%	66.5%	64.5%	63.0%	62.4%	62.7%	59.9%	62.9%	67.1%	71.5%	69.6%	71.9%	68.5%	69.3%	65.5%	13,876	21,184	68.9%		75.0%	Aug-26			
	% of patients seen within 4 hours (type 1)	Chief Operating Officer		44.5%	49.3%	50.9%	50.8%	49.5%	47.7%	48.0%	49.1%	47.1%	49.4%	54.8%	59.6%	56.6%	60.1%	55.4%	55.7%	51.2%	7,605	14,853	55.4%		61.1%				
	% of patients spending more than 12 hours in A&E ***NHSE NOF***	Chief Operating Officer		13.0%	10.8%	10.1%	8.9%	10.3%	12.3%	12.9%	11.9%	12.3%	13.2%	10.7%	7.5%	11.6%	11.6%	13.5%	12.3%	14.3%	2,131	14,853	12.7%		9.7%				
Elective care	Referral to Treatment - % of open pathways waiting < 18 weeks ***NHSE NOF***	Chief Operating Officer	**92%**	59.3%	59.8%	59.9%	59.1%	58.5%	59.3%	58.9%	57.5%	57.9%	57.3%	58.7%	62.6%	62.3%	62.5%	62.9%	61.7%	60.6%	36,106	59,859			64.5%	Jul-26			
	Referral to Treatment - % of non-admitted pathways waiting < 18 weeks for their first outpatient appointment	Chief Operating Officer	**72%**	63.1%	63.1%	62.2%	59.1%	58.5%	58.8%	58.4%	57.4%	57.5%	58.8%	60.7%	65.6%	67.6%	67.2%	66.3%	65.1%	63.8%					-				
	Referral to Treatment - % of open pathways waiting > 52 weeks ***NHSE NOF***	Chief Operating Officer	**0%**	1.65%	1.66%	1.72%	1.66%	1.57%	1.49%	1.51%	1.34%	1.24%	1.32%	1.42%	1.37%	1.45%	1.37%	1.04%	0.99%	1.0%	593	59,859			1.5%				
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	21	24	22	18	18	25	47	22	5	4	4	6	5	8	3	4	6					9,095				
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	104%	105%	105%	100%	95%	100%	97%	106%	98%	107%	104%	117%	104%	100%	101%	98%	95%	20,222	21,228	100%						
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	107%	106%	105%	103%	97%	102%	100%	105%	97%	107%	102%	113%	107%	102%	101%	100%	98%	58,890	60,063	102%						
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	106%	108%	98%	98%	98%	96%	97%	100%	95%	101%	97%	104%	102%	109%	105%	101%	104%	8,287	7,956	104%						
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	83%	84%	84%	83%	83%	83%	82%	84%	81%	84%	85%	85%	87%	86%	86%	86%	84%			85%		81%	Aug-26			
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)	Chief Operating Officer		40	37	55	50	21	46	32	36	50	40	61	42	44	44	65	37	33			223		22,029	Q1 26/27			
	Waiting Times - Diagnostic Waits >6 weeks ***NHSE NOF***	Chief Operating Officer	**<15%**	16.8%	16.2%	21.0%	24.9%	26.4%	24.9%	28.1%	27.4%	29.6%	27.6%	21.7%	24.5%	27.6%	29.5%	28.6%	30.6%	35.8%	5,611	15,682			23.1%	Jul-26			
Maternity	% of women who have been booked to see a midwife by 9 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	37%	37%	42%	47%	42%	49%	54%	55%	56%	50%	66%	65%	65%	65%	66%	65%	62%	264	425	65%						
	Rate of pregnant women with a delayed planned induction per 1,000 deliveries ***NHSE NOF***	Chief Nursing Officer												1.8			10.7												
	Maternity Activity (Deliveries)	Chief Nursing Officer		384	403	420	432	419	450	441	373	402	372	388	383	374	412	389	413	381			1,969						
Outpatient transformation	Missed outpatient appointments (DNAs) rate	Chief Operating Officer	**<4%**	4.5%	4.7%	5.0%	5.2%	4.9%	5.1%	5.2%	4.8%	5.0%	5.1%	4.6%	4.5%	4.6%	4.8%	4.8%	4.9%	4.7%	2,836	60,271	4.8%		6.8%	Jul-26			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	89%	90%	90%	89%	89%	89%	89%	90%	88%	88%	90%	90%	90%	89%	90%	89.5%	89.5%	32,420	36,207	89%						
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	109%	108%	105%	105%	98%	103%	102%	104%	97%	107%	101%	111%	108%	104%	101%	102%	100%	38,668	38,835	103%						
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	18%	18%	17%	17%	18%	18%	18%	18%	19%	19%	18%	18%	18%	19%	18%	19%	18%	10,453	58,139	19%		19%	Jul-26			
Prevention long term conditions	% of inpatients making a supported quit attempt with an in house tobacco dependence treatment service ***NHSE NOF***	Chief Nursing Officer					32.7%			28.8%			24.0%			23.4%			TBC			750	3,200						
	Maternity - Women who were smokers at time of delivery (SATOD)	Chief Nursing Officer		3.9%	6.5%	5.7%	4.4%	5.0%	4.4%	4.1%	4.0%	3.2%	3.5%	2.1%	2.3%	4.5%	4.4%	3.1%	4.1%	4.2%	16	381	4.1%						

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Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	96%	96%	95%	94%	93%	94%	94.5%	94.6%	93.4%	96.3%	95.5%	95.3%	95.0%	94.7%	96.2%	96.3%	95.7%	765	800	95.6%		95%	Aug-26				
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	55	62	46	60	52	55	53	56	61	58	38	64	50	50	50	52	48			250		5,431	Jul-26				
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	7.71	7.40	7.33	7.02	6.73	7.09	7.24	6.93	6.58	6.88	7.11	7.01	7.12	6.62	6.61	6.83	6.74	21260	3153	6.8		4.4	Feb to Jan				
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	3.1	3.1	3.3	2.5	3.6	3.4	3.16	3.7	3.63	3.29	3.84	3.4	3.96	3.9	4.04	3.60	3.59	1575	439	3.82		3.1					
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	12%	14%	16%	15%	15%	12%	12%	12%	11%	14%	16%	16%	15%	15%	14%	15%	15%	114	773	15%		23.1%	Dec				
	% of patients to acquire a new grade 3 or 4 pressure ulcer ***NHSE NOF***	Chief Nursing Officer		Placeholder - to be updated after publication by NHSE																										
	Number of patients cared for in corridors (ED only) ***NHSE NOF***	Chief Nursing Officer															1,723	1,895	2,041	2,142			7,801							
	30 day readmission rate band ***NHSE NOF***	Chief Medical Officer		Most recent publication of banding is 24/25. WAHT had a rate of 13.3 and a banding of B1 (Significantly lower than the national average at the 99.8% level)																										
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	4.65%	4.87%	4.62%	4.73%	4.67%	4.69%	4.44%	4.84%	4.86%	5.01%	4.84%	6.73%	7.32%	7.19%	6.70%	6.22%	4.93%	610	12378	6.5%		14.7%	24/25				
	Mortality SHMI - Rolling 12 months ***NHSE NOF***	Chief Medical Officer	**100**	110.71	110.55	111.77	111.51	111.51	112.19	111.00	110.04	107.99	108.05	107.75	FD									As expected						
	Number of MRSA Bacteraemia cases ***NHSE NOF***	Chief Nursing Officer	**0**	1	0	0	1	1	2	0	0	0	0	0	0	0	0	0	1	1			2							
	Number of E-Coli cases	Chief Nursing Officer	**102**	6	4	6	3	4	5	15	14	12	8	7	10	7	7	13	10	13			50							
	Rate of E-Coli ***NHSE NOF***	Chief Nursing Officer			0.96			1.01			1.06			1.11			1.00													
	Number of external reportable >AD+1 clostridium difficule cases	Chief Nursing Officer	**102**	4	8	11	10	11	14	12	8	14	5	10	8	9	8	6	9	6			38							
	Rate of c-difficile ***NHSE NOF***	Chief Nursing Officer			1.01			0.93			0.83			0.88			0.90													
	Rate of inpatient falls that cause harm (Hip Fracture only) ***NHSE NOF***	Chief Nursing Officer		Placeholder - to be updated after publication by NHSE																										
	% of safety incidents resulting in harm ***NHSE NOF***	Chief Nursing Officer		Placeholder - to be updated after publication by NHSE																										
	Number of falls with moderate harm and above	Chief Nursing Officer		3	4	4	4	3	4	1	1	1	2	5	4	4	4	7	3	1			19							
	VTE Risk Assessments	Chief Medical Officer	**95%**	91%	91%	91%	91%	92%	93%	93%	91%	92%	93%	94%	94%	93%	92%	95%	96%	96%	11,649	12,180	94%							
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	**80%**	47.5%	57.1%	57.9%	65.2%	67.3%	77.8%	62.5%	68.7%	66.7%	79.0%	68.3%	48.1%	81.1%	68.8%	60.9%	65.5%	81.3%	13	16	72%							
	Complaints resolved within policy timeframe	Chief Nursing Officer	**85%**	64%	69%	78%	54%	79%	67%	63%	65%	64%	56%	64%	63%	57%	73%	65%	67%	56%	48	85	64%							
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	**95%**	84%	81%	85%	84%	80%	80%	82%	81%	82%	84%	93%	89%	85%	87%	84%	82%	82%	2,354	2,887	84%		77%					
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	**95%**	96%	96%	96%	96%	95%	96%	97%	95%	95%	96%	94%	94%	96%	94%	93%	95%	93%	15,350	16,422	94%		94%	Jul-26				
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	**95%**	98%	93%	96%	97%	96%	97%	94%	94%	95%	97%	95%	97%	96%	92%	97%	96%	96%	85	89	95%		91%					
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**20%**	13%	25%	16%	24%	19%	18%	16%	15%	12%	17%	16%	21%	18%	17%	17%	32%	18%	2,887	16,078	20%							
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	32%	36%	35%	36%	31%	31%	38%	33%	32%	23%	37%	55%	53%	52%	52%	74%	57%	6,927	12,125	58%							
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	26%	21%	11%	23%	18%	14%	14%	17%	10%	11%	18%	18%	10%	11%	13%	17%	11%	89	828	12%							
	CQC inpatient survey satisfaction rate ***NHSE NOF***	Chief Nursing Officer		From Adult Inpatient Survey 2024 - 2.00 (somewhat better than expected or as expected)																										
	NHS staff survey advocacy rate ***NHSE NOF***	Chief Nursing Officer		6.60 (2025)																										
	NHS Staff Survey raising concerns sub-score ***NHSE NOF***	Chief Nursing Officer		6.47 (2025)																										
	Breadth and depth of clinical audit outliers ***NHSE NOF***	Chief Nursing Officer														NOF Score 1														

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People		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional	SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6%**	6.6%	4.8%	5.3%	4.6%	3.2%	4.6%	3.6%	4.1%	2.9%	3.4%	2.9%	1.6%	2.4%	2.7%	2.9%	2.7%	2.5%			2.7%					
	Appraisals - Non-medical	Chief People Officer	**90%**	83.0%	84.0%	84.0%	83.0%	82.0%	82.0%	83.0%	84.0%	85.0%	84.0%	83.0%	83.0%	84.0%	83.0%	83.0%	83.0%	85.0%	6,604	5,586	83.6%					
	Appraisals - Medical	Chief People Officer	**90%**	96.0%	96.0%	94.0%	94.0%	94.0%	93.0%	96.0%	95.0%	96.0%	94.0%	94.0%	94.0%	92.0%	93.0%	91.0%	92.0%	91.0%	652	594	91.8%					
	Mandatory Training	Chief People Officer	**90%**	90.0%	90.0%	91.0%	91.0%	90.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	89.0%	90.0%	83.0%	87.0%	87.0%	86.0%	78,731	91,264	86.6%					
	Sickness absence rate ***NHSE NOF***	Chief People Officer	**4.5%**	5.1%	4.8%	4.7%	5.2%	5.5%	5.5%	5.7%	5.6%	5.9%	5.8%	5.7%	5.4%	5.0%	4.9%	5.3%	5.6%	5.7%	12,942	225,315	5.3%					
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**12%**	9.0%	8.9%	8.6%	8.4%	8.1%	8.0%	7.9%	8.1%	7.7%	7.5%	7.5%	7.4%	7.6%	7.5%	7.4%	7.6%	7.7%	503	6,539	7.6%					
	Vacancy Rate	Chief People Officer	**8%**	7.2%	7.4%	7.3%	7.6%	7.1%	6.8%	6.2%	6.6%	6.6%	6.9%	6.7%	6.5%	7.3%	8.1%	7.8%	7.8%	7.9%	620	7,262	7.8%					
	NHS staff survey engagement theme score ***NHSE NOF***	Chief People Officer		6.84 (2025)																							
	National education and training survey satisfaction rate ***NHSE NOF***	Chief People Officer		76.74% (2025)																							
	NHS staff standards score ***NHSE NOF***	Chief People Officer		7.62 (2025)																							
	Healthcare worker flu vaccination rate ***NHSE NOF***	Chief People Officer							43.2%																			
	Temporary staffing cost relative band ***NHSE NOF***	Chief People Officer														NOF Score 3											

Finance and Use of Resources		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: Latest month v benchmark	SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
	I&E - Surplus/(Deficit) (£k) ***NHSE NOF***	Chief Finance Officer	**≥0**	-£3,631	-£3,063	-£2,149	-£339	-£2,292	-£745	£2,773	-£4,741	-£2,037	-£6,266	£3,417	£7,056	-£2,695	-£4,563	-£2,097	£5,626	£7,883			£25,530					
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	-5.7%	-4.8%	-3.3%	-0.5%	-3.6%	-1.1%	-5.7%	-7.2%	-3.0%	-9.9%	4.8%	7.0%	-3.9%	-6.8%	-3.0%	-8.4%	11.90%			-9.4%					
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£221	-£68	£141	£199	-£40	£23	-£12	-£6,148	-£3,559	-£8,366	£1,725	£4,310	£630	£1,028	-£505	£2,176	£2,587			£4,338					
	I&E - Variance from Plan (%) ***NHSE NOF***	Chief Finance Officer	**≥0%**	6%	2%	-6%	-38%	2%	-3%	0%	-437%	-234%	-398%	102%	157%	31%	29%	32%	63%	49%			20%					
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£593	£147	-£152	-£563	-£2,833	-£489	£2,346	-£4,574	-£4,190	-£4,411	-£2,654	£1,404	£591	£770	-£373	£1,456	£1,162			£3,193					
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	-£2,294	-£1,983	-£2,215	-£1,988	-£1,275	-£1,404	-£1,501	-£1,825	-£1,234	-£1,460	-£1,186	£1,186	£1,043	£1,173	-£1,272	£1,193	£1,122			£4,682					
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	6%	5%	5%	5%	3%	3%	4%	4%	3%	3%	3%	2%	2%	3%	3%	3%	2%			3%					
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£664	£328	-£378	£1,420	£11	£1,489	-£1,204	-£2,069	-£2,122	-£1,544	-£991	£4,866	-£3,612	-£3,063	-£2,448	£2,028	£3,649								
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£21.887m	£21.443m	£17.673m	£18.698m	£15.859m	£6.160m	£6.39m	£4.638m	£4.478m	£10.678m	£10.143m	£7.388m	£4	£15	£2	£3	£5								
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	92%	94%	94%	92%	90%	91%	90%	98%	90%	82%	75%	72%	79%	62%	48%	57%	60%								
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	91%	94%	91%	82%	90%	92%	94%	96%	89%	83%	71%	67%	60%	47%	49%	53%	53%								
	Relative cost difference (National Cost Collection Index) ***NHSE NOF***	Chief Finance Officer		103.5 (24/25 publication)																							

Productivity and Innovation		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: Latest month v benchmark	SPCs: Pass/ Fail	SPCs: Trend Variation
Productivity and Innovation	Implied productivity growth ***NHSE NOF***	Chief Finance Office								3.4%																	
	% of clinical trials set up within 90 days ***NHSE NOF***	Chief Medical Officer														100%											
	Data Quality Maturity Index ***NHSE NOF***	Chief Digital Officer		94.2%	94.8%	95.0%	94.9%	96.2%	96.2%	96.0%	95.8%	96.1%	95.1%	95.0%	95.1%	96.2%	96.2%										

Wells Jo
08/10/2026 16:12:40

Escalation and Assurance Report

Report from: Quality Governance Committee
Date of meeting: 22 September 2026
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Integrated Performance Report August 2026**
Rating rationale	Urgent and emergency care performance deteriorated, with increased corridor care and ambulance handover delays. Other pressures included diagnostic, elective and cancer waits, and poor fractured neck of femur performance because of bed and theatre constraints. Recovery plans were in progress, including winter, diagnostic and elective initiatives.
Outcome	**Action:** Report in October on the causes of elective demand and waiting-list growth, the recovery response—including fractured neck of femur performance—and the impact of delayed discharge on flow and quality.
Item/Topic	**Health and Safety Report – Quarter 1**
Rating rationale	Violence and aggression incidents increased and remained a significant risk. Other concerns included patient absconding, fire safety and under-reporting of inoculation injuries. Positive assurance included fewer RIDDOR incidents and improved fire and security arrangements.
Outcome	**Action:** Assess whether warning and caution letters are effective.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Maternity and Neonatal 10-Point Plan – Baseline Assurance Assessment**
Rating rationale	The baseline assessment reported 16 of 26 deliverables compliant, nine partially compliant and one non-compliant. Principal gaps included implementation of Martha's Rule, integrated reporting, leadership arrangements and maternity triage oversight. The assessment had been completed to a compressed national timetable and had not yet undergone the planned confirm-and-challenge process.
Outcome	Under delegated authority from the Board, the Committee approved the baseline return, subject to changing deliverable 3.1 from compliant to partially compliant, for submission to NHS England and retrospective reporting to the October Board. The Perinatal Assurance Group will apply reverse RAG challenge and report through QGC; the progress return is due by 31 December 2026. The Committee asked that overlapping maternity requirements be synthesised into a concise, usable delivery plan.
Item/Topic	**New and Emerging Issues: Thirlwall Inquiry and Martha's Rule**
Rating rationale	A national letter required the Trust to respond to the Thirlwall Inquiry report and associated immediate actions. A further letter required the expansion of Martha's Rule into Emergency Departments and maternity services. Both matters would require additional assurance reporting.
Outcome	**Action:** Bring the Trust response to the Thirlwall requirements to QGC following a high-level update to the October Board.
Item/Topic	**Regulation 28 Prevention of Future Deaths Reports**
Rating rationale	Three Prevention of Future Deaths reports concerned areas including enhanced observation, clinical monitoring and the quality of incident analysis. Responses were being managed through the established process and monitored by the Improving Safety Action Group. The Committee also noted the need to strengthen investigation oversight and support for staff attending inquests.
Outcome	Actions will be tracked through ISAG, with effectiveness testing of completed Regulation 28 actions using reverse RAG methodology. A strengthened support offer for staff attending inquests will launch on 1 October.
Item/Topic	**Nurse Safe Staffing**
Rating rationale	Fill rates remained stable and safe staffing controls continued. Registered nurse vacancies were low, although healthcare support worker vacancies and sickness remained elevated. Recruitment and data-quality issues were being addressed. The NHS England review of the Safer Nursing Care Tool methodology was scheduled for November.
Outcome	The Committee accepted the report and welcomed the planned external review, which would provide independent scrutiny of the Trust's methodology.
Item/Topic	**Improving Safety Action Group Assurance Report**
Rating rationale	Persistent concerns remained about intravenous fluid and electrolyte safety and duty of candour compliance. Improvement arrangements, including revised guidance and education, were in development. The Patient Safety Incident Response Plan required minor amendments and completed Regulation 28 actions required effectiveness testing.

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

Escalation and Assurance Report

Report from: Quality Governance Committee
Date of meeting: 22 September 2026
Report to: Trust Board

Outcome	**Action:** Present the duty of candour improvement plan to the October QGC. Future ISAG reporting will focus on evidence that actions are embedded and reducing risk.
Item/Topic	**Medicines Optimisation and Controlled Drugs Safe Handling Report – Quarter 1**
Rating rationale	Recurring risks included omitted and time-critical medicines, prescribing errors and communication at discharge and transfer. Incident volumes were stable and improvement work, including medicines reconciliation and electronic discharge arrangements, was progressing. Pharmacy exceeded its quarter-one cost productivity target.
Outcome	The Committee noted the report and emphasised the need for reliable medicines handover during ward transfers and discharge, alongside continued education and oversight of time-critical medicines.

Assure: Including assurance items rated green	
Item/Topic	**Exceptional Treatment Review Panel**
Rating rationale	The multidisciplinary panel considered a further request for exceptional treatment outside existing commissioning routes. The process provided fair, transparent and clinically informed oversight. The requested treatment was approved, with clinical outcomes and commissioning implications to be monitored.
Outcome	The Committee noted the decision and supported oversight of cases at Integrated Care Board level.
Item/Topic	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme – Quarter 1**
Rating rationale	The Trust was on track for full compliance with Maternity Incentive Scheme Year 8. Workforce, training and governance requirements were largely compliant, with neonatal medical staffing remaining under an action plan. Saving Babies' Lives Care Bundle compliance was reported at 99%, with limited further work required.
Outcome	The Committee acknowledged the specified evidence and accepted the report. A final quarterly report and declaration will be presented by the end of November.
Item/Topic	**Infection Prevention and Control Update**
Rating rationale	The measles outbreak had closed and the system debrief recognised a probable unidentified community source as well as effective Trust management. NHS England oversight had reduced from enhanced scrutiny to routine monitoring. C. difficile remained below the tighter threshold. Learning from two MRSA bacteraemias included line care and clinical documentation. Other issues remained under active management, including early influenza, neonatal infections and capacity constraints.
Outcome	The Committee commended the handling of the measles outbreak and the sustained improvement in infection prevention and control. The NHS England visit report will return to QGC.
Item/Topic	**Fundamentals of Care Assurance Report**
Rating rationale	The revised report format provided focused assurance on care-group priorities. Positive practice included improvements in complaints, falls and personalised care. Continuing areas of focus included communication, end-of-life planning and workforce and capacity pressures.
Outcome	The Committee accepted the report and supported continued development of a dashboard aligned to the report themes.
Item/Topic	**Research and Development Report – Quarter 1**
Rating rationale	Research activity and governance remained robust. The Trust was on track to deliver its key performance indicators, ranked third among acute trusts in the West Midlands for recruitment, and reported no serious breaches or adverse-event concerns. Development of the 2026–2029 Research Strategy continued.
Outcome	The Committee noted the report and took assurance from performance and governance arrangements.

To Note: Items received for information or approval	
Item/Topic	**Children and Young People Committee Terms of Reference**
Summary	The revised terms of reference confirmed a quarterly, cross-care-group committee providing assurance to QGC on services for children and young people, including safety, performance, risks and patient voice. A supporting dashboard was in development.
Outcome	The Committee noted the revised terms of reference and closed the related action.

Wells 29
08/10/2026 16:12:40

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

Escalation and Assurance Report

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

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Perinatal Incident Report - Quarter 1**
Rating rationale	There were two stillbirths and one neonatal death in the period. Initial reviews identified no immediate concerns; formal review processes and an MNSI action plan were progressing. Learning included communication, documentation, escalation, complex pathways and standardised management of obstetric anal sphincter injury and postpartum haemorrhage. The Committee sought assurance regarding theatre availability where multiple maternity emergencies occur concurrently. A clear escalation process was confirmed, with further detail to be considered through the Safety Champions forum. Work was under way on the national ten-point maternity plan and Ockenden response. A new Maternity and Neonatal Assurance Group was being established to provide focused oversight and streamline reporting into QGC.
Outcome	The Committee noted the report.
Item/Topic	**Safety Walkabouts**
Rating rationale	The programme remained valuable, but assurance on consistent action closure, feedback to staff and capture of recurring themes was variable. Potential overlap was identified between formal and informal walkabouts, Care Excellence Accreditation and mock inspections.
Outcome	The Chief Nursing Officer will review how the activities are triangulated, captured, tracked and closed.
Item/Topic	**Maternity Safe Staffing - Quarter 1**
Rating rationale	Safe staffing was maintained. Turnover among midwives remained low and 8.8 WTE posts were converted to substantive roles. Staffing levels had been uplifted to cover absence, leave and training. Sickness rates had plateaued.
Outcome	The Committee noted the report and took assurance from the staffing oversight and mitigation arrangements.
Item/Topic	**Integrated Performance Report**
Rating rationale	Emergency Department attendances were high and corridor care continued at Worcestershire Royal Hospital. Skin cancer performance remained a concern. Diagnostic backlogs persisted in non-obstetric ultrasound and MRI. Sepsis reporting did not yet accurately reflect clinical practice because of data issues. Fractured neck of femur performance remained affected by bed availability, inter-site transfer and theatre utilisation.
Outcome	The Committee noted the recovery actions and continuing risks. A further update on fractured neck of femur theatre performance and theatre utilisation was requested.
Item/Topic	**Getting It Right First Time**
Rating rationale	The Trust continued to engage with GIRFT through specialty reviews, high-volume low-complexity pathways and the Further Faster programme. Improvement work was supported by a new theatre oversight group reporting to the Operational Assurance Committee. Theatre booking and utilisation arrangements would be re-evaluated following the transfer of theatres into the Surgery division. The Committee noted the need for a clinically appropriate balance between discharge and patient-initiated follow-up, with suitable safety-netting and monitoring of new-to-follow-up ratios.
Outcome	The Committee noted the report and a planned virtual GIRFT system review in September. The report format will be revised to better reflect improvement activity, realised benefits and specialty-level actions.

Wells Jo
08/10/2026 16:12:40

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Escalation and Assurance Report

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

Item/Topic	Clinical Effectiveness - Quarter 1
Rating rationale	Established governance arrangements provided oversight of local and national clinical audit, NICE guidance, key documents and NCEPOD recommendations. Positive assurance included strong performance by the clinical effectiveness team, implementation of the Clinical Effectiveness Portal, increased use of rolling PDSA cycles and evidence of improvement from completed audits. Compliance with the NICE technology appraisal assessment KPI was achieved. Further assurance was required on non-participation in national audits, overdue key-document reviews and completion of improvement actions. Some low compliance results reflected incomplete audit recording.
Outcome	The report was accepted.
Item/Topic	**Improving Safety Action Group Escalations**
Rating rationale	Gaps were identified in electronic discharge summaries for patients who died or self-discharged. A Regulation 28 report relating to the discharge lounge remained under review. Corridor care, medical-device training and injectable-medicines governance remained under active oversight.
Outcome	The Committee took assurance from the report and confirmed that the format provided an appropriate level of assurance without duplicating other governance routes.

Assure: Including assurance items rated green	
Item/Topic	**Nurse Staffing Report**
Rating rationale	Neonatal qualified-in-speciality staffing exceeded the recommended standard and a supernumerary shift leader had been introduced. The Patient Decision Unit closed at the end of June, reducing capacity pressure. Agency reduction work continued and care hours per patient day showed sustained improvement. An independent review of the Safer Nursing Care Tool methodology was planned.
Outcome	The Committee assurance that safe staffing had been maintained.
Item/Topic	**Infection Prevention and Control Monthly Update**
Rating rationale	The measles outbreak had closed after two full incubation periods without a further case and no additional harm was reported. A system and internal debrief were planned. A community-onset, healthcare-associated MRSA bacteraemia linked to an unscreened overnight admission remained under investigation. Continuing development areas included staff immunity assurance and FFP3 fit-testing capacity.
Outcome	The Committee took assurance from and noted the report, recognising the effectiveness of the outbreak response and the need to complete learning actions.
Item/Topic	**Patient Safety Alerts - Quarter 1**
Rating rationale	No new national patient safety alerts were received. Progress on implementation and closure of alerts was good.
Outcome	The Committee took assurance from the report.
Item/Topic	**Experience of Care Improvement Framework**
Rating rationale	The Trust completed a self-assessment against the national Experience of Care Improvement Framework, which considered how effectively patient experience is embedded in service planning and improvement. The Trust assessed itself as **achieving** for its experience of care strategy and delivery plan and **progressing** in demonstrating how patient and community involvement informs decisions. Seven improvement actions were under way, including development of the Patient Voice and Involvement Strategy.
Outcome	The Committee welcomed the structured assessment and stakeholder involvement, noting that further work was required to demonstrate consistently how engagement influences decision-making. Progress would be reviewed through established governance arrangements.

To Note: Items received for information or approval

Wells Jo
08/10/2026 16:12:40

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Green	The Committee was assured that there are no gaps in assurance.

Escalation and Assurance Report

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

Item/Topic	Mortuary Safeguarding: Fuller Inquiry and NHS England Board Assurance Statement
Summary	The Committee reviewed progress against the 23 Fuller Inquiry recommendations assessed as applicable to the Trust. Three were evidenced and assured, eight were delivered but not yet fully evidenced and twelve were not yet delivered. A live risk relating to Level 3 safeguarding training was noted. The Committee identified a need for clearer direct Board oversight of mortuary services and reviewed lone-working arrangements out of hours.
Outcome	The Committee approved the four Board Assurance Statements for submission to NHS England. Quarterly updates would continue to the Committee and a biannual Mortuary Services and Fuller Inquiry assurance report would be added to the Trust Board planner. Arrangements to avoid lone working during out-of-hours attendance would be reviewed.
Item/Topic	**New and emerging issues**
Summary	• High temperatures in neonatal and paediatric drug storage rooms placed temperature-sensitive medicines at risk despite mitigation. • The Alexandra Hospital site SHMI moved outside the expected range, reflecting a reduced number of expected deaths rather than increased recorded deaths. • An MRSA bacteraemia has been attributed to the Trust and was currently under investigation. • A recent incident highlighted uncertainty around roles and responsibilities between organisations involved in SUDIC pathways.
Outcome	Provide an update on cooling options for drug storage rooms.

Wells Jo
08/10/2026 16:12:40

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Green	The Committee was assured that there are no gaps in assurance.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	**Public Board**
Date of Meeting:	**13.10.2026**
Title of Report:	Patient and Public Forum bi-annual report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Rosemary Smart, Chair of the Patient and Public Forum, Kimara Sharpe, Vice Chair, members of the Patient and Public Forum (PPF) and Anna Sterckx, Head of Patient, Carer and Public Engagement.
Reporting Route:	Trust Board
Enclosures included with this report:	Patient and Public Forum report PPF Outpatient Appointment cancellations report
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Patient and Public Forum (PPF) exists as a group of patients, carers and/or patient/carer public representatives, who work in partnership with the Trust to support continued improvements and to reflect patient and carer experiences.

The overall purpose of the PPF is to ensure that the voices of patients, relatives, carers and the public are heard by the Trust and acted on, in order to achieve the highest quality patient centred care.

In line with the PPF Terms of Reference, the PPF Chair and Chief Nursing Officer provide a twice-yearly report to the Trust Board outlining the business of the Forum.

Recommended Actions required by Board or Committee

To NOTE the continued progress and ongoing development of the Patient and Public Forum in terms of active participation and partnership with the Trust across a range of joint initiatives and partnerships.

Executive Director Opinion[1]

As CNO welcome this report from the Patient and Public Forum and thank members for their continued commitment to improving patient experience, quality and safety across the Trust. The breadth of engagement across committees, audits, safety walkarounds and service improvement initiatives demonstrates the significant value the Forum brings as a trusted critical friend.

I am particularly encouraged by the strengthened engagement with external partners and the positive progress highlighted in areas such as complaints review, patient safety and end of life care. The report also provides constructive challenge on areas requiring further improvement, including outpatient cancellations, transformation programmes and responsiveness to issues raised.

Wellbeing 08/10/2026 16:12:40

[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.

The Trust remains committed to listening to and working alongside the Forum, ensuring the voices of patients, carers and local communities continue to influence service improvement and the delivery of high-quality, person-centred care.

Wells Jo
08/10/2026 16:12:40

Worcestershire Acute Hospitals NHS Trust

Patient and Public Forum bi-annual report: October 2026

1. Purpose of the report

The Patient and Public Forum provide a bi-annual report to the Worcestershire Acute Hospitals NHS Trust Board which outlines member activity, forum achievements and raises any issues that the group would like to highlight. It is also an opportunity for the forum to publicly thank members of staff who have supported. The first report was presented at the April 2025 Trust Board meeting. This is the fourth report.

Executive summary

The Patient and Public Forum (PPF) is an independent group of people from different backgrounds, representing our patients, carers and the people of Worcestershire.

Our purpose is to act as a critical friend to the Trust with a view to supporting the patient experience and supporting staff. We achieve this in many ways, including committee representation, supporting the Trust with the ward accreditation programme and clinical and estate audits; we have listed our key activity areas over the last six months in this report.

We are pleased that external membership has continued over the last six months and we have welcomed Healthwatch and Carers and Communities to our meetings. This provides a rich opportunity for us to find out first hand about themes of patient and carer experience and to keep up to date with developments locally and further afield. For example, Carers and Communities shared their Accelerating Reform Fund report with our members at our meeting held on 27th May – further details can be found in the *Achievements* section of this report.

The purpose of this report is to inform the Trust Board of the activities of the PPF, achievements, frustrations and risks.

Report

We currently have 13 members. In the last six months we have recruited three new members, although one of these members has since left the PPF. We have interest from three additional people, who we are planning to meet with in September. The number of members is lower since previous reporting with three members leaving the group. One person left for personal full-time family caring responsibilities, one member left because they felt unable to continue their involvement due to a perceived lack of response to issues they had raised and the third member left because their commitment and capacity to volunteer, had changed. With recent recruitment and three potential additional members, the full membership is expected to remain stable overall.

Members range from 20 years old to 80+. Our members come from a variety of backgrounds; one member is a student, other members are in work and retired. Some of our members have physical disabilities and/or hidden disabilities.

All PPF members are Trust registered volunteers who complete mandatory training and an enhanced DBS. One PPF member also volunteers in another role as a Discharge Response Volunteer.

One member is a Patient Safety Partner (PSP). This role is carried out in addition to their role as a PPF member. The PPF appreciate the approach of how the Trust is now investigating incidents, with better learning for staff – the group recognise that the PSP's work is a huge undertaking and welcome the approach that the member takes with regular and informative updates back to members. The PPF is hoping to recruit a second Patient Safety Partner in the Autumn.

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Members meet bi-monthly with the Trust at formal meetings. At these meetings, the PPF value the conversations and discussion with Trust staff, alongside updates on key projects and initiatives, opportunities to collaborate and focus on the two Action Logs, which provide a clear and effective mechanism for tracking issues, monitoring progress, and ensuring accountability. One Action Log is created in the formal bi-monthly meetings, with updates provided at and monitored in between those meetings and a "You Said We Did" log, tracks actions raised outside meetings and supports with feeding back. Both logs are managed by the Trust, supporting structured oversight and follow-up of matters raised by the Forum. The PPF also have member meetings in between, where members plan and monitor their work schedule.

Activities overview from April – September 2026:

- Active engagement with 17 Committees and steering groups.
- Active participation in 14 Audits, Safety Leadership Walkarounds and Visits in this reporting period.

Committees: Quality Governance Committee, Nutrition and Hydration Committee, Strategic Programme Group, Fundamentals of Care, Trust Infection, Prevention and Control Committee, DREAMS, Executive Risk Management Committee, Dementia Committee, Learning Disability/Autism neurodiversity steering group, DSCG Board, Patient, Carer and Public Engagement steering group, Patient Safety Incident meetings, PEOG (Patient Environment Operational Group), AI Ethics Committee, Digital Committee, Hospital at Home working group and Independent Complaints Review Group. A member has also joined the People and Culture Committee and is looking forward to their first meeting. The group has also been invited to join the Green Committee and look forward to providing updates.

The PPF is pleased to have been invited to join the new Dermatology development review meetings and is looking forward to attending the first meeting.

<u>April 2026</u>:

- Outpatients Transformation Summit engagement meeting
- Care Quality Commission mock assessments
- Care in the Corridor audits
- Patient Experience Week awareness stands support alongside Trust staff members

<u>May 2026:</u>

- Review and edit of the Trust's Quality Account with suggestions made
- Progression of the kerb issue at WRH: meeting with Non-Executive Director
- Safety and Leadership Walkaround WRH
- CEA Panel and Lead Review WRH
- CEA Quality Assurance Visit WRH
- Care Quality Commission mock inspections
- Patient and Public Forum formal meeting

<u>June 2026:</u>

- Collaboration and co-production with Healthwatch Worcestershire to visit the Trust's two EDs to look at capacity and flow - originated as an "Enter and View" visit (initial visit to the Alex ED in March)
- Supported with Volunteer Week 2026
- Tested a listening device, identified by a member as a solution to supporting patients in hospital
- Members contacted to share content for the annual Equality, Diversity, Accessibility and Inclusion annual report

Wells, Jo
08/10/2026 16:12:47

<u>July 2026</u>:

- Mission Nutrition engagement
- Second member tested the listening device; awaiting meeting with Estates

- Care in the Corridor Audits
- Patient Portal evaluation and assessment
- Safety and Leadership Walkaround WRH
- CEA Panel and lead Review
- CEA Quality Assurance Visit
- Patient and Public Forum formal meeting

August 2026:

- Care in the Corridor audits
- Attended the Violence workshop
- Chairing and attendance of members with staff at the first Complaints Review Group
- Stroke Partnership board meeting with the patient representative and lead staff

One member continues to carry out regular "IPC walkarounds" at the ALX with Site Managers. Unfortunately, a number of these have been cancelled in recent months. The PPF is pleased that there is a new process in development to join monitoring officers at the hospital for additional visits.

In **September** we will be:

- Engaging with the development of the Trust's Quality and Safety Strategy and supporting with the development with the Big Quality Consultation survey.

Achievements:

- The PPF welcomed the Trust's approach for the Complaints Review group. This group is chaired by a member of the PPF and has held the first meeting. There has been a quantum leap in the quality of responses since the previous review.
- Engagement with the Stroke Partnership board has been progressed with two members speaking with the lead consultant, Chief Operating Officer and Lead Executive for Quality and Performance with Worcestershire CCG and Chief Clinical Strategy Officer at the Trust having previously spoken to the patient representative on the partnership board. Discussions focused on the stroke pathway and the PPF members were impressed with the work and research that has been done and particularly the addition of a clinical psychologist. Conversations are ongoing and the members are also linked in with the patient representative who sits on the board.
- A member is very impressed with reports at DREAMS that some wards are working towards the Gold standard for end of life care.
- The Chair of the PPF continued to meet with Chairs of the Foundation Participation Groups and the Chair of the Board. This continues to be a useful opportunity for shared learning with recent sharing of ED approaches regarding flow.
- Continued engagement with Committees and steering groups.
- Continued with Care in the Corridor audits to inform ongoing awareness of good care and areas for improvement – this continues to be PPF led and the Trust will also reach out to ask the PPF to carry out audits.
- The PPF is still monitoring Trust Outpatient appointment cancellation rates, which is a project that was initiated by a PPF member, to review the appointments cancelled by the Trust. A regular report is now generated and the PPF is now engaged with one of the Care Groups which has initiated further understanding of this issue in order to address issues as appropriate.
- The progression with external groups attending PPF meetings is very positive and supports a link with the local community and a mechanism to understand the patient experience as well as potential joint working. One example of this is the recent Carers and Communities *Accelerating Reform Fund* report which highlights that clinicians need to take greater notice of how carers can input and continue to support at home. A leaflet was highlighted in the report that it is recommended is handed out to carers on the ward.
- The PPF would like to thank the Non-Executive Director, Simon Murphy for attending the PPF meeting and members look forward to continued engagement.

Wells Jo 08/10/2026 16:12:34

- The PPF would like to thank Natalie Wellings, Patient Experience and Engagement Support Officer for successfully managing and running a new leaflet process which tracks PPF responses to leaflet requests and supports members to see the outcome from their engagement. The system, established by Anna Sterckx is working really well and the PPF would like to acknowledge Natalie for her focus, development and support.
- The PPF are interested to see the outcome from their Engagement with Mission Nutrition and is pleased to note that interested volunteers will receive developed assisted feeding training.
- The PPF members involved in the CEA are impressed with the process and outcomes. In particular, the involvement of the ward manager is excellent and the role of the PPF member is welcomed.

Areas for Improvement:

- A query was raised about the new GP advice and guidance referral route. A member was concerned and wanted to understand what guidelines are being given to staff. A response has been shared with the group to advise that the new system will be audited, that there is one portal and that consultants will use their admin time to deal with requests – it is about putting systems in one place. There is concern that the GP has to use this route to refer patients first before referral and the referral could be refused. Is there a failsafe method for the GP to ensure their patient is seen when the GP thinks this is clinically necessary?
- Two members attended the Outpatients summit meeting in January and the follow-up meeting in April. There are concerns with the lack of development and momentum since then. The PPF were pleased to see that Outpatients cancellations is included in the focus. A report from a member of the PPF about cancellations is attached in the appendix of this paper as there is still concern in the number of Trust initiated cancellations.
- Two members have raised concern with parking at WRH and KTC. There are comments on social media from patients.
- The PPF endorse the Peony Volunteer role and project as a whole and support the Peony coordinator post being made permanent.
- It is suggested that visible water fountains are needed to be accessible at all times at our hospitals and there should be signage Out of Hours to help people locate water. Climate change is here.
- There have been improvements in speed of responding to actions, however this is spasmodic. This relates to Safety Walkarounds and reports, following the visits. It would be good to receive a timeline to support expectations.
- Some members are concerned about using their own computers for their role as a PPF member. The Head of Patient, Carer and Public Engagement submitted an application to Charitable Funds for x20 laptops, however this was unsuccessful. This has been raised with the IT department who is investigating the social value route. Members access engagement opportunities through a Teams channel. There have been numerous methods to support members to access this, as the Channel seems to work differently on some devices. Training sessions and alternatives have supported resolution for most members and it is understood that providing a laptop which already has access in place will resolve the issue for all.
- The PPF feel that it would be better if all departments used the (same) Synertec Printing System to ensure that patients receive their OP letters in formats that they need and that all departments use the correct templates.
- A member is concerned that the bed cleaning updated video is still not live to support staff with IPC awareness. The film was updated following a member's comments. Unfortunately, the video has still not been made available to staff. We understand that this is due to the part-time nature of the member of staff who is tasked to take this forward.

Risk:

- We remain concerned with the abolition of HealthWatch and would like to be involved in any local initiatives concerning the overarching view of patient experience in Worcestershire. We will continue to explore links and partnership with HealthWatch Worcestershire which has developed over the last 6 months.
- Faster responses and momentum is needed with big summits and initiatives to maintain traction, for example the Outpatients Transformation work.

Wells, Jo
08/10/2026 11:13:40

- Concerns for Maternity – there are repeated reports and requests which must take up so much staff time to manage and respond to. Is there a way to refine the number of actions?

Thanks:
We would like to thank the following personnel for their support during the past six months:

- Hayley Flavell, Chief Nursing Officer
- Anna Sterckx, Head of Patient, Carer and Public Engagement
- Amy Gray and team within Healthcare Standards
- Natalie Wellings, Patient Experience and Engagement Support Officer
- Janet Neate, Volunteer Manager and Charlie Snead, Volunteer Support Officer
- Julie Webber, Patient Experience Lead Nurse
- Patience Ngundu, Quality Matron
- Frances Martin (Chair)
- Emma King, Director of Estates and Facilities, for supporting with water supply issues so promptly, sorting vending machines at ALX to provide more water.
- And all the other staff who have been so accommodating and supportive when members are visiting their areas.

2. Recommendation(s)

We would like to extend the invitation to attend a Patient and Public Forum meeting to any Board member. The dates of meetings are available from the Head of Patient, Carer and Public Engagement.

The PPF would like to highlight ongoing achievement and development of the Patient and Public Forum in terms of engagement and partnership with the Trust as well as community engagement.

Appendix

Outpatient cancellations

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PPF Outpatient Appointment Cancellations Report Update Quarter 2 2026

This update report is for Hospital Cancellations of Outpatient Appointments, which are additional (and larger) than Patient cancellations and Did Not Attend appointments.

15.1% of Total OP Appointments were cancelled in Q2 2026, a further small improvement overall compared to Q1 2026 and 2025. Total performance oscillates quarter by quarter in each of the major groupings below.

The level of Appointments cancelled by the hospital within 7 days of the appointment increased slightly to 5.4% of total appointments in Q2 2026, but in line with performance over the Last 18 months. This represents 210 patients a day having their treatment and arrangements disrupted on short notice.

	2024	2025	Q1 2026	Q2 2026
Most Critical Specialisms				
Number of Appointments	287147	282810	78371	71374
% Hospital cancellations	27.8%	24.8%	25.5%	23.1
% cancelled within 7 days	7.8%	6.9%	7.1%	6.9%
Critical Specialisms				
Number of Appointments	536918	555612	120438	135374
% Hospital cancellations	13.6	13.3	9.8	11.1
% cancelled within 7 days	6	5.4	4.7	4.9
Other				
Number of Appointments	122887	128320	48762	33055
% Hospital cancellations	15.80%	13.30%	16.20%	15.1%
% cancelled within 7 days	4.50%	3.90%	2.80%	4.1%
Total				
Number of Appointments	946952	967361	247571	239803
% Hospital cancellations	18.20%	16.60%	16.00%	15.1

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% cancelled within 7 days	6.40%	5.70%	5.30%	5.4%

A review of the causes of the cancellations should prioritise 'Most Critical Specialisms' and then Critical Specialisms (which together represent over 85% of total appointments) to assess likely changes to the booking policies to ensure some scheduled clinic appointments are left open till a late stage to accommodate most urgent patients. Resolution of all the operating/scheduling problems has to be done at the detail operating level. Achievement of the clinic schedule, day by day, is critical and should be routinely reported. Detail by new Care Groups for Q2 is shown on the next page.

Specialisms are grouped by their volume of OP Appointments and cancellation rates.

Most Critical specialisms

CLINICAL ONCOLOGY
DERMATOLOGY
EAR NOSE AND THROAT
GASTROENTEROLOGY
GENERAL SURGERY
HAEMATOLOGY (CLINICAL)
MEDICAL ONCOLOGY
ORAL SURGERY
RHEUMATOLOGY
UROLOGY

Critical Specialisms

ALL SPECIALTIES
CARDIO PULMONARY
CARDIOLOGY
COLORECTAL SURGERY
DIABETIC MEDICINE
GYNAECOLOGY
NEPHROLOGY
OBSTETRICS
OPHTHALMOLOGY
PAEDIATRICS
PHYSIOTHERAPY
THORACIC MEDICINE

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Simon Marriott PPF 14 09 26

Hospital Cancellations of Outpatient Appointments

Quarter 2 2026 Analysis

Care Group	Number of Out.Patient Booked Appts	Cancelled within 7 days		Total Cancellations %
		Number	%	
Medicine & Emergency	70851	3805	5.40%	12.30%
Surgery	61342	3772	6.10%	15.10%
Family Health	35159	2472	7.00%	18.10%
Diagnostics & Specialities	72451	2902	4.00%	12.40%
Total	239306	12877	5.40%	15.10%

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Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	13th October 2026
Title of Report:	CNST Q1 report MIS Year 8
Lead Executive Director:	Chief Nursing Officer
Author:	Justine Jeffery – Director of Midwifery Jane Wardlaw – Lead Assurance and Compliance Midwife
Reporting Route:	Quality Governance Committee
Enclosures included with this report:	Appendices 1. MIS Workforce Action Plan 26-27 2. Medical Rota Compliance and Additional Consultant Roles Audit Q1 26-27 3. Neonatal Nursing Workforce Tool – WAHT Q1 26-27 4. Neonatal Nursing Workforce Unit Data – WAHT Q1 26-27 5a. Midwifery Safe Staffing Report September 2025 5b. Midwifery Safe Staffing Q1 report 2026 6. Q1 Obs Cover - Anaesthetic workforce DayNightEve 7. Perinatal Incident report Q1 8. Q1 26-27 PMRT report 9a. Claims and incidents Q4 2025-2026 – FINAL 9b. MBRRACE Report 2026 (2024 report) 10. April 25 - March 26 Badgernet Audit of Interpreter use (summary) 11. CQC Action Plan 2026 (Coproduced with MNVP) 12a. 20th May 2026 Patient experience Meeting notes 12b. MNVP HLR REPORT JULY 2026 (Activity May-June) 13. Saving Babies Lives Q1 26-27 Summary 14. MCB Elements 1 to 5 Combined Action Plan Q1 26-27 15. Combined WAHT MOSS critical safety check Mar and April 2026 16. 24th April 26 Safety Champions minutes 17. 22nd May 26 Safety Champions minutes 18. Perinatal Culture and Equity Anti-discrimination Action Plan Q1 26-27
Purpose of report:	☒ **Assurance** ☒ **Approval** ☒ **Information**

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Brief Description of Report Purpose

Summary of changes from Year 7 to Year 8

NHS resolutions claim that year 8 moves from a process-heavy workstream to focusing on outcomes. This enables stronger board-level ownership of safety and culture, greater local flexibility with clear accountability, a more mature, improvement-focused scheme resulting in better outcomes for women, birthing people, babies and staff. This has been achieved by the following;

- Combined safety actions to reduce duplication and increase consistency (10 reduced to 6)
- Less actions, but some much broader in scope with a focus on outcomes
- Less explicit asks allowing for local variation and prioritisation.
- This is a balance of familiar actions used previously and new actions.



Purpose of Report

This report provides the Quality Governance Committee with a Quarter 1 assessment of the Trust's progress against the requirements of the NHS Resolution Maternity Incentive Scheme (MIS), Year 8. It brings together evidence on workforce and capacity, training, learning from investigations, service-user voice and equity, care bundle implementation, and Board oversight. Its purpose is to provide assurance on areas of compliance, identify gaps, risks and improvement actions, and support effective oversight of progress towards the final CNST declaration on 30 November 2026.

Recommended Actions required by Board or Committee

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

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Workforce and Capacity

1. **Acknowledge compliance with >80% consultant presence in defined acute care situations.**
2. **Acknowledge the current BAPM workforce position and associated action plan**, noting:
    - Neonatal Nursing workforce compliant.

- Neonatal Medical workforce non-compliant.
- Improvement plan in place and being monitored.

3. **Acknowledge that a fully funded midwifery establishment is in place.**
4. **Acknowledge compliance with 24/7 anaesthetic cover for obstetric services.**
5. **Receive assurance regarding ongoing workforce compliance monitoring through to the CNST declaration deadline of 30 November 2026.**

Training

1. **Acknowledge achievement of the CNST Year 8 Declaration Point 1 submitted on 3 June 2026**, confirming training compliance exceeds 90% across all required staff groups and training modules.
2. **Receive assurance that training compliance continues to be monitored and maintained towards the final CNST declaration.**

Learning from Investigations

1. **Acknowledge receipt of the quarterly Perinatal Incident Report demonstrating compliance with NHSE investigation requirements.**
2. **Acknowledge receipt of the quarterly PMRT reports demonstrating compliance with CNST Safety Action C.**
3. **Acknowledge receipt of the quarterly Perinatal Safety Report demonstrating compliance with CNST Safety Action C.**
4. **Receive assurance that learning, themes and actions arising from perinatal incidents are identified, tracked and monitored through governance arrangements (currently quarterly, Perinatal Incident Reporting, PMRT, MOSS, MBRRACE, Claims and Incidents).**

Service User Voice and Equity

1. **Acknowledge findings from the Communication Equity Audit and endorse the associated improvement actions.**
2. **Receive assurance that patient insight, feedback and experience data are captured, triangulated and used to inform service improvement within maternity and neonatal services (CQC annual survey action plan, Patient Experience meetings, MNVP highlights report).**

Care Bundles

1. **Acknowledge progress against Saving Babies' Lives Care Bundle (Version 3.2) implementation and agree the reported status of 99%.**
2. **Acknowledge progress against the Maternal Care Bundle action plan**, noting continued implementation activity and the requirement for Integrated Care Board support to achieve full compliance.
3. **Receive assurance regarding continued monitoring of care bundle compliance through to the final CNST declaration.**

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Board Oversight and Governance

1. **Acknowledge receipt of the quarterly Perinatal Safety Report, Perinatal Incident Report and CNST Report**, confirming alignment with the Perinatal Quality Surveillance Model (PQSM/PQOM).
2. **Acknowledge receipt of completed Maternity Outcomes Signal System (MOSS) alerts and associated action plans and receive assurance that identified actions are being monitored through governance processes.**
3. **Acknowledge receipt of the Safety Champions minutes and confirm that the PLT and MNVP lead discuss creating and embedding a safety culture.**
4. **Acknowledge receipt of the Perinatal Culture Improvement plan and its scrutiny.**

Executive Director Opinion[1]

The Quarter 1 CNST Maternity Incentive Scheme Year 8 report provides good assurance that maternity and neonatal services are progressing positively against the revised outcome-focused requirements of the scheme. Most safety actions are assessed as compliant or on track, with strong evidence of effective governance, workforce oversight, training compliance, implementation of safety initiatives, and active engagement with women and families. Notably, the Trust has achieved the first CNST declaration point for training compliance, maintains a fully funded midwifery establishment, demonstrates compliance with consultant and anaesthetic workforce standards, and continues to embed learning from incidents through robust governance arrangements.

There remain areas requiring continued focus, particularly neonatal medical staffing compliance against BAPM standards and progressing full implementation of the Maternal Care Bundle, where support and engagement from the ICB is required. These risks are recognised, are supported by clear action plans, and are being monitored through established governance processes.

Overall, I am assured that appropriate controls, oversight and improvement actions are in place to support delivery of the CNST Year 8 requirements and maintain momentum towards the final declaration deadline of 30 November 2026. The report demonstrates a strong commitment to patient safety, service-user involvement, equity, learning culture and continuous improvement across maternity and neonatal services

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Safety Action	Standard / Evidence	Required actions and recorded

[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.

		minutes required from QGC
	Workforce and Capacity	
A1 **On track**	**Obstetric Consultants** - >80% consultant presence in defined acute care situations Q1 Consultant presence audit Month / Cons Attendance / % Compliance April / 10/10 / 100% May / 4/5 / 90% June / 6/6 / 100% *In Q1 there was 1 case where a consultant didn't attend. This was an emergency caesarean section at 22.00hrs where the BMI was 54. The caesarean section was performed by 2 registrars. The operation was uneventful with a blood loss of 523mls.* Risk Register 5753 – *'highlights the risk of uncovered obstetric on calls due to staffing levels'*. Approved in May 2025, however it was initially rated as '8' as it was unlikely due to mitigations etc. At the end of Q1 it was rated as '4' moderate as there were no concerns with Obstetric on calls.	QGC/Trust board to acknowledge >80% consultant presence in defined acute care situations.
A2 **On track**	**Locum Certification** - Ensure Locum certification and maintenance of a local database of all short-term Locums No Short-term Locums during Q1	No Action required – ongoing compliance towards 30th November
A3 **On track** **QGC Action**	**Neonatal workforce (Nursing and medical)** – clear plan for fully funded neonatal nursing and medical establishment aligning with BAPM standards and nursing workforce calculator output (2020) See Appendix for staffing and plan 1. MIS Workforce Action Plan 26-27 2. Medical Rota Compliance and Additional Consultant Roles Audit Q1 26-27 3. Neonatal Nursing Workforce Tool – WAHT Q1 26-27 4. Neonatal Nursing Workforce Unit Data – WAHT Q1 26-27 • Neonatal Nursing staffing compliant *with NMAG monthly meeting.* • Medical Neonatal staffing non-compliant. *Risk Register 5991 Tier 2 for neonatal medical staffing does not align with current BAPM standards, therefore potential delays to patient care (opened 2025).*	QGC/Trust board to acknowledge BAPM action plan. Nursing (Compliant), Medical (Non-compliant) Plan in place

Safety Action A: Optimise Medical Staffing										Progress				
Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	2026 Q1	2026 Q2	2026 Q3	2026/27 Q4	Outcome
Wells Jo 08/10/2025 16:12:40 Tier 2 Medic/ANNP	Michael Croutear/ Dr Wasi Shinwari	BAPM compliance	100%	There is a resident tier 2 practitioner 09.00-17.00 5 days a week. Thereafter there is a resident tier 2 practitioner across both neonates and paediatrics. 09.00 - 14.00 there is 1 tier 2 practitioner covering neonates and paediatrics. 14.00 - 22.00 there is 2nd tier 2 practitioner solely covering neonates.	Amber	a 24/7 resident Tier 2 dedicated to the neonatal unit and entirely separate from paediatrics. This requires 16wte Middle grades and or Band 8b ANNP's to enable the rota to be separated from Paediatrics.	After 17:00hrs Mon-Fri. 09:00-14:00 and after 22:00hrs at weekends. We have 12wte at end of Q1. This includes 2 8b ANNP's leaving a GAP of 4.0wte	1.65wte ANNP funding agreed via MIS money in 2025. There is funding for a further 1.0wte Band 8b, but unable to recruit into. Advertised an 8a development post but also not recruited into. SuccessfulANNP trainee candidate to commence the ANNP course in September 2026. Business case required for any further funding.	To develop an 'I have an idea' business case by the end of Q3 2026. 1 staff member to commence ANNP course in September 2026.	Advertise funded place for ANNP course	Business case development for remaining gap	Successful ANNP trainee to commence course		Ongoing

A4 **Compliant** **QGC** **Action**	**Midwifery Workforce establishment** - Fully funded midwifery establishment that aligns with Birthrate Plus (BR+) within the last three years Q1 Compliant –Birthrate+ review took place in 2025 and presented to board in September 2025 Appendix 5a Midwifery Safe staffing report September 2025 Appendix 5b Midwifery Safe staffing Q1 report presented to QGC on 30.7.26 and NMAG meetings monthly	QGC/Trust board to acknowledge a fully funded midwifery establishment.
A5 **Compliant** **QGC** **Action**	**Anaesthetic Workforce** – ensure obstetric services have duty anaesthetist and assistant available 24/7 in line with ACSA standards Q1 Compliant – Appendix 6 Q1 Obs Cover - Anaesthetic workforce DayNightEve	QGC/Trust Board to acknowledge compliance with 24/7 anaesthetic cover for obstetric services.
A6 **On track**	**Planned caesarean birth capacity mapping** – Annual demand capacity review showing how planned C/S activity compares with available theatre time, staffing recovery and post-natal ward capacity. Q1 – Commenced - Ongoing – Initial planning meeting on 12th May 26, progress meeting planned for 16th July 26. Plan to use improvement team and regional tool launching in September.	No Action required – ongoing compliance towards 30th November
A7 **On track** **QGC** **Action**	**A six-monthly integrated workforce report** covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams (Due in Q2 CNST MIS year 8 report)	No Action required – ongoing compliance towards 30th November. Six-monthly report will be presented in Q2.
	Training	
B1 **On track**	**Obstetric emergency training** (annual, MDT, local learning, human factors, communication, teamwork, escalation pathways, situation awareness, Obs emergencies including impacted fetal head)	No Action required – ongoing compliance towards 30th November
B2 **On track**	**Neonatal Resus annual training** required against BAPM Neonatal Airway Safety Standard.	No Action required – ongoing compliance towards 30th November
B3 **On track**	**Fetal Monitoring annual training** (physiological EFM theory annual, MDT, local learning, human factors, communication, teamwork, escalation pathways, situation awareness, SBAR)	No Action required – ongoing compliance towards 30th November
B4 **On track**	**In situ multi-professional perinatal emergencies x2.** One begins in hospital area, other begins in community area. (Where possible including ED, Paramedics) Planned ED – 19th August, Community 28th September	No Action required – ongoing compliance towards 30th November
B5 **On track** **QGC** **Action**	**Training Compliance oversight** of training compliance quarterly maintaining > or equal to 90%, this must be achieved for every required staff group at TWO points during the MIS year. Screenshot below demonstrates 3rd June 2026 compliant. Training compliance features in the Perinatal Safety report quarterly.	QGC/Trust board to acknowledge 1st declaration point 3rd June 2026 – Training compliance over 90% for all training courses and required staff groups

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The training requires 90% attendance at two pre-determined points during the MIS Year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, at the following training where applicable dependant on staff group:	*Staff group*	*Compliance 3rd June 26*
1. Fetal monitoring training	Midwives Band 5,6,7,8	97.65%
	Obstetrician Consultants (that contribute to rota)	100%
	All other Obstetrician Doctors (that contribute to rota)	100%
2. Multi-professional maternity emergencies training	Midwives 5,6,7,8	99%
	Anaesthetists Consultants (that contribute to rota)	100%
	All other Anaesthetists (that contribute to the rota)	96%
	Maternity Support workers and Maternity Care Assistants	96%
	Obstetrician Consultants (that contribute to rota)	93%
	All other Obstetrician Doctors (that contribute to rota)	97%
3. Neonatal resuscitation training	Neonatal nurses	92%
	Medical staff (Pead's / Neonatal)	92%
	Midwives 5,6,7,8	99%

Learning from Investigations

C1 **On track** **QGC Action**	**Notify all qualifying events through NHSE (SPEN) portal** to MBRRACE-UK, NHSR EN AND MNSI as soon as possible after death/ diagnosis Appendix 7 Perinatal Incident report Q1	QGC/Trust board to acknowledge receipt of Perinatal Incident report that confirm NHSE compliance
C2 **On track** **QGC Action**	**Seek parents' views of care** (multiple opportunities) during PMRT review Appendix 8 Q1 26-27 PMRT report	QGC/Trust board to acknowledge receipt of the PMRT with Action C compliance
C3 **On track** **QGC Action**	**External MDT reviewers for a minimum of 60% of the deaths** reviewed and documented with the PMRT tool. Appendix 8 Q1 26-27 PMRT report	QGC/Trust board to acknowledge receipt of the PMRT with Action C compliance
C4 **On track** **QGC Action**	**Provide relevant information and access regarding the role of MNSI, NHSR EN scheme and PMRT reviews.** Information about duty of candour must be provided for all parents. Screenshot below from Q1 Perinatal Safety Report demonstrating DoC completed.	QGC/Trust board to acknowledge receipt of the Perinatal Safety Report with Action C compliance
C5 **On track**	Offer parents a meeting with relevant specialists to share the findings from reviews and investigations and relevant incidents reports	No Action required – ongoing compliance towards 30th November

4.2. Summary of current MNSI cases and actions

MNSI reference	Date of case	*DOC completed	Stage of investigation
MI-050057	Dec 2025	Yes	Investigation completed by MNSI – report received end of April – action plan completed and approved at PSIRG
MI-051956	Jan 2026	Yes	Draft report received in July 2026 and feedback shared with MNSI – report now with parents for their feedback
MI-055236	Mar 2026	Yes	Investigation underway – notes submitted to MNSI – staff meetings held
MI-056368	Apr 2026	Yes	Investigation underway – notes submitted to MNSI

**DOC completed – The provides confirmation that the family have received the relevant information regarding the nature of the incident (Duty of Candour disclosure), the role of MNSI and the EN scheme from NHS Resolution.*

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C6 **On track** **QGC** **Action**	**Thematic reports of learning and actions** that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT, PSIRF reviews, MOSS, NHSR claims scorecards. Use of demographic data to identify and understand any disparities in outcomes. See Appendix 7 Q1 Perinatal Incident report, Appendix 8 Q1 26-27 PMRT case report, Appendix 9a Claims and Incidents Q4 25-26 Appendix 15 Combined WAHT MOSS critical safety check Mar and April 2026 Appendix 9b MBRRACE Report 2026 (2024 data) A joint review of these reports will be created for Q2 to demonstrate the themes across all reports.	QGC/Trust board to acknowledge QGC/Trust board to acknowledge receipt of Perinatal Incident reports that inform the themes, learning and actions within Perinatal services
Service User Voice and Equity		
D1 **On track** **QGC** **Action**	**Communication equity, language support and accessible information** - Ensure translation, interpreting support, reasonable adjustments are supported Appendix 10 – April 25 - March 26 Badgernet Audit of Interpreter use (summary) • Completed a comprehensive audit covering April 25 – March 26. • Results – recognised documentation gaps, further Wordski translation devises to be purchased. • Action – 1) Introduce mandatory Badgernet Field requiring staff to record whether an interpreter had been used and if not provide a reason. 2) Staff to all be sent comprehensive guide on using digital translation tools across devices 3) PRM meeting to agenda the purchasing of further Wordski machines. • Plan - To meet with Anna Sterckx and team for support. Audit to be repeated.	QGC/Trust board to acknowledge local audit undertaken to further understand the use of current communication equity and immediate action and plans to address
D2 **On track** **QGC** **Action**	**Service user voice driving safety and quality improvement Insights from women, families and carers are captured and used to inform service improvement.** These insights are captured in bi-monthly patient experience meetings, CQC annual action plan, ECHO (local QI project – Experience Capture and Highlighting opportunities) and MNVP members are quorate with the perinatal safety champions workstream. Summary also provided in Section 9 Perinatal Safety Report. Appendix 11 - CQC Survey Feb 2025 Data WAHT Coproduced Action Plan 2026 Appendix 12a - Patient Experience minutes May 26 Appendix 12b - MNVP HLR Report July 2026 (Activity May-June)	QGC/Trust board to acknowledge patient insights are captured and actioned within the perinatal space.
Care Bundles		
E1 **On track** **QGC** **Action**	**Saving Babies Lives Care Bundle (SBL)** – Quarterly reporting to Trust Board on progress against full implementation. Q1 Compliant – Q4 review with ICB 20.5.26, Q1 review with ICB – 16.9 26 (compliance level – 99%) Appendix 13 - Summary of SBL Q1 26-27	QGC/Trust board to acknowledge and agree status/progress with SBL

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E2 **On track** **ICB engagement required** **QGC Action**	**Maternal Care Bundle (MCB)** – Implementation tool. In collaboration with all relevant services, the trust board agrees a plan to implement the bundle by March 27. Progress to be reviewed quarterly. Appendix 14 - MCB Elements 1 to 5 Combined Action Plan Q1 26-27 *Awaiting engagement from the ICB.* *National tool has formatting issues, local tool created and utilised until new tool uploaded to futures platform*	QGC/Trust board to acknowledge MBC action plan ongoing and engagement required from the ICB for full implementation
E3	**Neonatal pulse oximetry testing.** A standardised, equitable, and governance approved guideline required to the BAPM framework.	No Action required – ongoing compliance towards 30th November
Board Oversight and Governance		
F1 **On track** **QGC Action**	**Board Oversight of Maternity and Neonatal Quality and Safety.** Information received includes a comprehensive assessment of perinatal quality and safety (Training, workforce, staff, service user experience, care bundles). QGC findings and scrutiny are formally escalated to the Executive board according to the Perinatal Quality Oversight Model (PQOM).	QGC/Trust board to acknowledge receipt of the Perinatal Safety report, Perinatal Incident report and CNST report quarterly that aligns with the PQOM.
F2 **Compliant** **QGC Action**	**Maternity Outcomes Signal System (MOSS)** – trust must send a completed copy to region and national team (drill or real) MOSS submission 1. April 2026 2. 29.4.26 – Second MOSS alert Appendix 15 - Combined WAHT MOSS critical safety check Mar and April 2026	QGC/Trust board to acknowledge receipt of the of completed MOSS alert and associated action plan
F3 **Compliant** **QGC Action**	**Maternity and Neonatal Board Safety Champions –** Evidence that they are actively supporting the perinatal leadership team (including MNVP lead) in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust board where any concerns are identified. Appendix 16 – 24th April 26 Safety Champions minutes Appendix 17 – 22nd May 26 Safety Champions minutes June Champions meeting cancelled. *Evidence includes focused discussion around the Perinatal Anti-Discrimination Programme, External Feedback/ Alignment, Ongoing culture and equity work, Theatre/SCSD Interface*	QGC/Trust board to acknowledge receipt of the Safety Champions minutes and confirm that the PLT and MNVP lead discuss creating and embedding a safety culture.
F4 **Compliant** **QGC Action**	**Perinatal Culture Improvement Plan –** trusts must demonstrate they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources and presented at least 6 monthly Appendix 18 – Perinatal Culture and Equity Anti-discrimination Action Plan Q1 26-27	QGC/Trust board to acknowledge receipt of the Perinatal Culture Improvement plan and its scrutiny.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT

Report to:	**Public Board**
Date of Meeting:	**13 October 2026**
Title of Report:	Safer Staffing report - Nursing
Lead Executive Director:	**Chief Nursing Officer**
Author:	Sue Smith, Deputy Chief Nursing Officer
Reporting Route:	NWAG QGC
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during June 2026 with numerical data also presented for June 2026.

Recommended Actions required by Board or Committee

Board members are invited to:
Note the content of the report and receive **Assurance** that our safe staffing levels remain in line with National Quality Board (NQB) and NICE guidance.

Executive Director Opinion[1]

Staffing on Neonatal and Paediatrics:

Neonates and Paediatrics – all shifts safe throughout July 2026.

There were 80 red flags raised, all were deemed insignificant and minor harms. All red flags raised are addressed contemporaneously as they are now reviewed twice daily during the safer staffing huddles.

Due to the continued capacity and flow pressures in July 2026 some additional capacity has continued to be utilised in MSDEC at the WRH site and use of discharge lounges out of hours countywide and the continuation with AMA and ASA. Overall costs of additional capacity and PDSAs (not including additional staff in cross county A&E's) has reduced from £196k in June to £98K in July.

To note: An independent review is underway of the Safer Nursing Care Tool (SNCT) methodology and application by the NHSE CNO safer staffing faculty lead through May, June & July 2026 with a document submission and desk top review having been completed. An onsite visit is pending and will include an in person teaching session and update delivered by a representative from the CNO safer staffing faculty.

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[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.

Nursing Staffing Levels
August 2026

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

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1. Introduction

(including relevant updates)

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

2. Key highlights

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

Nursing (Registered)

Key Performance Indicator	Target	August 2026	July 2026	Additional notes
Vacancy rate RN		4.68%↑	4.46%	RN vacancy has risen slightly in August – Newly qualified pipeline is expected to join through Sep / October – biggest vacancy sits in MEC at 94.48 WTE (16.8 of these are related to PDU which has now closed, 9.45 IN A&E at AGH and 18.7 in A&E at WRH) - we are currently' quartile 2 (MHS) (good) for Registered Nurses.
Annual turnover RN	11.5%	5.45%↑	5.38%	Retention of registered nurses is stable and below both trust target (11%) and model health system (7.5%) and last year's position within the Trust was 7.36%
Sickness rate	4%	6.42%↓	6.56↑	Active sickness management in place as per policy and staff well-being is supported.
Vacancy rate HCSW		12.71%↓	13.05%↑	Vacancy decreased by 4.24 WTE recruitment pipelines remain positive and a deep dive into HCSW vacancies is currently underway.
Annual turnover HCSW	11.5%	12.53%↓	12.9%↓	Unregistered nursing turnover has seen a further slight decrease. In the coming months further analysis will be completed to look at localized turnover rates to identify areas for targeted support. Model health system benchmark is 16%

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				and last year’s position within the Trust was 12.33%
Sickness rate HCSW	4%	8.45%↑	7.78%↑	Active sickness management in place as per policy and staff well-being is supported

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3. Expectation 1: Right Staff

3.1 Evidence Based Workforce Planning

3.1.1 Safer Nursing Care Tool (SNCT)

- : The Spring / Summer SNCT data collection study ran from May 18th to June 16th inclusive across all adult Inpatient Wards in Acute Hospitals, Adult Acute Assessment Units and Children's and Young People's Inpatient Wards.
- Following completion of the study, data will be run and meetings will be held with the Care Groups with a second study to inform budget setting, plans for November 2026 following training scheduled to be provided by the NHSE Safer staffing faculty in November 2026.
- An independent review is taking place of the SNCT methodology and application by the NHSE CNO safer staffing faculty lead with an initial desktop review on the 9th of July 2026. The planned onsite visit will take place prior to the next review in November to provide assurance of methodology.

3.1.2 Bi-Annual Establishment Reviews 2026

- The first biannual review for 2026 commenced on 18 May 2026 using the appropriate Safer Nursing Care Tool (SNCT) methodology.
- The second biannual revie1w is scheduled for November 2026 and will be undertaken using the relevant SNCT.
- Any changes to the ward template, service provision, or specialty will trigger a review of the staffing establishment using the SNCT.
- Preparations for the paediatric staffing study are also underway. Allocate has been updating the paediatric nursing workforce tool, and dates have now been confirmed for the NHS England training programme on the revised tools and software. Following completion of this training, the studies for the relevant paediatric areas will be scheduled and undertaken.

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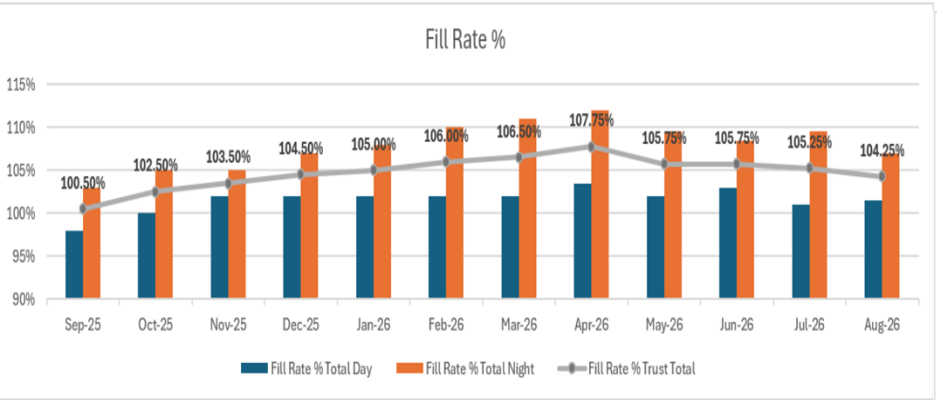
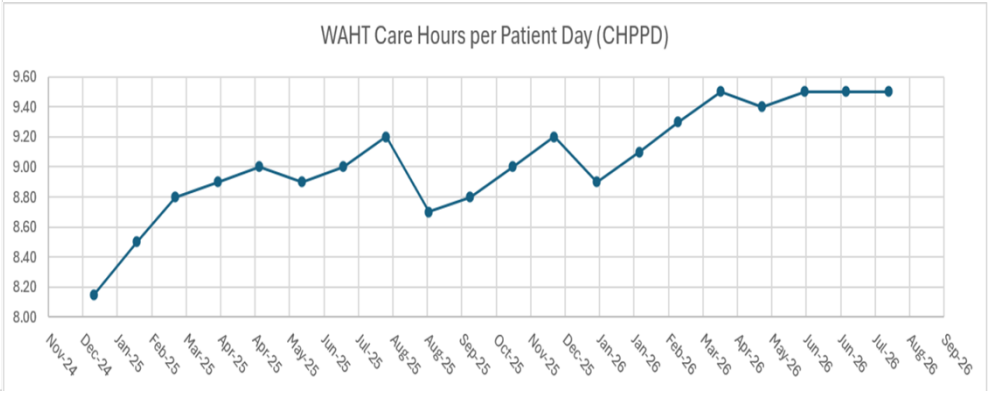
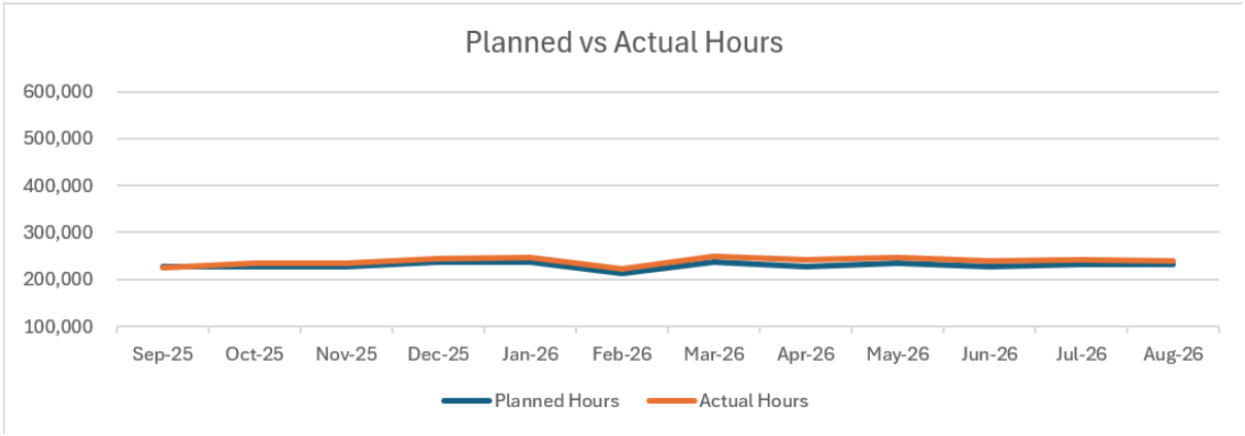
3. Expectation 1: Right Staff

3.2 Safety performance metrics (WAHT







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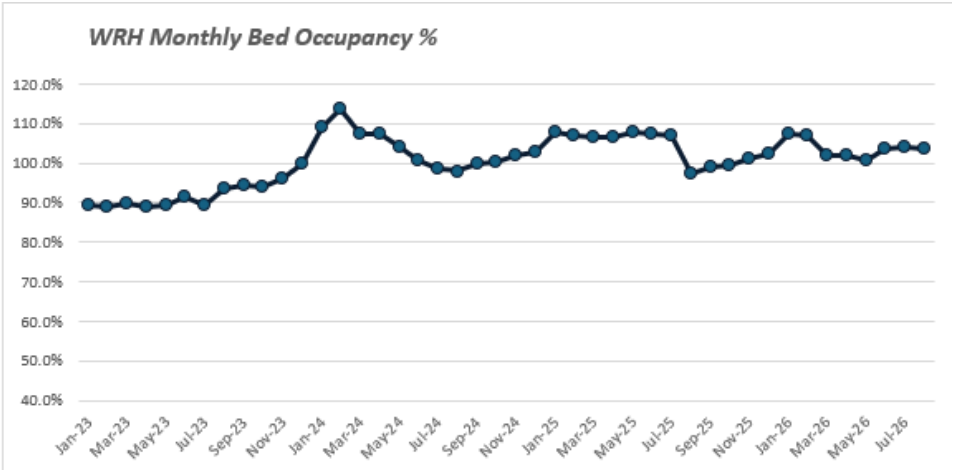

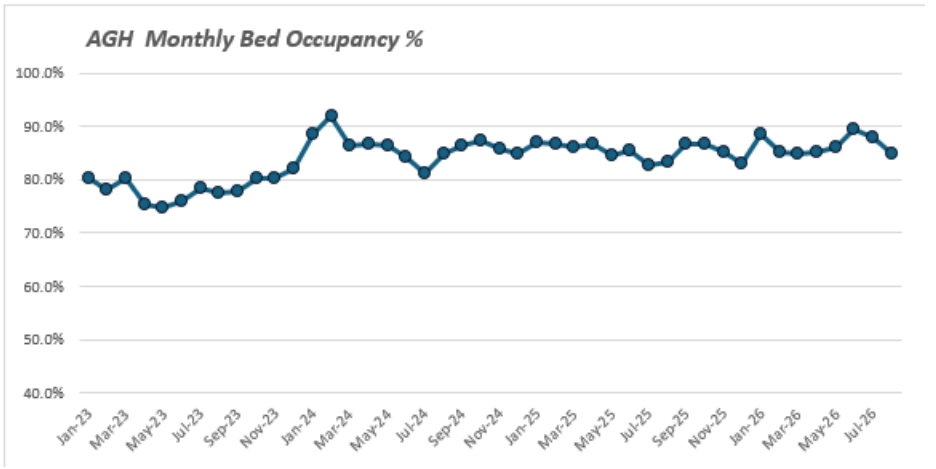

Narrative:

- RN average fill rate is slightly reduced from last month on the day shift but remains stable overall and above 95% (99% / 104% day and night respectively), HCA fill is also stable in August to 101% /113% (from 103% / 114%) in July.
- Reviewing locations and themes in areas reporting utilisation above 100%, the registered nursing variance in August was primarily associated with the use of additional RNs for the AMA PDSA in AMU (131% / 123% Day and night) and ASA on SAU (136% / 99%).
- For unregistered nursing, the top three outlying areas were Beech Trauma (174% nights) due to changes to patient profiles, Beech B (164% night) due to specialing for DOLS patients who cannot be co-horted due to acuity / infection and AFU (168%) due to specialing (falls risk)
- CHPPD in August 2026 is stable at 9.5 (9.5 in July) a detailed view (ward by ward) is included in Appendix 1
- No area fell below the 6.3 lowest level seen on national range in August 2026.

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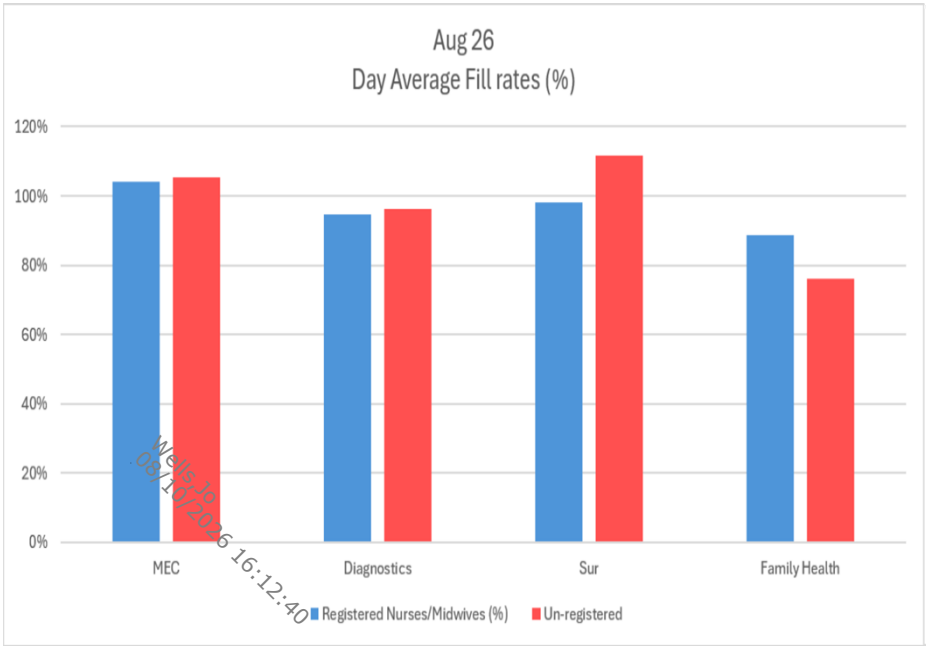
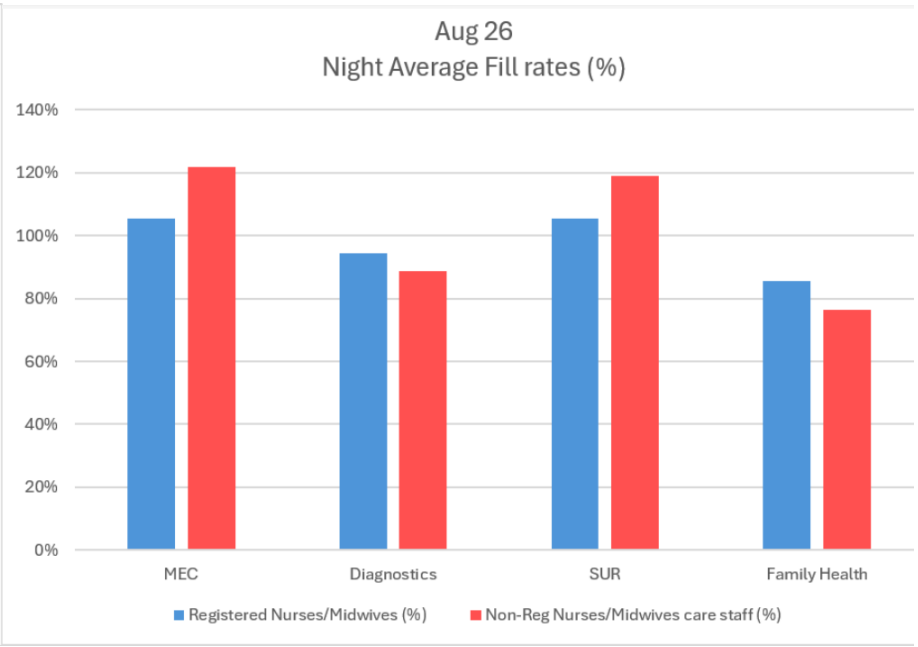
3. Expectation 1: Right Staff

3.2 Safety performance metrics

Narrative

- Analysis of average fill rates shows consistent fill across days and nights. ≤95 % only evident in Diagnostics and Specialties Care Group and Family Health Care Group 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





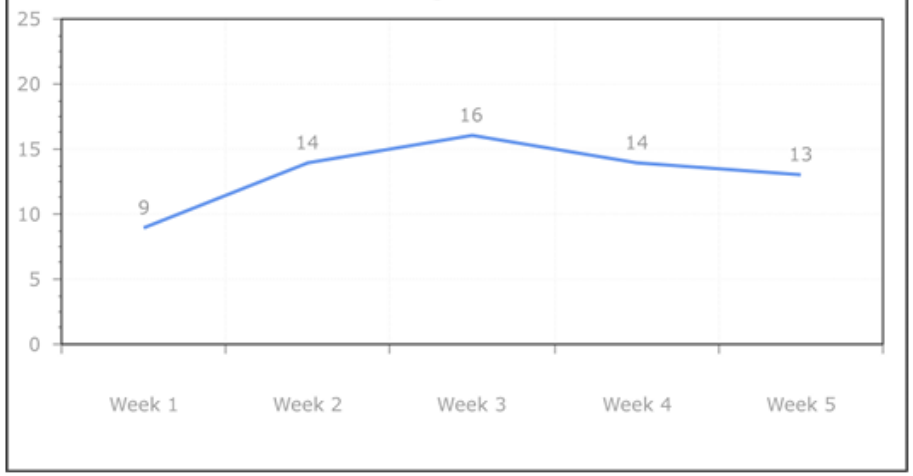
Allocate Optima Reports

Red Flag Analysis - WAHT excluding Medics

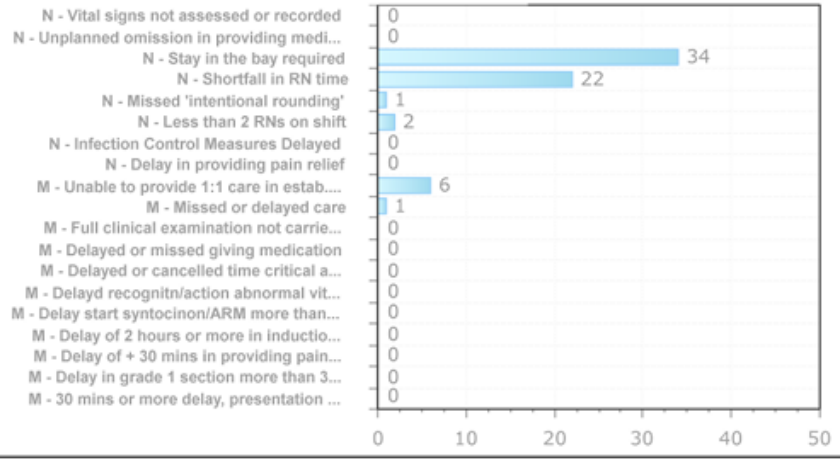
Flag Type: - **Start Date:** 01/07/2026 **End Date:** 31/07/2026 **Flag Status:** Open Or Resolved

WAHT excluding Medics

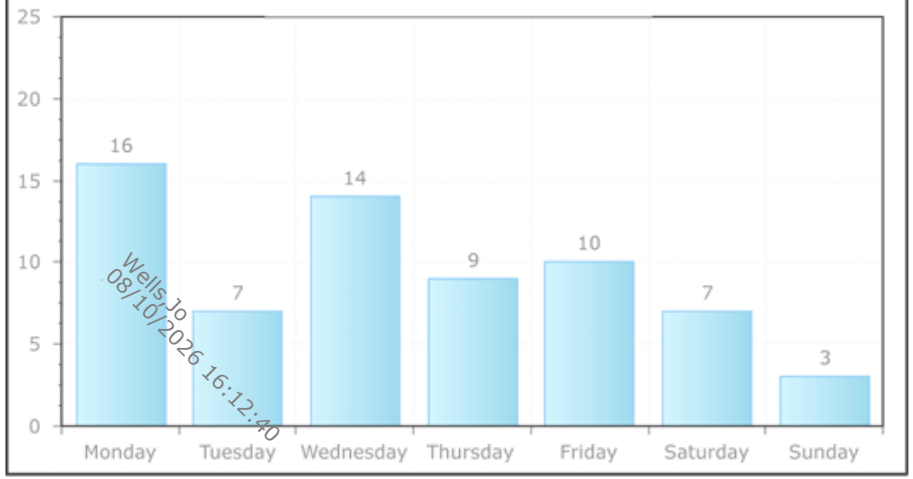
Total Flags Over Time



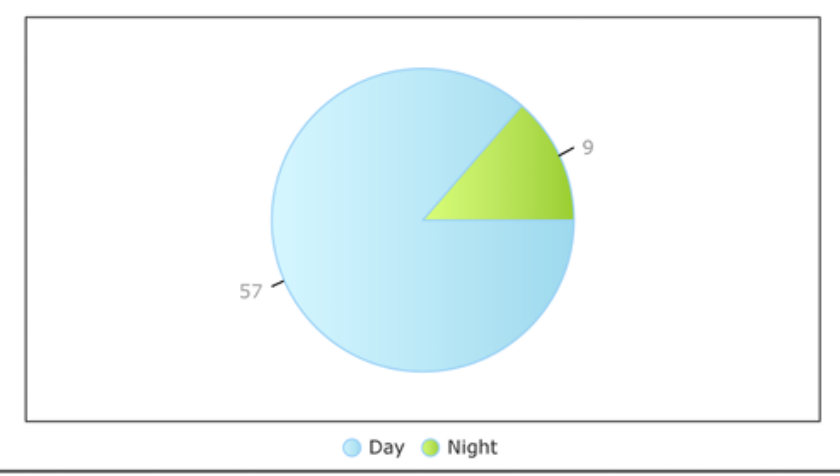
Flags by Type



Total Flags by Day of Week



Flags by Shift Type



Narrative

- August 2026 saw a reduction in red flags, with 74 reported compared with 80 in July and 104 in June. Of the 74 red flags raised, 30 related to 'unable to provide stay in the bay', 36 to a shortfall in Registered Nurse (RN) time, two to missed intentional rounding, two to an inability to provide 1:1 care, and three to shifts operating with fewer than two RNs.
- A review of the two red flags recorded as an inability to provide 1:1 care identified that these had been incorrectly coded by nursing staff and should have been recorded as an inability to provide Enhanced Therapeutic Observation and Care (ETOC).
- The three red flags relating to fewer than two RNs on duty occurred on Trauma & Orthopaedics A, Trauma & Orthopaedics B, and Ward 6. All have subsequently been marked as resolved, with ward managers providing narrative detailing the mitigating actions implemented to maintain safe staffing levels and patient care.
- The daily staffing escalation meeting continues to include a review of red flags across all care groups, with the aim of increasing visibility, oversight, and accountability. This approach has demonstrated positive outcomes, with only 19 of the 74 red flags raised in August (25.7%) remaining open at month-end. While this represents a slight increase compared with July, when 12 of 80 flags (15%) remained open, it remains a significant improvement in June 2026, when 61 of 104 flags (58.7%) were unresolved at the end of the month.
- The small increase in unresolved red flags during August may be attributable to annual leave affecting ward manager availability. This will remain an area of focus moving forward. A review of Datix incidents submitted during the month has provided assurance that the increase in open red flags has not been associated with an increase in staffing-related incidents, either in volume or severity.
- 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.

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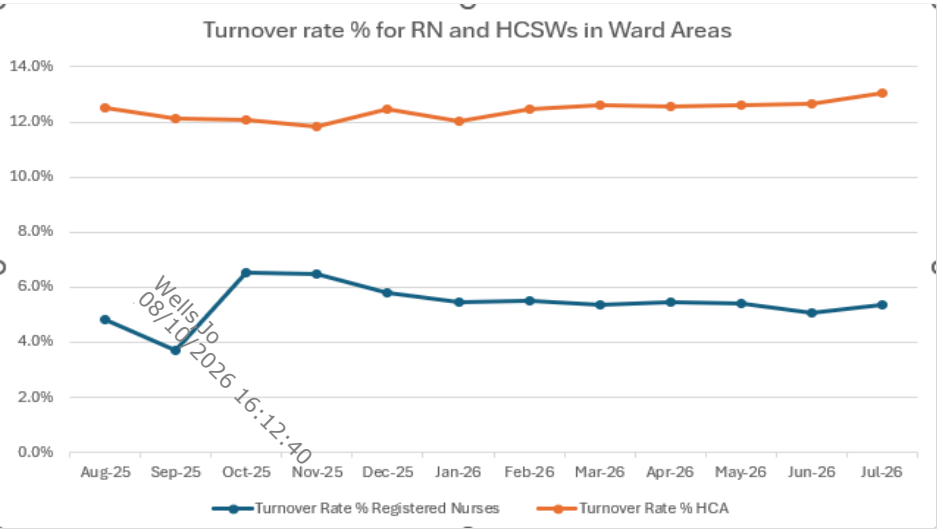
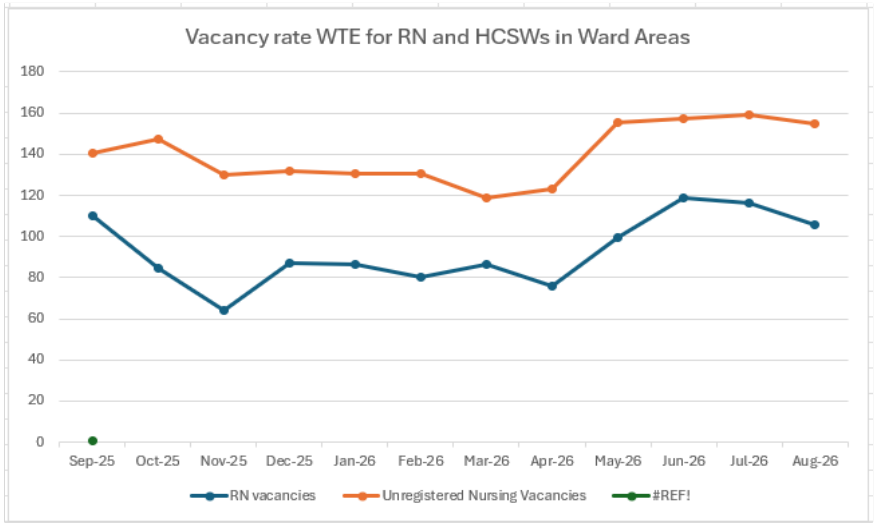
3. Expectation 1: Right Staff

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
Aug-26	4.68%	12.71%	111.25	154.94	266.19
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





Narrative

- RN vacancies for August 2026 currently stand at 111.25 WTE (4.68%), representing an increase of 5.38 WTE since July 2026. Looking ahead, a further Newly Qualified Nurse recruitment event took place on 16 May 2026, during which 113 candidates were interviewed. To date, 27 offers have been made, with a further four vacancies/maternity leave posts under consideration. Candidates are currently awaiting informal visits to clinical areas, following which additional offers may be made.
- HCSW vacancies remain a key focus for ongoing work across the divisions, Workforce Team, and HR Recruitment Team. Following three months of successful recruitment activity, resulting in approximately 75 offers being made, we have welcomed several international HCSWs from other organisations. Building on this success, an HCSW Careers and Engagement Event is planned at CHEC on 19 September. The Nursing Workforce Team has been working closely with the Communications Team to promote the event and maximise engagement with members of the local community interested in joining the Trust.
- HCSW vacancies decreased by 4.16 WTE in August compared with July, from 159.10 WTE to 154.94 WTE. A detailed review of HCA vacancies is currently underway.
- It is recognised that the current vacancy figures for both registered and unregistered staff include **16 WTE and 19 WTE respectively**, relating to the **PDU**, which closed at the end of June. These posts continue to be reflected in the vacancy data and should be considered when interpreting the overall vacancy position.

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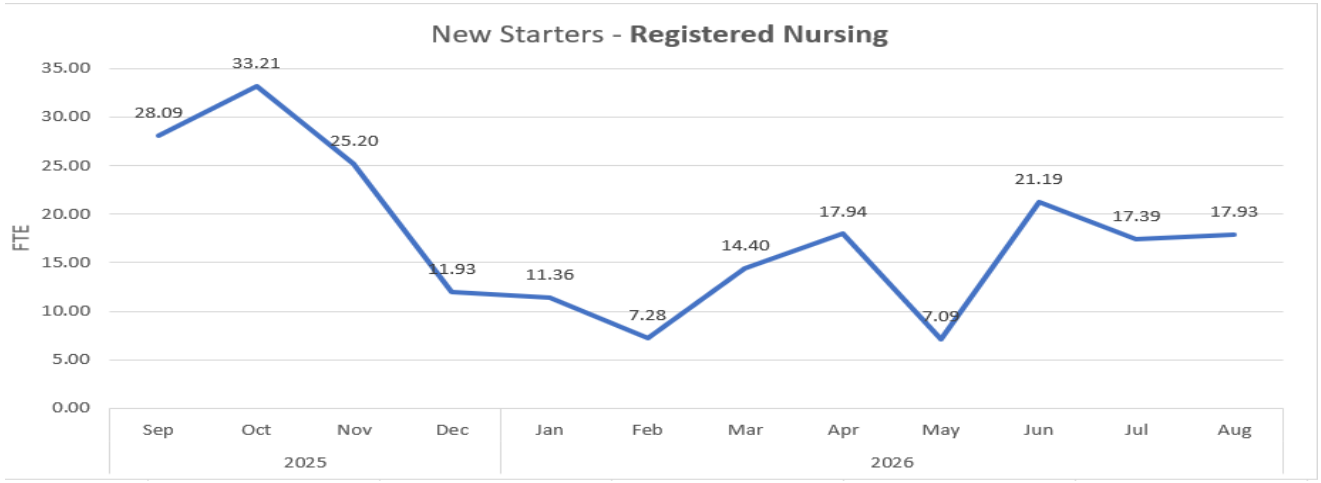
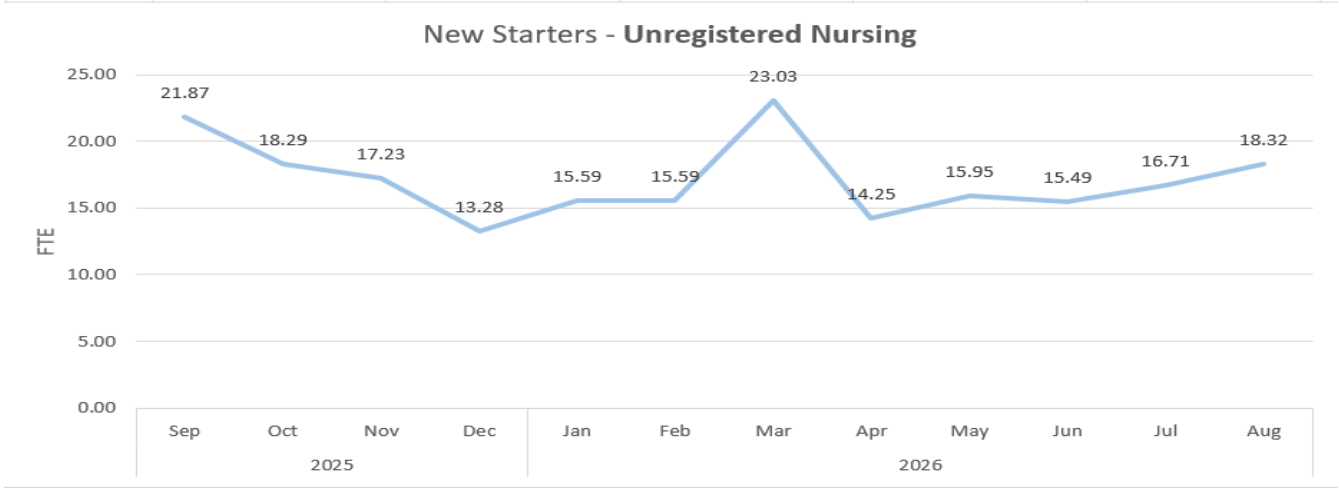
3. Expectation 2: 3.6 Right Skills





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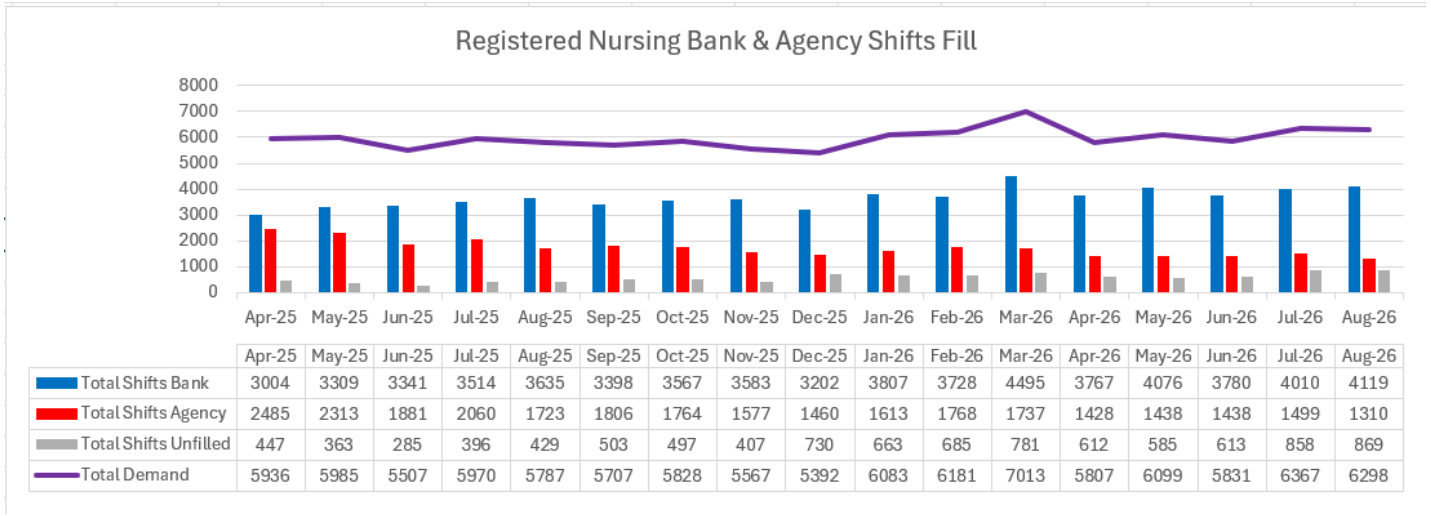
3. Expectation 3: Right Places

3.7 Effective Employment (Registered Temporary Staffing)



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Total Shifts Bank	3004	3309	3341	3514	3635	3398	3567	3583	3202	3807	3728	4495	3767	4076	3780	4010	4119
Total Shifts Agency	2485	2313	1881	2060	1723	1806	1764	1577	1460	1613	1768	1737	1428	1438	1438	1499	1310
Total Shifts Unfilled	447	363	285	396	429	503	497	407	730	663	685	781	612	585	613	858	869
Total Demand	5936	5985	5507	5970	5787	5707	5828	5567	5392	6083	6181	7013	5807	6099	5831	6367	6298

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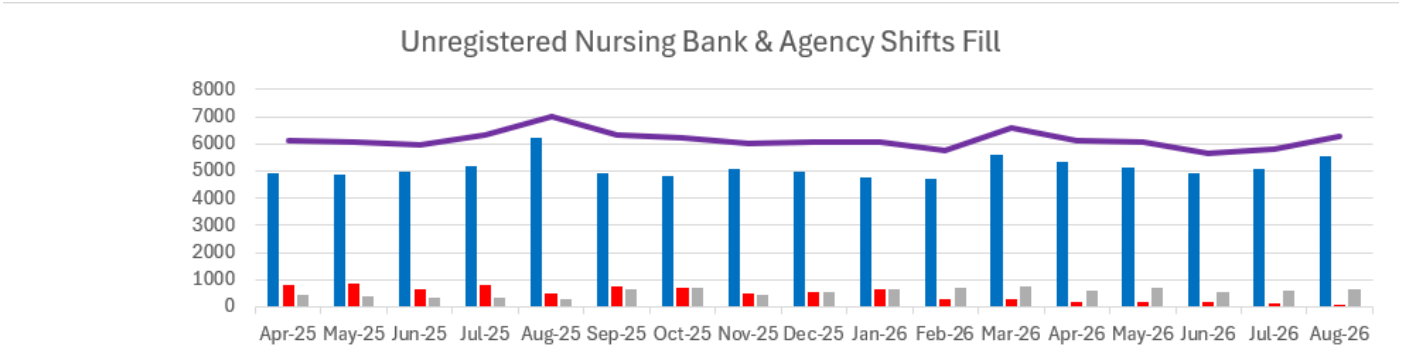
3.Expectation 3: Right Places

3.7 Effective Employment (Unregistered Temporary Staffing)



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Total Shifts Bank	4901	4853	4987	5153	6198	4930	4825	5052	4950	4762	4735	5615	5324	5145	4920	5051	5536
Total Shifts Agency	802	835	659	827	513	747	711	483	569	637	288	263	192	182	171	152	83
Total Shifts Unfilled	436	397	330	350	288	645	691	456	543	639	715	731	584	718	553	596	638
Total Demand	6139	6085	5976	6330	6999	6322	6227	5991	6062	6038	5738	6609	6100	6045	5644	5799	6257

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Narrative

- The safer staffing escalation meetings continued twice daily Mon-Fri throughout August 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 August across both registered and unregistered workforce groups. Registered staff usage marginally increased from 277.46 WTE in July to 278.29 WTE in August, while HCA usage rose from 263.44 WTE to 286.11. These figures are month on month but to acknowledge seasonal variation if figures are compared to the same period last year they show a +8.7 WTE rise in RN but a 36.1 WTE reduction in HCSW usage in August 2026 compared to 2025.
- 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 was 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 3.01 WTE** total usage (from 5.5 in July and 6.2 in June).
- **Price cap** (agency nursing and midwifery) compliance **94.3% compliant** – 27 (31) shifts in total 16 related to OH contact for George Ellot and SWIFT and 11 (16) relating to use of chemotherapy trained nurses.

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Additional Capacity used / open in August 2026:

Ward	Month	Registered		Unregistered		Registered	Unregistered
		Hours	Cost	Hours	Cost	WTE	WTE
Worcestershire Heart Centre	Aug	0	0	0	0	0	
Discharge Lounge WRH	Aug			202	£4,762.98	0.0	1.2
Discharge Lounge AGH	Aug	197	£6.093.20	293	£6,685.99	1.2	1.8
AMA	Aug	1,028	£30,095.00	690	£14,040.00	6.3	4.2
Ward 12 flip bays	Aug	35	£1270.31	23	£578.05	0.2	0.1
ASA	Aug	966	£26,711.06	644	£11,228.31	5.9	4.0
Medical SDEC WRH (overnight usage)	Aug	265	£8,280.07	276	£7,228.89	1.6	1.7
	Aug **Totals**	**2,491**	**£72,449.64**	**2,128**	**£44,524.22**	**15.2**	**13**

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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, considering agency usage, patient safety, and quality considerations.

The areas transitioned to date are outlined below. The programme will be temporarily paused during August, September and October 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-October**.**

	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.**

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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 has risen slightly from last month 126 (105). While Hospital acquired pressure ulcers (HAPUs) also risen to 22 from 14 in July.
  - 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.

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Band 5 Nursing Role Review

- In June 2025, the NHS Staff Council Job Evaluation Group published revised nursing and midwifery job-matching profiles. The review recognised that nursing roles have evolved significantly over time, with many Band 5 nurses undertaking responsibilities and duties that were not fully reflected within existing job profiles.
- The review also identified variation in the application of job evaluation processes across organisations, resulting in concerns that some nursing roles may not have been consistently evaluated against national profiles.
- A multidisciplinary Task and Finish Group has been established within the Trust, with representation from Nursing, Workforce, and Trade Union colleagues, to oversee delivery of the review programme.
- Initial work has focused on collating a representative sample of Band 5 and Band 6 job descriptions from across specialties and Care Groups to support the development of standardised generic job descriptions. This work has now been completed. Nursing colleagues have also met with Midwifery leads, who undertook a similar exercise within the last two years, to identify opportunities for shared learning and adoption of best practice.
- The established task and finish group is scheduled to meet on 15 September 2026, at which time it is anticipated that a comprehensive project delivery plan will be agreed in preparation for submission to NHS England. The meeting will also confirm key milestones, governance arrangements, and next steps for implementation.

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Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Public Trust Board
Date of Meeting:	13th October 2026
Title of Report:	NHSE 10 Point Plan for Maternity and Neonatal Services: Baseline Assurance Report
Lead Executive Director:	Chief Nursing Officer
Author:	Justine Jeffery, Director of Midwifery Jane Wardlaw, Lead Assurance and Compliance Midwife
Reporting Route:	Quality Governance Committee 22.9.26 Trust Board

Enclosures included with this report:

EV-01	CQC Survey Feb 2025 Data WAHT Coproduced Action Plan 2026 (annually)
EV-02	20th May 2026 Patient experience Meeting notes (Bi-monthly)
EV-03	FFT Quarterly data (extract from Perinatal Safety Report Quarterly)
EV-04	MNVP highlights report July 26 (bimonthly)
EV-05	NOTES - MNSChampions 22nd May 26 (monthly)
EV-06	Q1 Perinatal Safety Report to QGC (Quarterly)
EV-07	Complaints and Pals (Extract from Perinatal Safety Report Quarterly)
EV-08	ECHO Patient Experience QI Project Summary (September 26)
EV-09	CNST Q1 25-26 report
EV-10	Maternity Governance Minutes April 26 (item 8.1)
EV-11	Jan 25-June 25 WAHT Perinatal equality Dashboard presentation
EV-12	Region email regarding Equalities dashboard
EV-13	Maternal Care Bundle Q1 Action Plan
EV-14	SBAR Homebirth Review
EV-15	Briefing Paper Homebirth Service February 2026
EV-16	Homebirth Service Review (QGC)
EV-17	QGC Minutes from 23.3.26
EV-18	Perinatal Culture and Equity Anti-Discrimination Action Plan Q1 26-27
EV-19	MIS Workforce Action Plan 26-27
EV-20	Medical Rota Compliance and Additional Consultant Roles Audit Q1 26-27
EV-21	Neonatal Nursing Workforce Tool - WAHT Q1 26-27
EV-22	Neonatal Nursing Workforce Unit Data - WAHT Q1 26-27
EV-23	Midwifery Safe Staffing Report September 2025
EV-24	Q1 Obs Cover - Anaesthetic workforce DayNightEve
EV-25	Mortuary Safeguarding the Security & Dignity of Deceased People: Fuller Inquiry and NHSE Board Assurance Statement

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	EV-26	QGC Minutes 30 July 2026
	EV-27	QGC Mortuary Safeguarding the Security & Dignity of Deceased People & NHSE Statement
	EV-28	Fuller Report Master Action Plan 230726
	EV-29	Clinical Supervision of locum and Temporary Medical Staff in Obs and Gynaecology
	EV-30	Maternity Escalation and Safe Staffing Guideline
	EV-31	QGC Minutes 30 July 2026
	EV-32	QGC Minutes October 25
	EV-33	Maternity Home Births Change Proposal June 2026 Final
	EV-34	Consultation process for planned homebirths to be undertaken by Continuity of Carer Midwifery Teams
	EV-35	Maternity Triage Specification Benchmarking Audit Tool Dashboard
	EV-36	Family Health Care Group Safe Staffing Report - July 2026 (June Data)
	EV-37	Q1 Perinatal Incident Report 2026-27
	EV-38	Claims and incidents Q4 2025-2026 - FINAL
	EV-39	Notes- MNSChampions 24th July 26
	EV-40	Q1 26-27 PMRT case report - FINAL
	EV-41	QGC Minutes August 2026
	EV-42	MDT Simulation training demonstrating learning culture
	EV-43	A-Guide-to-Duty-of-Candour---Revised-2025
	EV-44	Being Open (Duty of Candour) Policy
	EV-45	The importance of reducing burnout and supporting staff (ISH Debrief)
	EV-46	Human factors 2025 (PROMPT - Debriefing)
	EV-47	Proposed Dashboard and live waiting room update dashboard for public (subject to change)
	EV-48	Minutes QSRM 26.08.2026
	EV-49	Maternity Training and Preceptorship Guideline (September 26)
	EV-50	Minutes 26.06.2026 Maternity Governance Meeting
	EV-51	Midwifery Safe Staffing Quarter One Report 2026
Purpose of report:	**Assurance**	**Approval** **x Information**

Brief Description of Report Purpose

On 12 August 2026 NHS England issued the Maternity and Neonatal 10 Point Plan assurance process following publication of Baroness Amos' independent investigation and Donna Ockenden's review of maternity services at Nottingham University Hospitals NHS Trust.

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This report presents the Trust's formal baseline assessment, assurance position, key gaps, mitigations and governance arrangements. It seeks approval for Trust Board sign-off and submission to NHS England by 25 September 2026.

Recommended Actions required by Board or Committee

- Receive and scrutinise the baseline assessment and supporting evidence log.
- Note the current position: 16 compliant, 9 partially compliant and 1 non-compliant deliverable across 26 deliverables.
- Recommend approval of the baseline return to Trust Board for sign-off and submission to NHS England by 25 September 2026.
- Support visible Board ownership and continued oversight of actions, risks and escalation through the Perinatal Assurance Group and Quality Governance Committee.
- Note that a further Trust Board-approved progress update is required by 31 December 2026.

Executive Director Opinion

The baseline assessment demonstrates that Worcestershire Acute Hospitals NHS Trust has responded proactively to the NHS England Maternity and Neonatal 10 Point Plan requirements and has established a credible assurance framework to support delivery. The position of 16 compliant, 9 partially compliant and 1 non-compliant deliverables reflects a generally positive level of preparedness, with evidence of strong governance, workforce oversight, incident management, learning culture and implementation of the post-death care requirements.

The areas assessed as partially compliant and non-compliant are understood, transparently reported and supported by identified actions and executive oversight. Particular attention is required to accelerate implementation planning for Martha's Rule, strengthen Board-level triangulation of maternity and neonatal quality metrics, embed inequalities reporting arrangements, and complete the maternity triage improvement programme. These gaps do not currently indicate an immediate safety concern but require focused delivery and monitoring to ensure sustained compliance with national expectations.

I am assured that appropriate governance arrangements are being established through the proposed Perinatal Assurance Group, with clear reporting lines to the Quality Governance Committee and Trust Board. The baseline submission provides a realistic assessment of current performance and demonstrates openness regarding areas requiring further development.

I therefore support approval of the baseline assessment for Trust Board sign-off and submission to NHS England, subject to continued executive and Board oversight of the identified actions, risks and mitigations, and receipt of regular progress updates ahead of the required December 2026 assurance return.

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1. Executive Summary

On 12 August 2026 NHS England published the national assurance process for implementation of the Maternity and Neonatal 10 Point Plan following Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and Donna Ockenden's review of maternity services at Nottingham University Hospitals NHS Trust. The immediate priority for trusts is delivery of the 10-Point Plan while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of 2026.

Trust Boards are required to provide visible ownership and scrutiny of delivery, ensuring that actions progress at pace, risks are managed and significant concerns are escalated through ICB and regional routes. Trusts must submit the standardised national template to NHS England at two points: the baseline assessment by 25 September 2026 and a progress update by 31 December 2026. Both submissions require Trust Board approval.

The current WAHT baseline comprises 26 deliverables: 16 compliant, 9 partially compliant and 1 non-compliant. The non-compliant position relates to maternity and neonatal rollout of Martha's Rule, where the local delivery model and digital requirements are not yet established. No immediate safety risk is recorded in the baseline assessment.

Established assurance is strongest across 24/7 staffing and responsiveness, homebirth review, incident and complaint governance, and the completed post-death care Board assurance statement. The principal gaps relate to monthly Board-level triangulation of outcome, experience and audit data; inequalities reporting; routine Clinical Director participation; maternity triage performance and implementation; and ongoing mortuary assurance.

2. National assurance requirements and timetable

The NHS England assurance process is intended to support and evidence progress without creating additional reporting burdens. Accountability should be embedded within existing governance arrangements wherever possible. The template aligns with Maternity Incentive Scheme Year 8, allowing trusts to use existing Board papers, committee reports, dashboards, minutes and MIS evidence rather than producing duplicate material.

- The immediate priority is delivery of the 10-Point Plan.
- Boards must provide visible ownership and scrutiny of delivery.
- Actions should progress at pace, with risks managed and significant concerns escalated through ICB and regional routes.
- Regional teams will review returns, provide constructive challenge, identify support requirements and escalate significant concerns nationally.

31st July 2026	Required completion date for the post-death care Board assurance statement
12th Aug 2026	NHS England issued the Maternity and Neonatal 10 Point Plan assurance process.
25th Sept 2026	A-Baseline assessment due to NHS England region following Trust Board approval.
31st Dec 2026	B-Progress report update due to NHS England region following Trust Board approval

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Within 12 Months	Implementation of improvements against the national maternity triage specification, supported by Board oversight of quality and performance
By the end of 2026	Maternity and Neonatal Taskforce comprehensive national action plan expected.

3. Baseline A assessment assurance position

Assessment	Compliant	Partially Compliant	Non-Compliant
Number of deliverables	16	9	1
Proportion of 26 deliverables	60.8%	34.2%	3.8%

Appendix 1 provides a screenshot table from the NHSE PRN02631iii-maternity-and-neonatal-services-reporting-WAHT August 26. Appendix 2 provides the Evidence log required to accompany the submission A-Baseline. This full document is required to be submitted by the 25th September as outlined in paragraph 2.

4. Summary of Key Assurance and Gaps by Action

Action	Rating	Current assurance / gap	Priority next step
1. Martha's Rule	Non-compliant	Trust and national engagement have commenced, but there is no confirmed local maternity/neonatal implementation model, named operational leads or established digital route.	Confirm leads and local pathway; continue engagement with the Trust and national programme; progress digital requirements.
2. Outcomes, experience and audit	Partially compliant	Multiple data sources are reviewed, but these are not yet brought together in a monthly, published Board summary. Ethnicity and deprivation analysis is being developed.	Use the developing assurance group and ECHO/inequalities dashboards to create a regular integrated report with actions and impact.
3. Joint Board accountability	Partially compliant	Joint executive accountability is established. Routine attendance of obstetric and neonatal Clinical Directors at Board when relevant matters are discussed is not yet formalised.	Confirm membership and attendance expectations through the new assurance arrangements.
4. Amos into action	*This action is being nationally led, and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services.*		
5. Inequalities and Maternal Care Bundle	Partially compliant	PEADP participation is supported. The inequalities dashboard and six-monthly Board scrutiny route require further development. The Maternal Care Bundle plan remains in progress.	Agree dashboard publication and review route; continue quarterly reporting and action-plan monitoring.
6. 24/7 safety and responsiveness	Compliant	Consultant presence, locum controls, midwifery and neonatal workforce plans, anaesthetic cover, escalation and redeployment arrangements are evidenced. Neonatal medical staffing remains under an action plan.	Continue quarterly monitoring; strengthen consolidated maternity and neonatal safe-staffing reporting and test escalation arrangements.

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7. Homebirth review	Compliant	The urgent homebirth review and supporting papers are available. Evidence should clearly link identified risks and mitigations to action tracking and regional correspondence.	Complete the evidence trail and retain regional correspondence with the action plan.
8. Humanity, candour and learning	Compliant	PSIRF, thematic complaints review, debriefing, family communication, key-contact and duty-of-candour processes are described as embedded.	Maintain oversight and strengthen demonstration of action impact.
9. Maternity triage	Partially compliant	The baseline audit and action plan are in development. Board oversight does not yet include the full national dataset, and implementation is not yet embedded.	Complete the benchmarking evidence, dashboard, pathway documentation, competency framework, equity measures and governance review.
10. Post-death care	Compliant	The Board assurance statement was completed. Further evidence is required for continuing oversight, implementation of national actions and the 10-year incident-record review.	Obtain corporate confirmation and evidence, including any residual mortuary capacity risk and mitigation.

5. Governance and monitoring

Operational owners will maintain the baseline assessment; evidence log and improvement actions. In response to the national requirement for visible Board ownership and scrutiny, the proposed Perinatal Assurance Group will provide structured oversight of the NHSE 10 Point Plan, Maternity Incentive Scheme Year 8 and other national maternity and neonatal safety requirements. It will use reverse RAG assurance, identify and escalate risks, and report through the Quality Governance Committee to Trust Board.

A Trust Board-approved progress return is due to NHS England by 31 December 2026. Deliverables achieved at baseline will not be repeated; remaining actions will be updated for status, delivery risk, evidence, gaps, due dates and regional challenge. The baseline assessment, evidence log and subsequent progress return will therefore form the Trust's formal assurance record against the national process.

6. Principal risks and mitigations

Risk	Current mitigation	Required assurance
Delay in Martha's Rule rollout	Trust/national engagement and digital change request are under way.	Named leads, agreed pathway, communications, training and digital implementation plan.
Fragmented Board-level data	Existing perinatal safety, patient experience, MNVP, FFT, complaints and audit routes continue.	Integrated monthly summary showing scrutiny, decisions, actions and impact.
Triage implementation and data gaps	BSOTS, dedicated triage staffing, 24/7 contact and current feedback routes remain in place.	Completed audit, dashboard, pathways, competency framework and evidence of sustained improvement.

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Neonatal medical staffing	Existing staffing action plan and risk oversight continue.	Evidence of delivery against the funded establishment plan and escalation of residual risk.

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Appendix 1

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Trust Board Assurance Template						
No.	**Deliverable / Scoping Prompt**	**Baseline Compliance Rating**	**Baseline Evidence Reference Please input reference number as listed in 3. Evidence Log tab**	**Gaps in Assurance Please provide detail of any gaps in assurance**	**Improvement Actions (Including Temporary Mitigations)**	**Comments**
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Non-compliant	*• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.*	• No Digital provision currently with Badgernet • Regional Lead not made contact with Trust • No local plan for implementation • No local leads at present (August 28) PLT/QUAD to name Directorate leads (1x Maternity 1x Neonates). HOM agreed to be lead of Division. • Rollout remains not yet established locally. The meeting recognised that current national implementation is limited and the local delivery model is not yet clear.	• System C request submitted 19.8.26 (AI1IDKLE) - Digital Midwife to discuss with clinical lead on 3rd Sept. • system C responded 20.8.26 - We are currently looking at the changes for Martha's rule. Once the change request is written it will be available for you to review the changes we propose. Your clinical specialist will be able to keep you up to date with the progress at your monthly meetings. (NHSE specification required) • Trust Martha's rule steering group - Maternity and Neonatal now invited to join the group (August 26) • Continue engagement with the national/Trust Martha's Rule work and develop the local maternity and neonatal implementation route as guidance and digital requirements become clear.	• EPR provision for Sunrise underway (but not in Maternity) Networking with Rachel Smits (Digital Nurse) to keep informed of trust wide developments • Webninar attended by Baylon, DOM and DDOM - no clear guidance of how to embed Martha's rule - Some examples given but not clearly embedded. • non-compliance at this stage was expected, as rollout had only occurred at a small number of pilot sites.
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-01 - CQC Action Plan (annually) EV-02 -20th May 2026 Patient experience Meeting notes (bi-monthly) EV-03 - FFT Quarterly data (extract from Perianatal Safety Report Quarterly) EV-04 - MNVP Highlights report July 26 (bi-monthly) EV-05 - Safety Champions May (monthly) EV-06 - Q1 Perinatal Safety Report to QGC (quarterly) EV-07 - Compliants and PALS EV-08 - ECHO Patient Experience QI Project Summary (September 26)	• Not a montly cycle to trust board • Patient experience meeting not monthly • MNVP resourcing - not enough resources to make monthly • Maternity and neonatal clinical audit pathways to board - Gap is where all of our dashboards/ clinical audits go to be seen and analysed	• Have monthly dashboards for maternity and neonatal collecting NNAP and Maternity data • Trust board receive monthly outcome data in terms of perinatal mortality rates, training data, workforce data (mirrors PSOM) • ATAIN and emergency audits are presented at M&N weekly. (List of all the Audits required) • New PAG meeting would provide the monthly scrunity required • Patient feedback to start featuring in M&N weekly meeting, with main themes. Plan for ECHO to become the main feature of this.	• Patient Experience Midwife role is substantive. Midwife is returning from materntiy leave on 7th September • Perinatal Safety Report is fully aligned with the Perinatal Oversight Surveillance Model and includes patient experience as per CNST requirements this is quarterly • Met CNST compliance with patient experience in years 6 and 7 • Safety champions receives monthly input from MNVP as a standard agenda item. • PALS and Complaints reviewed monthly in Divisional Governance

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2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-09 - CNST Q1 25-26 report EV-06 - Q1 Perinatal Safety Report to QGC (quarterly) • Board report and minutes (Example)	• Trust board does receive patient experience information but not an organised framework of dashboards and audits and does not publish a summary report • Trust board does not publish its scrutiny and how progress and impact is tracked	• Perinatal Assurance Group (PAG) is being developed by Trust board • TOR in draft	
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-08 - ECHO Patient Experience QI Project Summary (September 26)	• Trust board to publish a summary report that includes the ethnicity and deprivation of the patient feedback • Patient feedback to be collated with ethnicity and deprivation parameters built in to enable the gathering of data (this is built within ECHO)	• Dashboard in creation by informatics to support this space • ECHO is a QI project that brings together all forms of patient feedback and provides a narrative that results in areas and themes for improvement.	• ECHO project intends to pull this type of data during population of the survey • Informatics met with Susie Smith and Jane Wardlaw on 25th June 2026 to discuss the Inequalities dashboard. Parameters agreed around Saving Babies Lives and the Maternal Care Bundle • Awaiting national PREM project to reach completion and implementation
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant		• Weak evidence at present, TOR and Job plans being adapted and amended. However, this has been verbally agreed and discussed at Board. Awaiting minutes but due to timeframe unable to obtain		
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant		• Obs CD and Neonatal CD only attends when invited. • Obs CD and Neonatal CD not job planned to attend. • Obstetric and neonatal Clinical Directors are not routinely scheduled to attend Board. • Attendance currently occurs when invited, including previous attendance for CNST. • The route for routine involvement remains to be formalised.	• CNO is planning to get to Board • PAG group will need to decide if the CD's are members or not. • Confirm the formal governance route for Clinical Director participation when maternity and neonatal matters are discussed. • Consider membership and attendance expectations through the developing assurance arrangements.	• There is active senior discussion and an intention to increase Clinical Director involvement.

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5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	EV-18 Perinatal Culture and Equity Anti-Discrimination Action Plan Q1 26-27 ▪ *Board report and minutes (Example)*	• DDOM has met with national team and given feedback	• Programme was not flexible	• Everybody has been supported as much as they can be to go on the course (given acuity and availablity), however staff have not be able to be released in a way the programme wanted them released (ask was unrealistic)
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-10 - Maternity Governance Minutes April 26 (item 8.1) EV-11 - Jan 25-June 25 WAHT Perinatal equality Dashboard presentation (March 26) EV-12 - Email from Region regarding Equalities dashboard EV-50 Minutes 26.06.2026 Maternity Governance Meeting	• Local inequalities dashboard in creation - region advise triangulation with local data and national data for accuracy. • Role of analysing this data to be assigned to a role within the staffing structure • No clear guidance on the significance of data and when to action (What % difference initiates actions) • Trust board to have establish data required and pathway	• Perinatal Assurance Group (PAG) is being developed by Trust board - TOR to be created • Agreement to be met regarding timeline for publication of local dashboard • Agreement required for the pathway for the information/ or to continue through Maternity Governance 6 monthly (would be next due in October) • Perinatal Governance team (PLT/QUAD) to include in their anti-discrimination workstream	• National Dashboard published in Feb 26. • National Dashboard has been presented in Maternity Governance by Assurance M/W (March 26) • Escalated the Dashboard to region to ask how to present and against what parameters. Informed some inaccuracies highlighted on national dashboard and to ensure validation and triangulation against local data sources to draw conclusions. • Data challenges then later discussed in Maternity Governance on 24th July 26
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV-13 - Maternal Care Bundle Q1 action plan Q1 26-27 EV-09 - CNST Q1 report	• Aspects of the action plan yet to be achieved • ICB engagement required • National specification alignment with NICE and RCOG and funding required	• Trust Board will be presented with the MCB action plan quarterly in the CNST report received by QGC.	• QGC to receive plan in CNST report in September

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6. Ensuring 24/7 safety and responsiveness of services

6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-09 - CNST Q1 report EV-06 - Perinatal Safety Report to QGC (quarterly)	• Nil of Note - full compliance in Q1	• Nil of Note - full compliance in Q1 • Continue quarterly monitoring and reporting through established governance reports.	• Reported in both the Perinatal Safety Report and the CNST reports • in Q2 this will be in the Safe staffing report • Q1 data - April 10/10=100%, May 4/5=90%, June 6/6=100%
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Compliant	EV-09 - CNST Q1 report EV-29 - Clinical Supervision of locum and Temporary Medical Staff in Obs nd Gynaecology	• Nil of Note - no short term locums during Q1		• Keep local locum database and certification under review.
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	Compliant	EV-19 - MIS Workforce Action Plan 26-27 EV-20 - Medical Rota Compliance and Additional Consultant Roles Audit Q1 26-27 EV-21 Neonatal Nursing Workforce Tool - WAHT Q1 26-27 EV-22 Neonatal Nursing Workforce Unit Data - WAHT Q1 26-27 EV-09 - CNST Q1 report	• Neonatal nursing staffing is compliant, neonatal medical staffing is non-compliant • Risk Register 5991 relating to Tier 2 medical staffing • Neonatal nursing staffing is supported, but the neonatal medical staffing plan has not yet delivered the required establishment. Recruitment remains constrained by workforce availability.	•Continue delivery and monitoring of the existing neonatal medical staffing action plan, with progress reported through the established governance route.	• BAPM action plan presented to QGC in the CNST reporting cycle • Clear plan iin please however, recognising that it has not yet come to full fruition.
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	Compliant	EV-23 Midwifery Safe Staffing Report September 2025 EV-32 QGC Minutes October 25	• No Gap identified • Birthrate Plus had been completed within the required three-year period.	• Maintain routine workforce monitoring and reporting.	• Birthrate+ review took place in 2025 and was presented to Trust board in September 2025 • Continue safe staffing reports quarterly

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6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? (In line with MIS Year 8)	Compliant	EV-09 - CNST Q1 report EV-24 Q1 Obs Cover - Anaesthetic workforce DayNightEve	• Nil of Note - full compliance in Q1 • Quarter 1 assurance and supporting screenshots confirmed the required anaesthetic provision.	• Anaesthetist and Perioperative team staffing to be added to the safe staffing report • Continue routine monitoring and include assurance in the safe staffing reporting route.	• Newly configured safe staffing report in development in Q1 to deliver in Q2 to QGC/Trust board
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV-29 Maternity Escalation and Safe Staffing Guideline EV-31 QGC Minutes 30 July 2026 EV-36 Family Health Care Group Safe Staffing Report - July 2026 (June Data) EV-51 Midwifery Safe Staffing Quarter One Report 2026	• Board oversight of neonatal safe staffing is not as direct or consolidated as maternity oversight. • The neonatal nursing safe staffing report currently follows divisional and Nursing and Midwifery Advisory Board routes rather than going directly to Trust Board.	• Amend the neonatal safe staffing report to the relevant safety report to strengthen visibility. • Transfer neonatal staffing content into the new consolidated staffing report when developed, with senior sign-off before implementation.	• Meetings discussed retained a compliant view but identified this reporting change as a way to strengthen Trust Board assurance.
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Compliant	EV-31 QGC Minutes 30 July 2026 EV-49 Maternity Trianing and Preceptorship Guideline (September 26)	• No material gap identified in the ability to redeploy appropriately skilled staff. • A potential assurance gap is that the practical effectiveness of escalation and redeployment arrangements has not been routinely tested through a structured assurance exercise. • All specialists (Bereavement, Infant feeding, Diabetes, safeguarding and Preterm) attend all training as a delegate and also train on their own bespoke sessions - The Training guideline explicitly explains this Relates to evidence in 7.1	• Use Safety Champion walkabouts or a Cappuccini-style assurance exercise to test staff understanding of escalation, who can be redeployed and how specialist services remain safe. • Confirm that specialist staff remain appropriately trained for the clinical areas to which they may be redeployed.	• Meetings confirmed a clear escalation policy, robust training and the ability for specialist and senior staff to support clinical care within their competence. Can provide signing in sheets for all specialist roles across all domains of training

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7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV-14 SBAR Homebirth review EV-15 Briefing Paper Homebirth Service Feb 26 EV-16 Homebirth Service Review (QGC) EV-17 QGC minutes from 23.3.26	• No additional gap identified from the meeting. • Existing evidence includes the initial SBAR and the paper presented to QGC in March.		• Local meetings supported the compliant assessment and confirmed that the relevant papers were available.
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Compliant	EV-33 Maternity Home Births Change Proposal June 2026 Final EV-34 Consultation process for planned homebirths to be undertaken by Continuity of Carer Midwifery Teams	• Evidence needs to clearly connect identified homebirth risks, mitigations and actions to the Regional NHSE sharing route.		• We didn't need to report it to the regional team because the service was continuing and we didn't need to suspend.
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-37 Q1 Perinatal Incident Report 2026-27 EV-31 QGC Minutes 30 July 2026 EV-38 Claims and incidents Q4 2025-2026 - FINAL EV-40 Q1 26-27 PMRT case report - FINAL EV-50 Minutes 26.06.2026 Maternity Governance Meeting	• The required PSIRF processes are in place. • quality could continue to improve, but no gap was identified against the existence and governance requirements in this prompt. • Compliant assessment because learning and actions are reviewed, shared with families and reported through the safety report.	• Maintain review of learning, actions and outcomes through the safety reporting route and use improvement work to strengthen the quality of delivery.	
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-39 Notes- MNSChampions 24th July 26 EV-06 Q1 Perinatal Safety Report to QGC (Quarterly) EV-31 QGC Minutes 30 July 2026 EV-48 Minutes QSRM 26.08.2026	• The thematic review and reporting process is in place, although it is recognised there is scope to improve how themes, actions and impact are demonstrated.	• Continue to strengthen thematic reporting and show more clearly how improvement actions are monitored for impact. • Continue development of ECHO. • Development of PAG group	

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8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-41 QGC Minutes August 2026 EV-42 MDT Simulation training demonstrating learning culture EV-43 A-Guide-to-Duty-of-Candour---Revised-2025 EV-44 Being Open (Duty of Candour) Policy EV-45 The importance of reducing burnout and supporting staff (ISH Debrief) EV-46 Human factors 2025 (PROMPT - Debriefing) EV-48 Minutes QSRM 26.08.2026	• No additional gap identified against the core requirement. • confirmed that open learning, compassionate debriefing, a key contact and early duty of candour processes are in place. • ISH is not recorded formally, the 223 bleep holder maybe able to complete a proforma of the event (timestamped, attendee's, further actions). Documentation then to be sent/uploaded/collated via Governance for auditing purposes.	• Maintain existing processes and continue using feedback to improve practice. • Birth reflections (debriefing service provision) currently being created with DMT.	ISH (Immediate Support Huddle) is advocated in all clinical areas. Specific training has been provided to key members of staff to chair an ISH. Each member of staff recieves the powerpoint presentation during PROMPT annually. All staff received human factors training on PROMPT. 2025 sessions presentation included several slides on the debriefing of patients. Signing in sheets can be provided of all staff present. WAHT was compliant with Safety Action 8 in Year 7 Case by Case evidence available on request for family debrief / engagement
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Compliant	EV-35 Maternity Triage Specification Benchmarking Audit tool Dashboard	• The current WAHT baseline comprises 26 deliverables: 17 compliant, 8 partially compliant and 1 non-compliant.	• Completion of the benchmarking tool has generate a score and actions to follow over the coming months. • Review the triage guideline/SOP against each benchmark requirement, confirm the staffing standards and escalation content, • National Audit template requirements are recognised and currently being worked on by informatics.	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant		• Current Board information is limited to initial assessment compliance at 15, 20, 25 and 30 minutes, plus redeployment information through the staffing report. • There is not yet a complete triage performance dashboard covering waiting, assessment, review, delays, outcomes and inequalities. Proposed Dashboard in development and a screenshot of this can be viewed in EV-47	• Complete the dedicated triage performance dashboard. Include attendance, urgency, waiting and review times, redeployment, delays, outcomes and inequality measures. • Agree routine review and escalation through the Board/governance reporting route.	

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9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	EV-47 Proposed Dashboard and live waiting room update dashboard for public (subject to change)	• Implementation has started but is not yet embedded. • Key gaps include incomplete access and referral documentation, poor or inconsistent signage, no documented system-wide agreement, incomplete handover and discharge routes, inconsistent communication of waiting categories, no formal triage competency framework, incomplete equality data and real-time feedback, and insufficiently explicit escalation thresholds within the SOP.	• Strengthen the triage SOP and guideline; document walk-in, telephone, community, ambulance, ED, primary care, NHS 111, mental health and safeguarding routes; improve signage and web information; confirm handover and discharge communication; develop a competency framework and relevant equality/cultural competency training; complete the performance and inequality dashboard; and test escalation and staffing arrangements. Continue telephone triage and existing open-door access as temporary mitigations while documentation is strengthened.	• Meetings agreed partial compliance and described the overall triage position as amber. Existing strengths include BSOTS use, dedicated triage staff, a 24/7 contact number, Badger documentation, mutual-aid pathways and current service-user feedback through MNVP/CQC routes.
10. Post death care						
10	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-25 Mortuary Safeguarding the Security & Dignity of Deceased People: Fuller Inquiry and NHSE Board Assurance Statement EV-26 QGC Minutes 30 July 2026 EV-27 QGC Mortuary Safeguarding the Security & Dignity of Deceased People & NHSE Statement	• No gap identified. The assurance statement had been completed, presented to Board and included in the Board paper.		• Meeting confirmed action 10.1 was complete.
10	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	EV-28 Fuller Report Master Action Plan 230726	• The delivery responsibilities within the plan are assigned to named action owners, supported by due dates, delivery status, progress status, completion measures and evidence requirements. •The plan is held by the Diagnostics & Specialties Care Group Governance Team.	• Route to be confirmed to strengthen evidence (including minutes) currently - Improving Safety Action Group and Health and Safety Committee (ISAG) - Quality Governance Committee (QGC) - Trust Board.	

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Appendix 2

NHS
Worcestershire
Acute Hospitals
NHS Trust

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Assurance Notes	Evidence Quality	Why it meets the deliverable / scoping prompt
EV--02	2.1	Xcel Action Plan	CQC Survey Feb 2025 Data WAHT Coproduced Action Plan 2026 (annually)	Co-produced action plan translating CQC maternity survey findings into local improvement actions.	Strong	Shows that patient-experience data are collected, analysed and acted on with service-user involvement.
EV--01	2.1	Minutes	20th May 2026 Patient experience Meeting notes (Bi-monthly)	Bi-monthly meeting record reviewing patient feedback, themes, actions and progress.	Strong	Demonstrates a regular forum for analysing experience intelligence and agreeing action.
EV-00	2.1	Report Extract	FFT Quarterly data (extract from Perianatal Safety Report Quarterly)	Quarterly Friends and Family Test results and themes drawn from the Perinatal Safety Report.	Strong	Provides current patient-experience data used within the Trust's review cycle.
EV-01	2.1	Report	MNVP highlights reports July 26 (bimonthly)	Bi-monthly summary of Maternity and Neonatal Voices Partnership activity, feedback and priorities.	Strong	Provides independent service-user intelligence and shows MNVP input into improvement priorities.
EV-02	2.1	Minutes	NOTES - MNSChampions 22nd May 26 (monthly)	Monthly Safety Champions meeting record, including review of safety, patient voice and local assurance information.	Strong	Shows recurring multidisciplinary review and escalation of maternity and neonatal intelligence.
EV-03	2.1 & 2.2,6 (All)	Report	Q1 Perinatal Safety Report to QGC (Quarterly)	Quarterly integrated report covering maternity and neonatal safety, workforce, outcomes, experience, risks and improvement activity.	Strong	Brings multiple intelligence sources together for committee scrutiny and supports Board-level oversight of outcomes, experience and 24/7 safety.
EV-04	2.1	Report Extract	Compliants and Pals (Extract from Perinatal Safety Report Quarterly)	Extract summarising complaints, PALS contacts, key themes and learning.	Strong	Shows that concerns are collected and analysed as part of the patient-experience evidence base.
EV-05	2.3	Powerpoint presentation	ECHO Patient Experience QI Project Summary (September 26)	Quality-improvement summary describing the ECHO approach to combining feedback sources, identifying themes and tracking improvement, including development of demographic analysis.	Strong	Supports triangulation of experience data and the planned identification of variation by ethnicity and deprivation.
EV-06	2.2 & 5.3, 6 (All)	Report	CNST Q1 25-26 report	Quarterly assurance report to QGC covering workforce, incident learning, patient experience, care bundles and Board oversight requirements.	Strong	Demonstrates formal committee scrutiny, quarterly Maternal Care Bundle monitoring and workforce assurance across maternity and neonates.
EV-07	5.2	Minutes	Maternity Governance Minutes April 26 (item 8.1)	Governance minutes recording review and discussion of perinatal inequalities information.	Strong	Shows that inequalities data were considered through an established governance route.
EV-08	5.2	Powerpoint presentation	Jan 25-June 25 WAHT Perinatal equality Dashboard presentation	Presentation of perinatal outcome data by equality measures for local review.	Strong	Provides the dashboard evidence needed for six-monthly review of inequalities trends and variation.
EV-09	5.2	Email	Region email regarding Equalities dashboard	Regional correspondence giving advice or challenge on use and interpretation of the equality dashboard.	Strong	Shows engagement with the regional team and supports validation and triangulation of inequalities data.
EV-10	5.3	Xcel Action Plan	Maternal Care Bundle Q1 Action Plan	Action plan covering implementation of the Maternal Care Bundle, progress, gaps, owners and required support.	Adequate	Provides the implementation plan required for delivery by March 2027 and a basis for quarterly Board or delegated-committee review.
EV-11	7.1	SBAR (Briefing Paper)	SBAR Homebirth Review	Structured briefing setting out the homebirth position, risks, mitigations and recommendations.	Strong	Evidences that an urgent review of homebirth services was completed and risks were identified for senior review.
EV-12	7.1	Briefing Paper	Briefing Paper Homebirth Service February 2026	Private Board paper describing current provision, operational challenges, mitigations and planned improvements.	Strong	Shows that the Board received the urgent review and was asked to note and agree the proposed safe service model.
EV-13	7.1	Report	Homebirth Service Review (QGC)	Formal QGC report on the homebirth review and associated actions.	Strong	Demonstrates committee scrutiny and governance oversight of the urgent review and resulting actions.
EV-14	7.1	Minutes	QGC Minutes from 23.3.26	Minutes recording QGC consideration of the homebirth review.	Strong	Provides evidence of receipt, scrutiny and action by the delegated Board committee.
EV-15	5.1	Action Plan	Perinatal Culture and Equity Anti-Discrimination Action Plan Q1 26-27	Action plan for culture, equity and anti-discrimination improvement, including participation, actions, owners and monitoring.	Strong	Supports evidence that the Trust is enabling multidisciplinary engagement with the Perinatal Equity and Anti-Discrimination Programme and tracking delivery.
EV-16	6.3	Workforce Action Plan	MIS Workforce Action Plan 26-27	Workforce plan setting out neonatal nursing and medical establishment, compliance position, gaps and actions.	Strong	Demonstrates a clear plan against BAPM staffing expectations and the route to address the neonatal medical workforce gap.
EV-17	6.3	Staffing Audit	Medical Rota Compliance and Additional Consultant Roles Audit Q1 26-27	Audit of neonatal medical rota coverage and additional consultant roles against required standards.	Strong	Provides measured assurance on current medical staffing and identifies any establishment or rota shortfall requiring action.
EV-18	6.3	Xcel Workforce Tool	Neonatal Nursing Workforce Tool - WAHT Q1 26-27	Completed neonatal nursing workforce calculator/tool for the unit.	Strong	Shows the calculated nursing requirement against unit designation and supports the funded-establishment assessment.
EV-19	6.3	Xcel Workforce unit data	Neonatal Nursing Workforce Unit Data - WAHT Q1 26-27	Underlying unit-level staffing, activity, vacancy, absence and workforce data used in the neonatal assessment.	Strong	Provides the source data supporting the workforce-tool output and assurance against neonatal nursing standards.

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EV-20	6.4	Report	Midwifery Safe Staffing Report September 2025	Board-level safe-staffing report including establishment, Birthrate Plus position, workforce metrics, acuity and mitigations.	Strong	Shows that the funded midwifery establishment is aligned with a recent Birthrate Plus review and subject to routine oversight.
EV-21	6.5	Rota Screenshots	Q1 Obs Cover - Anaesthetic workforce DayNightEve	Rota screenshots showing anaesthetic and assistant coverage across day, evening and night periods.	Strong	Provides direct evidence of 24/7 duty anaesthetist and trained anaesthetic-assistant availability.
EV-22	10.1	Report to QGC	Mortuary Safeguarding the Security & Dignity of Deceased People: Fuller Inquiry and NHSE Board Assurance Statement	QGC report containing the Trust's mortuary assurance response to the Fuller Inquiry and NHS England requirements.	Strong	Demonstrates completion and formal presentation of the required Board assurance statement.
EV-23	10.1 & 8.1	Minutes	QGC Minutes 30 July 2026	Committee minutes recording scrutiny of the mortuary assurance statement and perinatal incident/safety reporting.	Strong	Provides evidence of Board-delegated oversight, challenge and acknowledgement for post-death care and PSIRF governance.
EV-24	10.1	Presentation	QGC Mortuary Safeguarding the Security & Dignity of Deceased People & NHSE Statement	Presentation used to brief QGC on mortuary safeguards, national recommendations and the assurance statement.	Strong	Supports evidence that the assurance statement and its basis were presented for committee scrutiny.
EV-25	10.2	Action Plan	Fuller Report Master Action Plan 230726	Corporate action plan assigning owners, dates, status, completion measures and evidence for Fuller Inquiry recommendations.	Strong	Shows continuing oversight and implementation of national mortuary actions, including review and monitoring arrangements.
EV-26	6.1	Guideline	Clinical Supervision of locum and Temporary Medical Staff in Obs and Gynaecology	Guideline defining governance, supervision and assurance requirements for locum and temporary medical staff.	Strong	Supports the requirement for certification, local control and safe oversight of short-term locums on tier 2/3 rotas.
EV-27	6.5	Guideline	Maternity Escalation and Safe Staffing Guideline	Guideline describing staffing escalation, operational response, redeployment and management of service pressure.	Strong	Shows a defined process to respond to increased demand, reduced workforce availability and changing clinical risk.
EV-28	6.6	Minutes	QGC Minutes 30 July 2026	Minutes recording discussion of safe staffing and the Perinatal Incident Report.	Limited	Provides evidence that workforce pressures, acuity and escalation activity were scrutinised through the Board governance route.
EV-29	6.4	Minutes	QGC Minutes October 25	Minutes evidencing discussion of the Birthrate Plus review and midwifery establishment.	Strong	Shows Board-delegated scrutiny of the Birthrate Plus assessment supporting the funded midwifery establishment.
EV-30	7.2	Risk Assessment Report	Maternity Home Births Change Proposal June 2026 Final	Formal consultation and change proposal to transfer planned homebirth provision to Continuity of Carer teams, with rationale, risk assessment and implementation arrangements.	Strong	Shows that identified service risks were converted into a timed mitigation and service-change plan.
EV-31	7.2	Presentation	Consultation process for planned homebirths to be undertaken by Continuity of Carer Midwifery Teams	Presentation explaining the proposed operating model and staff consultation process.	Strong	Supports evidence that the mitigation plan was communicated, consulted upon and progressed towards implementation.
EV-32	9.1	Screenshot	Maternity Triage Specification Benchmarking Audit tool Dashboard	Dashboard screenshot from the completed national triage benchmarking audit.	Strong	Provides the required audit evidence, including the baseline assessment of triage safety, responsiveness, staffing and capacity.
EV-33	6.6	Report presentation	Family Health Care Group Safe Staffing Report - July 2026 (June Data)	Care-group safe-staffing presentation covering workforce position, pressures, mitigations and escalation.	Strong	Shows active monitoring of staffing and service pressure across the care group and supports escalation to senior governance.
EV-34	8.1	Report	Q1 Perinatal Incident Report 2026-27	Quarterly report of maternity and neonatal incidents, investigations, actions, learning and oversight.	Strong	Demonstrates embedded PSIRF governance, review of learning and actions, and reporting through QGC/Board safety routes.
EV-35	8.1	Report	Claims and incidents Q4 2025-2026 - FINAL	Quarterly claims and incident analysis identifying themes, learning and actions.	Strong	Supports systematic review of incidents and claims, with learning used to inform improvement and governance oversight.
EV-36	8.2	Minutes	Notes- MNSChampions 24th July 26	Safety Champions minutes including review of complaints, concerns, patient experience and related actions.	Strong	Shows thematic discussion of concerns and escalation of learning through the perinatal leadership and Safety Champions route.
EV-37	8.1	Report	Q1 26-27 PMRT case report - FINAL	Quarterly Perinatal Mortality Review Tool report covering case review, learning, actions and family involvement.	Strong	Provides evidence of structured review, shared learning, action monitoring and engagement with bereaved families.
EV-38	8.3	Minutes	QGC Minutes August 2026	QGC minutes recording scrutiny of duty of candour, complaints and family liaison arrangements.	Strong	Demonstrates senior oversight of open learning, family communication, key-contact arrangements and early duty of candour.
EV-39	8.3	Communication story	MDT Simulation training demonstrating learning culture	Learning story from multidisciplinary simulation showing reflection, debrief and changes to practice.	Strong	Provides practical evidence that staff are supported to learn openly and use debriefing and feedback to improve care.
EV-40	8.3	Guide	A-Guide-to-Duty-of-Candour---Revised-2025	Staff guide explaining duty-of-candour expectations and communication with patients and families.	Strong	Supports consistent staff practice for timely, open and compassionate communication after incidents.
EV-41	8.3	Policy	Being Open (Duty of Candour) Policy	Trust policy setting out responsibilities and processes for openness, apology, communication and follow-up.	Strong	Provides the formal embedded process for early duty of candour and engagement with women and families.

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EV-42	8.3	Powerpoint presentation	The importance of reducing burnout and supporting staff (ISH Debrief)	Training presentation on Immediate Support Huddles, staff wellbeing and post-event debrief.	Strong	Shows staff are trained and supported to take part in compassionate debriefing and immediate learning after events.
EV-43	8.3	Powerpoint presentation	Human factors 2025 (PROMPT - Debriefing)	PROMPT human-factors training with specific content on debriefing patients and staff.	Strong	Provides education evidence that staff are prepared to communicate effectively, debrief and learn following clinical events.
EV-44	9.3	Screenshots	Proposed Dashboard and live waiting room update dashboard for public (subject to change)	Screenshots of the developing internal performance dashboard and proposed public waiting-room information display.	Limited	Shows active implementation of national triage improvements, including improved oversight, transparency and responsiveness.
EV-45	8.2	Minutes	Minutes QSRM 26.08.2026	Weekly quality and safety review minutes showing review of incidents and staff/family support.	Strong	Demonstrates routine review of concerns, learning, support, communication and follow-up actions.
EV-46	6.7	Guideline	Maternity Training and Preceptorship Guideline (September 26)	Guideline describing maternity training, preceptorship and maintenance of staff competence, including specialist input.	Strong	Supports assurance that staff retain the knowledge and skills needed when specialist practitioners are unavailable or redeployed.
EV-47	8.1 & 5.2	Minutes	Minutes 26.06.2026D5:D54 Maternity Governance Meeting	Monthly governance minutes recording review of PMRT and related incident-learning information.	Strong	Shows that incident outcomes, actions and learning are routinely reviewed through established maternity governance.
EV-48	6.6	Report	Midwifery Safe Staffing Quarter One Report 2026	Quarter One assurance report to the Quality Governance Committee covering April to June 2026. It describes how safe midwifery staffing is monitored through Birthrate Plus acuity tools, staffing red flags, midwife-to-birth ratios, SitRep reporting, daily safety huddles, workforce indicators, redeployment and mitigation actions.	Strong	Demonstrates Board-delegated oversight of workforce acuity, staffing pressures and escalation activity. It provides evidence of how the service responds to staffing shortfalls and changing demand through daily monitoring, professional judgement, internal redeployment, escalation and recorded mitigations, while identifying residual workforce risks.

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Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board**
Date of Meeting:	**13th October 2026**
Title of Report:	Responsible Officer Report
Lead Executive Director:	**Chief Medical Officer**
Author:	Head of CMO Services
Reporting Route:	TMB, P&C & Trust Board
Enclosures included with this report:	Responsible Officer Report (Annex-A-FQAI April 2025 - March 2026)
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

This report provides NHS England with assurance that the Trust is compliant with and continues to improve responsible officer functions.

Completion of the report will therefore:

a) help us as a designated body in the pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer,

c) act as evidence for CQC inspections.

Recommended Actions required by Board or Committee

The Board are invited to note the content of this report and continue to support the responsible officer function for the Trust.

Executive Director Opinion[1]

We continue to make progress with improvements across the Responsible Officer function, with a focus on quality of appraisals & ensuring we have appropriate processes in place to monitor compliance.

There continues to be a significant amount of work needed in the MHPS process, including development of KPI's and a new policy. We hope to have this in place for April 2027.

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[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.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Worcestershire Acute Hospitals NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Ensure Deputy Chief Medical Officers are appropriately trained.
Comments:	Deputy CMO has received appropriate training and continues to be involved in cases to ensure continuation of skills / learning
Action for next year:	Continue to ensure appropriate cover for the Responsible Officer is in place.

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1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Continue to embed streamlined processes and advisory group.
Comments:	The Trust has appropriate capacity and resources for the RO function.
Action for next year:	Continue to monitor processes and resources aligned to the RO function

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Embed the welcome letter, and induction process for new consultants.
Comments:	Welcome process has been implemented and has been well received; this includes a welcome meeting with the CMO.
Action for next year:	Develop a training package for consultants who are new to leadership roles to allow continued professional development

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Continue to work with our medical leadership teams to reduce job plans over 12 PA's.
Comments:	Amendments to processes for approval of job plans are in place, including those over 12 PAs. We continue to work with our senior medical leadership team to reduce the number of doctors with over 12 PAs.

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Action for next year	Develop and embed new job descriptions for Associate Chief Medical Officers to ensure appraisal & revalidation within the care group(s) are monitored and reviewed.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	Review the terms of reference for the RO Group. Audit of the current processes / information discussed at the RO Group.
Comments:	The Terms of Reference for the RO Group remain under review; due to the changes to the processes, we are implementing.
Action for next year:	Arrange a peer review across the foundation group or with neighbouring trusts next year

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Continue to monitor these processes trust wide.
Comments:	We continue to support our locum and short-term placement doctors with induction, CPD and other associated training to ensure compliance.
Action for next year	We will continue to monitor our current processes, and ensure improvements are made where identified.

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1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Inclusion of criteria such as productivity and clinical outcomes in appraisals (based on model hospital data)
Comments:	Productivity and clinical outcomes data has been included in our appraisals, allowing colleagues to reflect on their practice.
Action for next year:	Liaise with private sector colleagues to ensure robust and appropriate information transfer as part of appraisal processes if or where required

1B(ii) Where in Question 1B(i) this does not occur; there is full understanding of the reasons why and suitable action is taken.

Y/N	Not applicable
Action from last year:	
Comments:	
Action for next year:	

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes

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Action from last year:	Continue to monitor and review national guidance to embed any amendments to policy if required.
Comments:	Policies in place and reviewed annually, where there is a change in guidance, the policy is updated as appropriate.
Action for next year:	Continue to monitor our policies compliance against national guidance to embed any amendments to policy if required.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	The current appraisal and revalidation lead is retiring in March 2026. Recruitment of a new appraisal and revalidation lead, linked to the deputy chief medical officer.
Comments:	Our previous Appraisal & Revalidation Lead made significant changes and impact on our processes, this has now been handed over to our new lead, who continues to embed best practice and improvements where required. New Appraisal & Revalidation lead commenced in post in March 2026, allowing for handover. The lead reports directly to the Responsible Officer.
Action for next year:	The Chief Medical Officer (RO) will continue to work with the A&R lead, monitoring agreed outcomes & objectives.

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[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue to engage with our medical appraisers. Succession planning for our appraisal and revalidation lead.
Comments:	Appraisers are required to attend a minimum of 1 Appraiser Network events per year hosted by the Medical Appraisal Lead. These events provide a forum for networking and discuss any issues or challenges. Attendance is monitored and reviewed through our Medical Appraisal and Revalidation Group, held bi-monthly.
Action for next year:	Continue to embed good practice through engagement sessions and feedback, ensuring there is appropriate communication to ensure learning & development across the appraisal network.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Audit of the current processes
Comments:	Quality Assurance of appraisal outputs undertaken and will be reported going forward. Annual Medical Appraisal and Revalidation report is submitted to the Trust Board and People and Culture committee to provide assurance. Processes were audited, and improvements, such as data available for appraisals have been implemented.
Action for next year:	Continue to monitor the processes for appraisal & revalidation. Continue quality assurance checks of appraisals by the Lead.

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1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Embed co-ordination of appraisal information with appraisal and revalidation team to ensure sufficient information requirements are met for timely revalidation recommendations
Comments:	Recommendations are made to the GMC in a timely manner & regular meetings with the ELA in place. All recommendations to the GMC are discussed at the responsible officer group to ensure all appropriate action has been taken.
Action for next year:	Review the Terms of Reference for the Responsible Officer Advisory Group, ensuring they include all the necessary information.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Ensure appropriate communication and welfare support is provided to doctors where recommendations to the GMC are made.
Comments:	RO standard procedure is to confirm deferrals in writing with doctors. Trust process for non-engagement is followed, including communication with doctor and the GMC as appropriate.
Action for next year:	Continue to monitor and engage with our doctors where there are recommendations to the GMC.

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1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	Include clinical outcomes via model hospital data in appraisal information
Comments:	Clinical governance processes are in place and are supported by clinical governance teams in each division. Clinicians are regularly invited to be involved in clinical governance.
Action for next year:	Continue to engage with our medical leadership teams, including events to further implement PSIRF and to allow our clinical teams to understand their role in these processes Appoint human factors lead to provide expert advice to our consultants, allowing further implementation & embedding of PSIRF

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Continue to discuss conduct and performance at the Responsible Officer group, ensuring appropriate action is taken and feedback to the relevant clinician is given
Comments:	We have a policy for managing performance and conduct within the Trust and is in line with Maintaining Higher Professional Standards. We have implemented discussions regarding conduct and performance at the advisory group to ensure monitoring & equity.
Action for next year:	Review and amend the Maintaining Higher Professional Standards Policy to ensure more timely action is taken, ensuring processes do not cause delays.

Wells Jo
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1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Reduce number of deferrals due to insufficient information by ensuring information is available in a timely manner
Comments:	We continue to provide relevant information to doctors for appraisals to reduce the number of deferrals for this reason
Action for next year:	Audit the number of deferrals to check for themes with a view to taking action to reduce this number. This will be discussed at the advisory group to ensure oversight

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Continue to action and monitor responding to concerns in line with Trust policy
Comments:	We continue to monitor concerns and our responses through the Responsible Officers Group, ensuring that, where appropriate and equitable action is taken.
Action for next year:	Continue to action and monitor responding to concerns in line with Trust policy, ensuring the policy is reviewed and updated when required. Utilise the being fair tool through the RO group if or where patient safety concerns are raised

Wells Jo
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1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	KPI's for MHPS Investigations to be developed and reported to the responsible officer group
Comments:	Annual reports to the People and Culture committee, including quality assurance are submitted and reviewed.
Action for next year:	KPI's for MHPS Investigations to be developed and reported to the responsible officer group, these will feed into the People & Culture Committee.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Monitoring of KPI's related to MPIT requests including timeliness of connections
Comments:	The Appraisal and Revalidation Team support the completion of MPIT forms on behalf of the Responsible Officer to transfer information. If the query is urgent the RO will contact the other RO directly to ensure there are no delays in information transfer.
Action for next year:	Continue to monitor KPI's related to MPIT requests & transfers of information

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1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	Continue to monitor and assess safeguards and clinical governance arrangements through the medical professionals group. Introduce KPI's.
Comments:	All concerns regarding a doctors practice, are monitored and discussed at the Responsible Officer Group, this ensures an equitable approach to responding to concerns.
Action for next year:	Embed and utilise the being fair tool where appropriate in ROAG discussions, ensuring that all information is available.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Continue to engage, learn and implement opportunities for improved governance.
Comments:	The Trust continues to implement the patient safety framework (PSIRF). National Patient Safety Alerts and Regulation 28 (local and regional) have been integrated into this reporting. The Trust has engaged with GIRFT and NCEPOD audits & reviews.
Action for next year:	Review processes for responding to national reviews & enquiries. For example, Fuller, Amos & Ockendon to ensure appropriate learning and measures are implemented. Appoint human factors lead to provide expert advice to our consultants and services

Wells Jo
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1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Review medical leadership structure and introduction of leadership development specifically aimed at our medical leaders
Comments:	The restructure of our medical leaders is underway and will be in place by 1st November 2026.
Action for next year:	Embed the new medical leadership structure, ensuring a training programme is in place for newly appointed leaders.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Continue to monitor pre-employment checks to ensure there are minimal delays and restrictions
Comments:	Processes are in place to ensure minimal delays / restrictions. Internal audit has been completed. Escalation is available to the CMO where appropriate. Internal audit into employment checks for medics completed gave assurance that appropriate processes are in place
Action for next year:	Continue to monitor pre-employment checks to ensure there are minimal delays and restrictions to practice

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict.

Wells Jo 08/10/2025 16:12:40

	Launching the Anti racism charter, embedding this approaching into our work and policies and procedures.
Comments:	We continue to embed the new values & behaviours across the organisation. • Being open & Honest • Ensuring people feel cared for • Showing Respect for everyone
Action for next year:	Develop and implement training packages specifically for doctors to support our culture and learning

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict. Launching the Anti racism charter, embedding this approaching into our work and policies and procedures.
Comments:	We continue to embed the new values & behaviours across the organisation. • Being open & Honest • Ensuring people feel cared for • Showing Respect for everyone
Action for next year:	Develop and implement training packages for our doctors to support our culture and learning. Ensuring that these promote inclusivity, compassion, fairness and diversity.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Wells Jo
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Y/N	Yes

Action from last year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict. Launching the Anti racism charter, embedding this approaching into our work and policies and procedures.
Comments:	Freedom to speak up guardian is promoted in all new inductions and in the welcome letter to new consultants.
Action for next year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict. Ensure our leaders have training in facilitated conversations.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Continue to embed professional standards, including appropriate communication regarding any changes
Comments:	Feedback is gathered through the appraisal process. There is a formal complaints procedure is available for all staff.
Action for next year:	Continue to embed professional standards, including appropriate communication regarding any changes to practice or themes.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	Continue to monitor & assess the parity in concerns, investigations and disciplinary processes as part of the Responsible Officer Group.
Comments:	We discuss all concerns through the Responsible Officer Group, following our policy. Any concerns are discussed anonymously to ensure equity & parity.
Action for next year:	Continue to monitor & assess the parity in concerns, investigations and disciplinary processes as part of the Responsible Officer Group.

Wells Jo
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1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Explore options for cross group responsible officer committee to ensure consistency
Comments:	The responsible officer attends network meetings and regular meetings with other responsible officers within the foundation group.
Action for next year:	Continue to engage with regional RO's, NHS Resolutions and the GMC where appropriate.

Wells Jo
08/10/2026 16:12:40

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	655
Total number of appraisals completed	518
Total number of appraisals approved missed	0
Total number of unapproved missed	6
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	39
Total number of late recommendations	0
Total number of positive recommendations	28
Total number of deferrals made	11
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	16
Total number of trained case managers	13
Total number of concerns received by the Responsible Officer[2]	6
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	1139
Median duration of concerns processes closed (working days)[3]	735
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	2

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Wells, Jo
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Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	112
Total number of new employment checks completed before commencement of employment	112
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

We continue to make improvements for our doctors, ensuring that there are fair & equitable processes in place for concerns, appraisal & revalidation. There continues to be a focus on the reduction of missed or delayed appraisals, ensuring that these are escalated as appropriate. Where there are outstanding appraisals, or missed appraisals, appropriate action is taken (in line with Trust policy).

Of the 6 missed appraisals, 2 are being managed through the non-engagement process and have been discussed with the GMC ELA, with a plan in place for both. The 4 others have now been completed.

The new medical leadership structure will provide more opportunity for our Clinicians to learn and embed these processes, ensuring clear understanding. As part of the training package for this cohort, we plan to ensure there is training for appraisal & revalidation and responding to concerns.

Actions still outstanding

- Review & Update MHPS Policy, including appropriate KPI's – this has not been completed yet due to the complexity of the current processes. Identifying ways of streamlining aspects of the process whilst still maintaining appropriate professional standards has caused delays. We hope to have a revised policy for April 2027.

- Review of the Terms of Reference for the Responsible Officer Advisory Group – these have been updated and reviewed several times since introduction, and we continue to adapt them further adaptations continue to be put in place. This will be in place by November 2026.

Wells Jo
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[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- Medical Leadership Restructure – this is ongoing and is currently being implemented. The new structure will be in place from 1st November 2026. There has been a delay in implementation due to terms & conditions of those affected.

Current issues

There are challenges surrounding the MHPS process and its complexities, there is a plan in place to update these processes with a view to streamlining, reducing the length of some of our investigations.

There are some challenges with our current HR function within the MHPS / Medical Workforce space, these are being discussed with our Chief People Officer to find more effective ways of working.

We are awaiting guidance from NHSE regarding Physician Associates and the delivery of their regulation from December 2026. We are unable to assess the impact on the workload currently.

There are ongoing discussions surrounding the oversight of the administration of appraisal & revalidation and job planning function in the Trust and whether this should remain as a People & Culture function or move to the CMO Team.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Section 1A:

- Continue to ensure appropriate cover for the Responsible Officer.
- Continue to monitor processes and resources supporting the Responsible Officer function.
- Develop a training package for consultants who are new to leadership roles, supporting their continued professional development.
- Develop and embed new job descriptions for Associate Chief Medical Officers, ensuring that appraisal and revalidation within the care groups are monitored and reviewed.
- Arrange an appraisal and revalidation peer review across the Foundation Group or with neighbouring trusts.
- Continue to monitor arrangements supporting locum and short-term placement doctors, making improvements where identified.

Section 1B:

- Liaise with private-sector colleagues to ensure robust and appropriate transfer of information as part of appraisal processes, where required.
- Continue to monitor compliance of relevant policies against national guidance and incorporate amendments where required.
- The Chief Medical Officer, as Responsible Officer, will continue to work with the Appraisal and Revalidation Lead to monitor agreed outcomes and objectives.
- Continue to embed good practice through engagement sessions and feedback, ensuring appropriate communication and learning and development across the appraisal network.
- Continue to monitor appraisal and revalidation processes.
- Continue quality assurance checks of appraisals by the Appraisal and Revalidation Lead

Section 1C:

Wells Jo
08/10/2026 16:12:40

- Review the Terms of Reference for the Responsible Officer Advisory Group to ensure that all necessary information is included.
- Continue to monitor and engage with doctors where recommendations are made to the GMC.

Section 1D:

- Continue to engage with medical leadership teams, including through events supporting further implementation of the Patient Safety Incident Response Framework and understanding of clinical teams' responsibilities.
- Appoint a Human Factors Lead to provide expert advice to consultants and support further implementation and embedding of the Patient Safety Incident Response Framework.
- Review and amend the Maintaining High Professional Standards Policy to support more timely action and reduce delays.
- Audit appraisal deferrals to identify themes and take action to reduce their number, with findings discussed at the Responsible Officer Advisory Group.
- Continue to respond to and monitor concerns in line with Trust policy, ensuring the policy is reviewed and updated when required.
- Use the Being Fair tool through the Responsible Officer Advisory Group where patient safety concerns are raised.
- Develop KPIs for Maintaining High Professional Standards investigations and report these to the Responsible Officer Advisory Group and People and Culture Committee.
- Continue monitoring KPIs relating to Medical Practice Information Transfer requests and transfers of information.
- Embed and use the Being Fair tool, where appropriate, in Responsible Officer Advisory Group discussions.
- Review processes for responding to national reviews and enquiries, including Fuller, Amos and Ockenden, to ensure that appropriate learning and measures are implemented.
- Embed the new medical leadership structure and ensure that a training programme is in place for newly appointed leaders.

Section 1E:

- Continue to monitor pre-employment checks to minimise delays and restrictions to practice

Section 1F:

- Develop and implement training packages for doctors to support organisational culture and learning.
- Ensure that training promotes inclusivity, compassion, fairness and diversity.
- Continue to embed the Trust's values and behaviours in everyday practice.
- Encourage feedback and facilitated conversations to resolve workplace conflict.
- Ensure leaders receive training in facilitated conversations.
- Continue to embed professional standards and communicate appropriately regarding changes to practice and emerging themes.
- Continue to monitor and assess parity within concerns, investigations and disciplinary processes through the Responsible Officer Group.

Wells Jo
08/10/2026 16:12:40

Section 1G:

- Continue to engage with regional Responsible Officers, NHS Resolution and the GMC, where appropriate.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

We continue to make good progress with job planning across the organisation, with a focus on service level job planning in the future.

We have good assurance on the Appraisal & Revalidation processes and oversight of the process, with escalations as required.

We recognise that it continues to be a challenging working environment for our consultant teams, especially the NOF status. We will continue to support our workforce with the challenges they face.

Wells Jo
08/10/2026 16:12:40

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Wells Jo
08/10/2026 16:12:40

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board**
Date of Meeting:	**13th October 2026**
Title of Report:	Thirlwall Inquiry Board Update
Lead Executive Director:	
Author:	
Reporting Route:	Trust Management Board 7.10.26 Board
Enclosures included with this report:	Thirlwall Inquiry: Public Board Update
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To provide the Board with an overview of the findings and recommendations arising from the Thirlwall Inquiry, the immediate actions required of the Trust in response to national requirements, and the proposed governance arrangements to ensure effective oversight, assurance and implementation. The report highlights key areas relating to safeguarding, patient safety, speaking up culture, mortality oversight, leadership accountability and organisational learning.

Recommended Actions required by Board or Committee

To note the findings of the Thirlwall Inquiry and the actions being taken by the Trust in response.

Executive Director Opinion[1]

The findings of the Thirlwall Inquiry reinforce the fundamental responsibility of NHS organisations to prioritise patient safety above all other considerations. The Trust has already commenced work to review compliance against the immediate national requirements, including safeguarding arrangements, SUDIC processes, insulin security and mortality oversight. Existing governance structures provide a strong foundation for implementation; however, continued Board oversight and assurance will be essential to ensure actions are delivered within required timescales and that learning is embedded throughout the organisation. The proposed approach will strengthen our ability to identify, escalate and respond to emerging patient safety concerns while further promoting a culture where staff feel confident to raise concerns and be heard

Wells Jo
08/10/2026 16:12:47

[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.

Purpose

To provide the Board with an overview of the Thirlwall Inquiry, the key findings and recommendations, immediate actions required of the Trust, deadlines, and the proposed governance arrangements to oversee implementation.

Background

The Thirlwall Inquiry, chaired by Lady Justice Thirlwall, examined the circumstances surrounding the actions of former neonatal nurse Lucy Letby and the wider organisational, governance and cultural failings that allowed concerns to remain unaddressed. The final report was published on 15 September 2026 and contains 17 recommendations aimed at NHS organisations, regulators, NHS England and Government.

The Inquiry found significant weaknesses in:

- Patient safety governance
- Safeguarding arrangements
- Escalation of concerns
- Organisational culture and speaking up
- Mortality oversight
- Leadership accountability
- Use of safety intelligence and data.

The central message for NHS Boards is that patient safety must always take precedence over operational, reputational or employment considerations.

Key Themes for Boards

1. Safeguarding

The Inquiry concluded that concerns about potential deliberate harm should be treated as safeguarding issues from the earliest point of suspicion and escalated appropriately.

2. Culture and Speaking Up

Staff must feel confident to raise concerns without fear of detriment. Boards should actively seek evidence that concerns are heard, escalated and acted upon.

3. Leadership Accountability

The Inquiry highlighted delayed decision-making and a tendency to prioritise organisational reputation over patient safety. Leaders are expected to act decisively on emerging concerns.

4. Governance and Assurance

Boards should strengthen oversight of mortality, incidents, complaints, safeguarding concerns, Freedom to Speak Up intelligence and emerging clinical risks.

Wendy Jo
01/10/2026 16:12:40

Immediate NHS Actions and Deadlines

A letter was received on 21st September 2026 from Duncan Burton, CNO England and Sarah – Jane Marsh COO England outlining the immediate actions. Currently there is no clear national reporting identified.

Item	ACTION	DEADLINE
TRUSTS WITH NEONATAL UNITS		
SUDDEN AND UNEXPECTED DEATH IN CHILDREN (SUDIC)	Urgent communication to all relevant staff and the board that the SUDIC process applies as set out in the SUDIC Protocol NB SUDIC reporting runs alongside internal reporting processes	28 SEPTEMBER 2026
INSULIN	Urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units. NB Until such a point that access to insulin requires the provision of biometric data The cameras should store recordings for at least 28 days.	30 NOVEMBER 2026
	Ensure that neonatal units meet requirements for access control and storage of insulin as set out in the GIRFT neonatology guide to safe insulin use	31 MARCH 2027
ICBS AND PROVIDERS		
NATIONAL BEREAVEMENT CARE PATHWAY FOR STILLBIRTH AND NEONATAL DEATH	Improve care of the bereaved as has already been set out in the Medium-Term Planning Framework (October 2025).	Immediately
SAFEGUARDING	Ensure that all staff and board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. • Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required. • In addition, trusts are reminded that the Insightful provider board guide is intended to help boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.	Immediately
Board Oversight	**Every trust and ICB board to review the Thirlwall report and to consider its findings** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.	Next available public board meeting

Worcestershire Acute Hospitals Trust Immediate Position

The Trust has identified that:

SUDIC

- SUDIC policy is already in place.
- Staff communication completed in response to NHS England requirements.
- Assurance testing should be undertaken through governance routes.

Insulin Security

- Review of current compliance against GIRFT neonatal insulin requirements.
- CCTV requirements for insulin storage areas being scoped.

Safeguarding

- Reviewed compliance with safeguarding training requirements for staff, Board members and NEDs.
- Prepare for implementation of the national Suspicion of Deliberate Harm Protocol.

Mortality and Safety Intelligence

- Review current mechanisms for oversight of neonatal and child deaths.
- Confirm escalation routes for emerging safety concerns and mortality trends.

Governance Arrangements

Currently working through overall governance arrangements, to ensure timely implementation, robust assurance and board oversight. There are existing groups and committees that will oversee the implementation of the immediate actions.

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Key Risks for Board Consideration

1. Failure to meet mandated national deadlines.
2. Insufficient assurance regarding safeguarding responsiveness.
3. Lack of visibility of neonatal and paediatric mortality intelligence.

4. Delayed implementation of CCTV and insulin security requirements.
5. Insufficient staff awareness of SUDIC and future deliberate-harm protocols.
6. Resource implications associated with technology, training and governance requirements.

Board Recommendations

The Board is asked to:

1. Note the findings and recommendations of the Thirlwall Inquiry.
2. Discuss Governance arrangements
3. Agree oversight via specialist committees including the newly formed Perinatal Assurance Committee with formal assurance through Quality Governance Committee and escalation to Board
4. Request quarterly assurance updates on delivery against national requirements and Inquiry recommendations.

Wells Jo
08/10/2026 16:12:40

Thirlwall Inquiry



Key Facts

Statutory public inquiry established October 2023, chaired by Lady Justice Thirlwall.

Purpose

- To examine the circumstances surrounding the murders and attempted murders of babies by former neonatal nurse Lucy Letby at the Countess of Chester Hospital

- To determine what lessons the NHS must learn to prevent similar events in the future

Current Status

- The Inquiry's evidential hearings concluded in March 2025

- The official Inquiry website published the final **Thirlwall Report** on 15 September 2026

Kelly Jo
08/10/2026 16:12:40

Investigated three broad areas

Families Experience

Examining the experiences of the parents and families of the babies involved, including how concerns and events were communicated to them by the hospital.

Wells Jo
08/10/2026 16:12:40

Actions within the CoC hospital

Investigating:

- Whether concerns should have been identified earlier.
- Whether LL should have been removed from clinical duties sooner.
- Whether the police and regulators should have been informed earlier.
- How executives, managers, doctors and nurses responded when concerns were raised.
- Whether organisational culture, leadership and governance contributed to the failure to protect babies.

Wider NHS systems & culture

Examining:

- NHS governance and accountability arrangements.
- Professional regulation and external scrutiny.
- How concerns are escalated and acted upon.
- Whether NHS culture enables staff to speak up and challenge poor practice.
- How accountability of senior leaders can be strengthened.
- What changes are needed to improve the safety of babies receiving neonatal care.

Recommendations

1. Neonatal CCTV monitoring	Install in-cot cameras with livestream capability on all neonatal cots and incubators, enabling parents to observe their babies remotely. NHS England to publish an implementation roadmap by March 2027.
2. Safer insulin management	Strengthen access controls to insulin storage, introduce CCTV monitoring of storage areas, and mandate national compliance with insulin testing and reporting guidance.
3. Bereavement care	Implement the National Bereavement Care Pathway for neonatal deaths in all NHS Trusts by August 2027.
4. Safeguarding responsibilities	Mandatory safeguarding training for all NHS staff and Board members.
	Employment contracts to include a duty to follow safeguarding guidance and procedures relating to suspected deliberate harm.
5. Interoperable digital systems	Accelerate NHS-wide digital interoperability so neonatal and maternity information can be entered once, shared appropriately, monitored and reviewed in real time.
6. Board-level mortality oversight	All Trusts should have robust mechanisms for monitoring baby and child deaths and clear escalation routes for concerning patterns or trends.
7. Improved neonatal data reporting	Designate trained “lead reporters” in neonatal units to oversee data submission, analyse trends, and report regularly to Trust Boards
8. Strengthen SUDIC processes	Ensure Sudden Unexpected Death in Infancy and Childhood (SUDIC) procedures apply to babies who die unexpectedly in hospital and update national guidance accordingly.
9. National Suspicion of Deliberate Harm Protocol	Introduce a mandatory protocol requiring immediate action when concerns arise that a healthcare worker may have deliberately harmed a patient, with safeguarding and police involvement where appropriate.
10. Independent clinical expert panel	Establish a national pool of independent experts who can rapidly investigate emerging concerns about patient harm.
11. Strengthen the medical examiner system	Provide specific guidance for neonatal deaths, improve safeguarding checks, expand neonatal expertise, and review funding arrangements.
12. Increase paediatric and perinatal pathologists	Expand training numbers to address workforce shortages and improve specialist pathology capacity.
13. Greater accountability for NHS managers	Develop a barring scheme for managers, strengthen fit-and-proper-person requirements, introduce an individual duty of candour, and reinforce the principle that patient safety comes first
14. Reform Care Quality Commission (CQC) inspections	Increase unannounced inspections, involve practising clinical experts, and focus inspections on actual patient safety and outcomes, not just processes.
15. Stronger oversight of CQC	Subject CQC performance to regular scrutiny by the Health and Social Care Committee.
16. Enhanced whistleblowing arrangements	Transfer National Guardian's Office functions to the Parliamentary and Health Service Ombudsman and expand support and oversight for whistleblowers.
17. Audit implementation of inquiry recommendations	Give the National Audit Office responsibility for monitoring implementation of recommendations arising from NHS statutory inquiries.

Wells Jo
03/10/2026 16:12:40

Common themes across Amos & Thirlwall

Two independent investigations. One shared mission: safer care, listening to families and a health service that learns and acts.

BARONESS AMOS REVIEW

Independent Review of Maternity Services (2026)

FOCUS

- Maternity care safety and outcomes
- Reducing inequalities and addressing bias
- Personalised, woman-centred care
- Family engagement and involvement
- Compassionate leadership and support for staff

SHARED THEMES

The priorities both investigations place at the centre of safer care

- Listening to families
- Culture of safety
- Speaking up
- Data and safety intelligence
- Learning, not blame
- Safeguarding vigilance
- Workforce capability

LADY THIRLWALL INQUIRY

Independent Inquiry into Neonatal Care (2026)

FOCUS

- Detection of harm and deterioration in neonatal care
- Safeguarding failures and missed opportunities
- Acting on concerns and responding effectively
- Governance, assurance and oversight
- Systems, processes and accountability that protect babies

OUR SHARED COMMITMENT

PUT FAMILIES FIRST

Listen, involve and partner with women, babies and families in every decision.

ACT EARLY

Recognise risks, escalate concerns and take timely, decisive action to prevent harm.

BE OPEN AND HONEST

Be transparent, share evidence and communicate clearly with families and staff.

LEARN AND IMPROVE

Use data and insight to learn, improve and drive continuous improvement in care.

BE ACCOUNTABLE

Leaders at all levels must take responsibility and be held to account for safety and quality.

Different inquiries. Shared lessons. One purpose: Every baby. Every family. Every time.

Key Themes

Domain	Key Finding from Thirlwall	Implications for NHS Executives	Board Assurance Questions
1. Safeguarding	A failure to recognise that safeguarding action should begin when deliberate harm is suspected, rather than waiting for certainty of guilt. The inquiry identified a "complete failure" to invoke safeguarding procedures.	• Treat serious patient safety concerns involving staff as safeguarding issues. • Escalate concerns earlier to safeguarding partners, regulators and police where appropriate. • Ensure executives understand safeguarding duties relating to staff conduct as well as clinical care. • Test organisational readiness to respond to allegations of deliberate harm.	• Would we recognise deliberate harm as a safeguarding issue? • Are escalation pathways clear and tested? • How quickly would concerns reach executive and board level?
2. Culture	A culture characterised by defensiveness, failure to listen to concerns, barriers between clinicians and managers, and inadequate engagement with families. The inquiry highlighted the need for curiosity, transparency and safeguarding vigilance.	• Build psychological safety and encourage challenge. • Promote openness, learning and transparency. • Treat concerns as intelligence rather than criticism. • Partner with families as contributors to safety and learning. • Address professional hierarchies and tribal behaviours.	• Do staff feel safe to raise concerns? • What happens when concerns are repeatedly raised? • How do we know families feel listened to? • What evidence demonstrates a culture of speaking up?
3. Leadership	Delayed responses to concerns, insufficient challenge, and reluctance to act on emerging evidence contributed to harm. The inquiry questioned whether reputation was prioritised over safety.	• Demonstrate visible safety leadership. • Prioritise patient safety over organisational reputation. • Act decisively when concerns emerge. • Support clinical challenge and dissent. • Develop a leadership culture of curiosity and accountability.	• How do leaders know they are hearing bad news early enough? • Would executives respond differently to weak signals of harm today? • Is patient safety visibly prioritised over organisational interests?
4. Governance	Governance systems existed but failed to translate information into timely action. The inquiry identified weaknesses in oversight, escalation, intelligence gathering and accountability.	• Strengthen triangulation of safety intelligence. • Improve scrutiny of mortality, incidents, complaints, FTSU and safeguarding data. • Create clear accountability for escalation and action. • Ensure independent challenge and effective assurance processes. • Focus on identifying emerging risks, not simply demonstrating compliance.	• How do we know concerns are converted into action? • Can our governance systems detect emerging harm? • Are unresolved safety concerns routinely visible to the Board? • How effective are our Freedom to Speak Up arrangements?

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The core challenge

The core challenge from the Thirlwall Inquiry for NHS boards is straightforward:

Do our systems reliably turn concerns into protection, learning and action?

The Inquiry suggests NHS organisations should move:

- From certainty to precaution (Safeguarding)
- From defensiveness to curiosity (Culture)
- From reassurance to accountability (Leadership)
- From assurance to intelligence-led oversight (Governance)

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Next Steps

National letter issued to NHS leaders: **22 September 2026**

Read the national letter

No further national deadlines or processes are currently known for the remaining recommendations. Government is considering the recommendations in full.

Item	ACTION	DEADLINE
TRUSTS WITH NEONATAL UNITS		
SUDDEN AND UNEXPECTED DEATH IN CHILDREN (SUDIC)	Urgent communication to all relevant staff and the board that the SUDIC process applies as set out in the SUDIC Protocol NB SUDIC reporting runs alongside internal reporting processes	28 SEPTEMBER 2026
INSULIN	Urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units. NB Until such a point that access to insulin requires the provision of biometric data The cameras should store recordings for at least 28 days.	30 NOVEMBER 2026
	Ensure that neonatal units meet requirements for access control and storage of insulin as set out in the GIRFT neonatology guide to safe insulin use	31 MARCH 2027
ICBS AND PROVIDERS		
NATIONAL BEREAVEMENT CARE PATHWAY FOR STILLBIRTH AND NEONATAL DEATH	Improve care of the bereaved as has already been set out in the Medium-Term Planning Framework (October 2025).	Immediately
SAFEGUARDING	Ensure that all staff and board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. • Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required. • In addition, trusts are reminded that the Insightful provider board guide is intended to help boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.	Immediately
Board Oversight	**Every trust and ICB board to review the Thirlwall report and to consider its findings** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.	Next available public board meeting

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NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Microsoft Teams
Tuesday 4th August 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
	Hayley Flavell (HF)	Chief Nursing Officer
	Catherine Driscoll (CD)	Non-Executive Director (Observing)
	Simon Murphy (SM)	Vice Chair & Non Executive Director
Attendees	Rich Luckman (RL)	Assistant Director of People & Culture
	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Louise Pearson (LP)	Associate Director (Nursing) Workforce and Education
	Justine Jeffery (JJ)	Director of Midwifery
	David Southall (DS)	Chaplaincy Team Leader and Equalities Engagement Lead
	Lottie Merriman (LM)	Lead Patient Safety Investigator
	Cathy Perkin (CP)	HR Business Partner
	Luke Simonds (LS)	Deputy Director of Medical Education & TCMS Education Site Director
Apologies	Bianca Edwards (BE)	Assistant Director of People & Culture
	Richard Haynes (RH)	Director of Communications
	Liz Faulkner (LF)	Deputy Chief People Officer
	Katie Osmond (KO)	Chief Finance Officer
	Sue Sinclair	Non Executive Director

	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 2nd June 2026 were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly.	
	Staff Story – Moments that matter	
	'Moments that Matter' shares learning from PALS and complaints, demonstrating how seemingly small interactions can make a meaningful difference to patients. LM described the	

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experience of a transgender man who wished to share his story of receiving care at WAHT but chose not to make a formal complaint because he wanted to remain anonymous.
The patient described two attendances at the Emergency Department where, despite having legally changed his name and gender marker, staff repeatedly used his birth name and misgendered him. Using a former name with which a person no longer identifies can cause psychological harm, leaving them feeling unseen and uncomfortable. It can also compromise their safety by disclosing their trans status in an open environment. LM shared an example of a person who was misgendered in GP correspondence sent to their home, unintentionally disclosing their identity to those they lived with and resulting in an assault.

The patient did also have his chosen name utilising #callme on all his documentation and wristband but was repeatedly deadnamed, misgendered and even referred to as just "Mrs".
This was the second time the patient had experienced this and it is thought that staff were picking up his previous name from older records as he was attending with a recurring problem. This added complexity as the problem the patient was attending with was Endometriosis, so staff may have also assumed that the patient was female.

The patient also described a contrasting positive experience in another department, where staff discreetly and respectfully confirmed his name, identity and preferred form of address. Although he found questions such as whether he could be pregnant uncomfortable, he appreciated the sensitive and considerate way they were asked. In addition, the year before formally changing his gender marker, the patient underwent a laparoscopy. Staff recognised his lived identity and supported his recovery in an appropriate environment that protected his safety, dignity and privacy, while acknowledging that female patients recovering from gynaecological procedures might have felt uncertain about sharing a bay with a male patient. The discussion emphasised that the issue was not a political debate about gender identity, but the need to treat every patient as an individual with dignity and respect.

The Committee noted that #callme was not a new initiative and had been assumed to be well embedded. It was suggested that the initiative be re-communicated to staff and incorporated into re-induction for longer-serving employees. LS proposed including pronouns on wristbands, and HF advised that #callme would be reinvigorated through a new steering group.

Network Update – Faith Network & Lord Mann update

The Faith Network is a small but active network that seeks to recognise and value the perspectives of staff of all faiths and none, providing a voice for staff to promote the values and principles of their faith. David Chamberlain has stepped down as chair and will sadly be leaving the trust soon. This is an opportunity for the Network to reflect on what they've done so far and any goals or direction for the future.

Reference was made to Dr Munir's previous attendance and his reflections on Ramadan, including how faith can shape a person's identity. The Multi-Faith Hub now has representation from all major world faiths, having been approached by two Jewish faith leaders interested in supporting its work. This provides visible evidence of the Trust's commitment to valuing staff religious beliefs and recognising faith as a significant part of individual identity.

The Committee discussed the use of the title "Chaplain". DS explained that discussions had taken place within the community and that the term continues to be used. SM noted that this was a practical example of the Trust seeking to be as supportive as possible, including through the provision of the Wudu facility. AK advised that work was also underway to accommodate female Friday prayer space.

Lord Mann review

NHSE recommended a number of actions following the Lord Mann review, most of which had already been completed or were in progress through the Anti-Racism Charter. Additional work is also underway in relation to the NHS Staff Standards, against which the Trust is currently undertaking a self-assessment.
One action was to update the Trust's EDI HR policy, which has now been completed. The Trust has adopted the definition of anti-Muslim hostility, having already adopted the definition of antisemitism in November last year. Progress remains on track, with a Board workshop planned

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for September on the NHS Staff Standards, including the specific roles of Board members in supporting anti-racism work.

AK noted that, while the Trust has already signed up to the Anti-Racism Charter, the focus now needs to be on how this is applied in practice, particularly what happens when a member of staff reports an experience of racism or antisemitism. Ongoing monitoring of casework and Freedom to Speak Up data will be important in understanding staff lived experience and assessing whether the work is making a meaningful difference.

SC highlighted that too much responsibility can be placed on the victim, who may be asked what they want to happen when the organisation should take appropriate action without placing that burden on them. The Committee also discussed the need to work with Health and Safety to identify any hotspots, particularly in light of the zero-tolerance posters displayed across the hospital. It was agreed that data should be triangulated to assess whether the actions taken are having a meaningful impact.

People & Culture Updates:

Chief People Officer Report

The Trust is currently assessing its position against the newly published NHS Staff Standards to identify any gaps and clarify its responsibilities in achieving compliance. In relation to violence prevention and reduction, an initial workshop has been arranged to consider how the Trust supports and treats both colleagues and patients, as well as how it engages with relevant communities. A number of related workstreams are already underway, but these need to be brought together into a more coordinated approach. This includes considering how incidents are monitored through Health and Safety, and how cases are managed where the behaviour involves a patient who lacks capacity.

AK provided an update on the future education strategy, noting that several workshops had been held with a range of stakeholders to support the development of a coordinated approach to education and training. The work has focused on identifying areas of duplication and opportunities for improvement, while ensuring that education programmes and interventions are aligned to the needs of the future workforce and workforce planning priorities.

CH commented that staff experience forms part of the formal assessment process and highlighted the significant amount of data required to support this. AK noted that measures of success should be reflected through staff survey outcomes and practical evidence of colleagues' day-to-day lived experience.

AK noted her disappointment with the decision to disinvest in progressive apprenticeships, citing the potential impact on succession planning. She highlighted the value of apprenticeships in supporting younger people, developing digital skills, and building the future workforce, reinforcing the need for ongoing investment.

The Committee noted that the Smoke Free Policy is not currently achieving its intended outcome, as smoking by staff, patients and visitors continues on site. Vaping shelters were piloted however did not have the desired effect. Joint discussions with Public Health are ongoing to identify a more effective approach.

Temporary staffing reduction

Several workforce programmes support financial recovery and the ambition for patients to be cared for by substantive staff wherever possible and safe. Work has focused on reducing or eliminating agency use; however, this has increased bank expenditure. Although most bank workers are also substantively employed by the Trust, spending on temporary staffing remains too high and is a national outlier.

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The plan will focus on controlling demand, closing PDU and replacing temporary staffing with substantive posts where possible, while avoiding unnecessary growth in headcount.

The reduction in bank rates will take effect on 1 September, with staff given notice in accordance with contractual requirements. Care groups have submitted break-glass requests

	for areas considered to present the greatest risk. These will be reviewed with the Executive Triumvirate to assess the impact and make recommendations. Any exceptions must have a clear rationale and defined duration. As the Trust's bank service is outsourced to NHSP, this can affect whether staff can raise a grievance. Communications have been clear that the bank rate is not a contractual entitlement subject to negotiation with Staff Side. Although this is a difficult decision, the Trust cannot continue to pay the current rates. In some areas, a small increase in substantive headcount may be required to reduce reliance on bank staff.	
	Workforce Transformation	
	The programme has been relaunched with Associate Chief Operating Officer Becky Williams leading on clinical admin review elements to embed digital systems like TPRO. MARS settlements have been achieved, with staff leaving the Trust at the end of the month at which point savings can be tracked. Target operating models are being reviewed. There is a need to understand care group and corporate workforce plans for the remainder of the year from headcount reduction perspective.	
	Sickness reduction	
	Sickness absence has decreased in areas including Estates and Facilities but has increased within Diagnostics and Specialties. Rapid reviews with care groups are having a positive impact. Work continues on the Sickness Absence Policy and winter flu campaign. SC suggested exploring alternative support for staff experiencing stress-related absence.	
	Additional Updates:	
	Job Planning	
	Trust-wide job-planning compliance currently stands at 88%; 91% for consultants, although SAS doctors remain slightly behind. Team-based job planning will begin between October and December, with full compliance anticipated by April 2027.	
	Band 5 Nursing Job Evaluation	
	NHSE has requested a review of all Agenda for Change Band 5 nursing roles by October 2028 to ensure that job descriptions reflect the work undertaken. Two Band 6 profiles have been identified, covering specialist knowledge and expertise, and leadership and coordination responsibilities. A phased delivery plan will focus on ward and team engagement during the remainder of 2026. Approximately 150 job descriptions will be reviewed by October 2028 as part of a programme affecting around 1,300 staff. Key risks include job evaluation capacity and programme management, with Staff Side engagement continuing. National clarification is awaited on the use of generic job descriptions and back-pay dates. Monthly meetings will continue, alongside development of a detailed project plan, draft job descriptions for initial discussions and an implementation toolkit. The financial risk to the organisation will depend on whether generic job descriptions can be used. HF advised that allocation of funding to individual organisation would not be transparent across trusts and would depend on each trust's own submission. The Trust's plan had been shared with the regional RCN representative and received positive feedback. Agreed for update to be brought to a future meeting.	
	Education Board update (annual) incl NETS survey	
	Results of the survey were similar across all disciplines, including medical staff. A deep dive highlighted concerns about the reporting of sexual safety discrimination, and bullying and harassment, for example, incidents witnessed but not reported. As similar issues have been identified across the ICS, a system-wide response is being developed. The university is providing students with a session on raising and reporting concerns, while a new NHSE sexual safety package has been shared with educators across the group. A Values and Behaviours tile has also been added to the student app, allowing concerns to be emailed to the Academy and pastoral support to be offered within 48 hours.	

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	LS advised that medical trainees were more likely to experience discrimination and harassment from patients than from staff. During placements, 25% had experienced discrimination and 13.5% had experienced harassment from patients. The data did not account for patient capacity or behaviour arising from an ongoing medical condition. While the impact on staff could be the same, these circumstances required different management and preventative actions.	
	Maternity culture feedback	
	JJ provided an update on maternity culture, noting two further inquiries and significant media attention affecting the profession. Staff morale remained generally low. Concerns have been raised through Freedom to Speak Up during quarters 3 and 4, although the number of concerns had recently decreased. Perceptions of favouritism continue to be reported Regular walkabouts are continuing, supported by the Maternity Safety Champions, and a potential maternity rumour mill has been discussed. Drop-in sessions have been divided between the Director of Midwifery and Deputy Director of Midwifery to provide a more team-focused approach and help staff feel more able to speak up. RCM colleagues have also been asked to engage with the team to understand how staff would prefer to be involved. Some dissatisfaction remains among support workers.	
	People & Culture Risk Register	
	The changes in the report were discussed at the previous meeting regarding the bank and agency risk. Board assurance framework updates are also shared for information.	
	Workforce /WDES/WSOES	
	Action plans for WRES, WDES and WSOES will be published on the Trust website. Progress is being made across all three standards, including reduced harassment, bullying and abuse by colleagues and managers. However, these issues remain prominent, particularly where they involve patients or the public, and concerns about reporting persist. They will therefore remain a priority over the next 12 months. NHS guidance and a review of the available data have informed the action plans. **WRES:** Representation has improved, including at Band 8a and above. Voting Board member representation and harassment by patients and the public remain areas of concern. **WDES:** Representation and the provision of reasonable adjustments have improved, while harassment and bullying by managers have reduced. Confidence in career progression has declined, and harassment by patients remains a concern. **WSOES:** Harassment by managers and colleagues and reported discrimination have reduced. More staff feel that the Trust respects individual differences, although reporting harassment, bullying and abuse remains a challenge. The committee confirmed approval for publishing.	
	Any Other Business (AOB)	
	None raised.	
	Date of Next Meeting	
	The date of the next meeting is Tuesday 6th October, Crompton A, CHEC.	

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Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	13th October 2026
Title of Report:	Workforce Gender Pay Gap Report
Lead Executive Director:	Chief People Officer
Author:	Ali Koeltgen
Reporting Route:	
Enclosures included with this report:	WAHT EDI Annual Report 2026 - Gender Pay Gap section
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

This report provides assurance on the Trust's Gender Pay Gap position based on the snapshot at 31 March 2026 and the action being taken to improve pay equality.

The mean gender pay gap reduced from 27.7% in 2025 to 26.5% in 2026. The median gap increased from 11.6% to 12.6%. Bonus pay gaps remain substantial, although both the mean and median measures reduced slightly. Bonus payments mainly relate to historic Clinical Excellence Awards, as the local scheme ended in 2024 and there were no new recipients in 2025/26.

The paper also summarises the Trust's work to support fair recruitment, flexible working, leadership and career development, transparent pay processes, staff networks and Freedom to Speak Up arrangements.

Recommended Actions required by Board or Committee

The Board is asked to:

- note the 31 March 2026 Gender Pay Gap position and year-on-year changes;
- take assurance from the actions in place to support fair recruitment, career development, flexible working and pay equality; and
- support continued monitoring of progress
- through the People and Culture Committee and the annual EDI reporting process.

Executive Director Opinion[1]

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[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.

The 2026 data shows continued improvement in the mean gender pay gap following the slight increase reported in 2025. However, the median gap has widened by one percentage point.

The overall position continues to be shaped by the distribution of women and men across roles and pay bands, including lower female representation in senior medical roles.

We will maintain our focus on inclusive recruitment, flexible working, leadership and career development, and use workforce data to identify where further action is needed.

Large employers are legally required to publish Gender Pay Gap data both on their own website and the government website under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017.

It is important to note that the Gender Pay Gap is not the same as unequal pay, which is paying men and women differently for performing the same (or similar) work. Unequal pay has been unlawful since 1970.

The Gender Pay Gap is the difference between men's and women's average (mean or median) earnings across a workforce. Gender Pay Gap calculations are based on employer payroll data drawn from a specific date each year (the snapshot). The snapshot date is set as 31 March each year. As a Trust, we must publish this data by 30 March the following year.

The data below provides this year's (31 March 2026) data and highlights the changes in our Gender Pay Gap from 31 March 2025 (last year's data). The data also provides this year's (31 March 2026) data on bonus payments with a comparison against last year's data. This shows an improvement in the mean calculation with the gap shortening between male and female.

The snapshot for Gender Pay Reporting is 31 March 2026. Gender Pay Gap data for the Trust is:

- The Trust's mean gender pay gap is **26.5%**
- The Trust's median gender pay gap is **12.6%**
- The Trust's mean bonus gender pay gap is **48.5%**
- The Trust's median bonus gender pay gap is **55.6%**
- The proportion of males receiving a bonus payment is **3.42%**
- The proportion of females receiving a bonus payment is **0.34%**

The gender pay gap shows the difference between men's and women's average (mean or median) earnings. This is expressed as a percentage of men's earnings, used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation in out-of-hours services, and how effectively talent is being maximised. The Trust aims to reduce our gender pay gap, with the intention to create greater equality in our pay framework.

Worcestershire Acute Hospitals NHS Trust Gender Pay Gap Comparison Data

Snapshot Date	31st March 2021	31st March 2022	31st March 2023	31st March 2024	31st March 2025	31st March 2026
Mean Gender Pay Gap	31.7%	30.8%	29.9%	27.3%	27.7%	26.5%
Median Gender Pay Gap	16.0%	18.3%	18.8%	13.4%	11.6%	12.6%
Mean Bonus Gender Pay Gap	39.7%	45.2%	42.6%	46.0%	49.2%	48.5%
Median Bonus Gender Pay Gap	40.1%	35.6%	41.1%	40.8%	58.3%	55.6%
Males Receiving Bonus Payments	5.90%	4.57%	3.93%	4.18%	3.79%	3.42%
Females Receiving Bonus Payments	0.50%	0.44%	0.39%	0.36%	0.33%	0.34%

The Trust does not as a rule pay bonuses, aside from Clinical Excellence Awards. The Local CEA scheme ended in 2024. Therefore, there were no new recipients of a CEA award for 2025/2026.

Our Gender Pay Gap had shown a consistent improvement in percentage terms from March 2020, which has continued after the slight dip in 2025. We aim to continue to reduce our gender pay gap year on year, to create greater equality in our pay framework.

Reducing our gender pay gap implies increasing the proportion of men in the organisation and continuing the focus on creating pay equity across pay bands. Effective policies for closing the gender pay gap seek to address factors and barriers common to all women (such as the number in lower-grade jobs with lower pay) and target inequalities faced by women belonging to specific groups based on characteristics such as ethnicity, age and profession.

Work undertaken to improve the flexible working opportunities for our staff will enable more women to progress in their careers, reflecting positively on our Gender Pay Gap.

As with previous years, the Trust acknowledges that there could be greater female representation in its senior medical roles. However, in general the consultant workforce has a greater proportion of males to females across the NHS, which limits the pool of available applicants to these types of roles.

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We continue to implement our leadership development training to strengthen the skills of our existing staff and to support career development within the organisation.

Our Board representation as of 31st March 2026, shows we have the following:

Role	Number	Percentage
Executive Directors	4 Male 4 Female	50% Male 50% Female
Non-Executive Directors	3 Male 5 Female	44% Male 56% Female

Actions to Close the Gap:

- Through our People and Culture Committee, monitor our recruitment and other aspects of equality which form part of our equality and diversity annual report which is published on our website.
- We recruit through NHS Jobs, and it is our policy to remove any personal information from applications, which helps to avoid gender or other bias at the shortlisting stage.
- We provide training to our recruiting managers in equality, diversity & inclusion to emphasise the need to ensure that all applicants are recruited fairly, openly and transparently.
- We have implemented a Recruitment Champion role which is required to take part in all Band 8A and above recruitment.
- Works to the national NHS Agenda for Change pay scales and job matching processes, which are open and transparent.
- Ensures all staff undertake mandatory equality and diversity training with a 93% compliance as of 31st March 2026. All of our Divisions meet the 90% target for this training.
- Promotes flexible working for all our staff.
- Development offers, including access to coaching & mentoring for all colleagues.
- We have embedded our FTSU Guardian role, supported by FTSU Champions, to encourage staff to Speak Up if they have any concerns in relation to any aspect of their employment, including pay equity.
- We have a well-established Women's Staff Network that supports career progression initiatives, gender equality and allyship, with a particular focus on encouraging women to develop into senior roles.

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Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 10 September 2026
Report to: Trust Board

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Internal Audit Progress Report**
Rating rationale	The 2026/27 plan was on trajectory for delivery. Three final reports and one draft report had been issued; three terms of reference were presented for Mortuary Security, Temporary Escalation Spaces and the Head of Internal Audit Opinion. The Committee requested that the Temporary Escalation Spaces review include the authorisation process and financial consequences of opening capacity. Implementation of recommendations was positive, with all high and medium-risk actions completed on time. The Auditor reported full engagement and effective escalation arrangements.
Outcome	The Committee was assured by progress and the positive approach to implementing recommendations.
Item/Topic	**Internal Audit: NHS Professionals (NHSP) Staffing**
Rating rationale	The additional review was commissioned following an incident and was rated significant assurance. Testing confirmed that key pre-employment and ward-level identity controls were generally operating effectively and staff understood the required processes. One medium and one low-priority action were agreed to strengthen retained evidence, sign-off and use of the current checklist. The Committee noted the need to sustain awareness once the immediate learning from the incident became less prominent.
Outcome	The Committee welcomed the significant assurance opinion and noted that the two agreed actions would strengthen the audit trail.
Item/Topic	**Internal Audit: Visa Review**
Rating rationale	The review provided significant assurance over visa sponsorship arrangements. Sample testing of 31 sponsored workers and applicants showed a high level of compliance, with no systemic control weakness. One low-priority action addressed consistent retention of financial approvals and communications; one medium-priority action required clearer guidance and document control within the sponsor reporting procedure. Both actions were agreed, with implementation to be confirmed through follow-up.
Outcome	The Committee welcomed the significant assurance opinion and was assured that the agreed actions addressed the recommendations.
Item/Topic	**Internal Audit: Data Security and Protection Toolkit (DSPT)**
Rating rationale	The annual independent assessment reviewed 12 outcomes across all five Cyber Assessment Framework objectives. All minimum achievement levels were met, producing an overall low-risk rating and high confidence in the Trust's self-assessment. Four low-priority recommendations were agreed, covering Board-level strategy and action planning, backup recovery for extreme scenarios, responsibility for root cause analysis and clarity of responsibility for subject access requests. The Committee was advised that the findings were expected and work was under way, with one action already completed. Strong governance, investment and regional and national support were helping the Trust respond to evolving standards, supply-chain risk, artificial intelligence and legacy infrastructure. Internal Audit identified several areas of good practice and considered performance to have improved materially over recent years.
Outcome	The Committee welcomed the positive assurance in this high-risk area and noted the agreed actions. It was assured that the remaining toolkit outcomes were subject to the same internal assessment process and that future optional audit outcomes would continue to be selected according to the greatest current and emerging risks.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 10 September 2026
Report to: Trust Board

Item/Topic	Counter Fraud Progress Report
Rating rationale	Counter-fraud activity was progressing according to the plan, with increased phishing and payment-diversion threats communicated to staff and preparations completed for the next National Fraud Initiative exercise. Three new cases concerned alleged secondary employment while working from home, working while off sick and timesheet fraud. Two further investigations remained open, alongside two cases brought forward from previous years. The Committee noted an emerging national and local trend involving misuse of home-working or study-leave arrangements for secondary employment. Closed-case outcomes included disciplinary or professional referral action, financial recovery and earlier successful prosecutions. Reactive demand had used the planned investigation allocation, although the service remained within budget and would continue to be monitored.
Outcome	The Committee noted the report. **Actions:** The Chief People Officer would review the clarity and practical application of policies and manager guidance covering secondary employment, home working and study leave. The Company Secretary would incorporate relevant anonymised counter-fraud learning into conflicts-of-interest communications.
Item/Topic	**Board Assurance Framework**
Rating rationale	The BAF remained very high risk, with most principal risks scored 15 or above. The Committee welcomed the heat map, the explicit link to the Trust's highest operational risks and the strengthened summary of Executive Risk Management Committee oversight. It was agreed that committee agendas should be driven by the principal and extreme risks and that target scores should remain credible, particularly where risk is inherently high. A committee confidence assessment was suggested to test whether risk trajectories and target scores were realistic. Further work was required to ensure extreme care-group risks were reported to the relevant assurance committee and escalated where appropriate.
Outcome	The Committee noted the continued development of the BAF. Consideration would be given to periodic deep dives that test the quality of controls and assurance for a selected BAF risk, while retaining the Committee's focus on the effectiveness of the risk-management process.
Item/Topic	**Managing Conflicts of Interest**
Rating rationale	The Committee received assurance on the ESR-based process introduced in 2024/25 and the updated Register of Interests. Compliance remained strong, with declarations completed by 88.2% of non-medical and 86.0% of medical decision-making staff. Cross-checking against private practice and industry registers, refreshed policy content and bite-sized guidance strengthened the process. ESR limitations meant continued reliance on targeted communications and proportionate follow-up. It was agreed that assurance should cover not only declaration rates but also how identified risks were assessed and managed.
Outcome	The Committee noted good progress and supported continued emphasis on individual accountability, clear guidance and risk-based review of declarations. Internal Audit would seek comparative compliance data from other organisations.

Assure: Including assurance items rated green	
Item/Topic	**Single Tender Waivers**
Rating rationale	Waivers reduced from 24 to five and in there was a significant reduction in value compared with the same period in 2025/26. This reflected earlier engagement with Procurement, improved forward planning and greater use of compliant routes to market. The remaining waivers were mainly for specialist corporate education and occupational health services, with no material concerns identified. Wider procurement transformation was progressing towards a group shared service to improve resilience, category management, contract management and analytics. Collaborative procurement was already being undertaken where appropriate.
Outcome	The Committee welcomed the substantial improvement. A further update on implementation of the group procurement model would be brought to the next meeting, subject to completion of partner approvals.

Wells Jo
08/10/2026 16:12:40

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: 10 September 2026
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**External Audit Update**
Summary	The 2025/26 audit opinion had been issued, but the completion certificate was awaiting National Audit Office confirmation. Planning for 2026/27 was expected to start in December or January. The review of the Charles Hastings Education Centre documentation and governance would be progressed during the second half of the year.
Outcome	The update was noted.

Wells Jo
08/10/2026 16:12:40

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.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	13 October 2026
Title of Report:	Board Assurance Framework and High Risk Report
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Company Secretary
Reporting Route:	Audit and Assurance Committee
Enclosures included with this report:	Board Assurance Framework
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Board Assurance Framework provides a structure and process that enables the Board to focus on the risks that might compromise achievement of the Trust's strategic objectives. It includes the key controls in place to manage these risks and assurances as to the effectiveness of the controls.

The attached Board Assurance Framework (BAF) comprises:

- A headline summary of all BAF risks
- The current Trust objectives to which the BAF risks are aligned.
- A risk heat map and a reminder of the Board risk appetite statement
- A summary of the Executive Risk Management Committee oversight of Trust risks
- A summary of all risks scoring 15+ on the Trust risk register
- A separate summary of each BAF risk.

Each BAF risk shows progress (updates shown in red font for ease of reference) but no significant changes are proposed.

The high risk report and summary of Committee oversight of Trust risks provides improving assurance of active risk management.

Recommended Actions required by Board or Committee

The Board is asked to note and accept the BAF and High Risk report for assurance.

Wells Jo
08/10/2026 16:12:40

Board Assurance Framework and Trust Risk Report October 2026

This report provides an update on the Board Assurance Framework, the risks rated 'extreme' (scored 15+ out of 25) on the Trust Risk Register, and a summary of the exectutive oversight of risk management by the Care Groups and Corporate Departments.

Key to Symbols

↑	Better/improved
↓	Worse/deteriorated
↔	No change

Board Assurance Framework (BAF)

The BAF risks have each been updated but there has been little movement in risk scores.

The heat map shows that the risk profile remains very high risk, with the majority scored 15+ and two scored as high risk (12).

Trust Risks

The Executive Risk Management Committee reviewed risk management reports from ten Groups and Departments in July and September, and was assured that risk management processes had improved to a good level and that the understanding of risks and risk management was strong.

Wells Jo
08/10/2026 16:12:40

Board Assurance Framework Headlines October 2026

#	Risk	Primary Pillar/Priority	Secondary Pillar/Priority	Linked BAF Risks (interdependencies)	Entry Risk Score (LxC)	Previous Quarter Score (LxC)	Current Risk Score (LxC)	Target Risk Score (LxC)	Lead Chief Officer	Oversight
BAF01	Financial delivery	Effectiveness: Financial	n/a	BAF03, 05.	4x4=16	4x4=16	4x4=16	1x4=4	CFO	Financial Recovery Board
BAF02	Health & wellbeing	People: Experience	People: Workforce transformation	BAF03, 04	4x4=16	4x4=16	4x4=16	2x4=8	CPO	People & Culture Committee
BAF03	Workforce transformation	People: Workforce transformation	n/a	BAF01, 02, 04	4x4=16	4x4=16	4x4=16	2x4=8	CPO	People & Culture Committee
BAF04	People Culture	People: Experience	People: Leadership; People: Development	BAF02, 03	5x3=15	4x3=12	4x3=12	2x3=6	CPO	People & Culture Committee
BAF05	Urgent & emergency care	Collaboration	Patients: Safe, high quality care	BAF06	5x4=20	5x4=20	5x4=20	2x4=8	COO	Board
BAF06	Digital strategy	Excellence	n/a	BAF01, 05, 07	4x4=16	3x4=12	3x4=12	1x4=4	CDIO	Digital Programme Board
BAF07	Cyber security	Excellence	n/a	BAF05, 06	4x5=20	4x5=20	4x5=20	3x5=15	CDIO	Digital Programme Board
BAF08	Fire Safety	Effectiveness: Buildings and Infrastructure	n/a	BAF01	4x5=20	3x5=15	3x5=15	2x3=6	MD	Quality Governance Committee

Risk Rating	Score
Very high	15–25
High	8–12
Moderate	4–6
Low	1–3

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Who we are

We are experts in healthcare services. Dedicated to improving the health of our population, we provide joined-up services with partners that meet everyone's needs, nearer to home.

NHS Worcestershire Acute Hospitals NHS Trust

Why we exist
Our Purpose

Helping people to live healthier, more fulfilling lives

What we do every day
Our Mission

Being the best team we can be for our patients, each other and our partners

Where we want to get to
Our Vision

Everyone is proud of the difference we make. We are more than a hospital, we bring care together for people

How we will get there
Strategic Priorities

By being better connected with what matters

People
Nurturing a culture people want to be a part of

Patients
Meeting the needs of our patients and communities

Collaboration
Building strong connections and pathways

Excellence
Focusing on continuous improvement

Effectiveness
Enhancing our efficiency and effectiveness

Guided by our Values

Being open and honest • Ensuring people feel cared for • Showing respect to everyone

Our Strategy 2025-30

PLAN ON A PAGE - Annual Objectives 2026-27

Helping people to live healthier, more fulfilling lives

NHS Worcestershire Acute Hospitals NHS Trust

ACROSS OUR TRUST WE WILL

PEOPLE - nurturing a culture people want to be part of (Lead: CPO)	PATIENTS - meeting the needs of our patients & communities (Lead: CNO)	COLLABORATION - building strong connections & pathways (Lead: CCSO)	EXCELLENCE - focusing on continuous improvement (Leads: CMO & CDIO)	EFFECTIVENESS - enhancing our efficiency & effectiveness (Leads: CFO & COO)
• Support at least 96% of colleagues to remain well and at work, helping those who are unwell return as soon as appropriate • Deliver measurable improvement in staff survey performance	• Embed PSIRF & improve patient safety learning across all sites • Minimise the risk of Hospital Acquired Functional Decline	• Establish joint, patient-centred services with primary care partners	• Maximise the use of digital technology to enhance delivery of patient-centred care • Focus on making every pound go further for our patients	• Deliver cancer standards for Faster Diagnosis and 62-day treatment standards • Improve elective productivity to eliminate 52-week waits and increase the Trust's position to within the top 25 for RTT • Deliver the required Emergency Access and Trolley Wait standards, whilst eliminating corridor care • Deliver the financial plan, achieving our CPIP target in full

ACROSS OUR CARE GROUP OR CORPORATE DIVISION WE WILL

• Early intervention & review of sickness absence • Develop and implement Care Group Staff Survey engagement and action plan	• Identify incident themes & implement learning • Develop & implement plans to avoid admission and reduce length of stay	• Create integrated service models at neighbourhood level with primary care • Transform outpatient services jointly with primary care	• Implement ambient voice technology across all specialties • Embed the digital bed management processes across the care group • Improve the Cost per Weighted Activity Unit - a 3 decile improvement at least, no lower than a median WAU	• Deliver cancer standards for all tumour sites • Deliver top decile performance for theatre & outpatient productivity • Minimise DTAs, maximising flow • Deliver financial plan & CPIP target in full

KEY METRICS (END OF YEAR TARGETS)

Urgent and emergency care: 4 hr EAS	Elective care: 18-week RTT	Elective care: 52 week waits	Cancer: 62 day referral to treatment	Diagnostics: 6 week wait	Finance: CPIP delivery	Workforce: Staff Survey response rate
Target - 82%	Target - 68.5%	Target - 0%	Target - 80.4%	Target - 14.8%	Target - £57.1m	Target - Above national average

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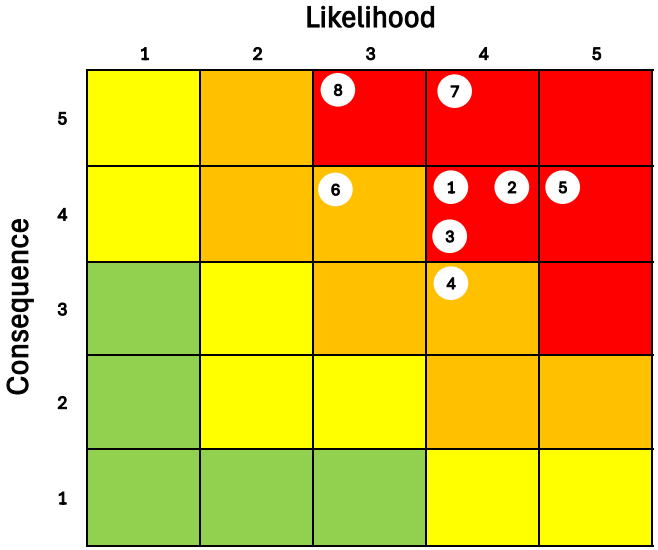
Board Assurance Framework Heat Map October 2026

Risk Ratings:	
Very high:	15-25
High:	8-12
Moderate:	4-6
Low:	1-3



Risk Appetite Statement

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST RISK APPETITE STATEMENT

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0. NONE - Avoid Avoidance of risk and uncertainty is a key system objective	1. LOW- Minimal 'As low as reasonably possible' (ALARP) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2. MODERATE – Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3. HIGH – Open Willing to consider all potential delivery options and accept a degree of inherent risk while also providing an acceptable level of reward (and VfM)	4. SIGNIFICANT – Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5. SIGNIFICANT – Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
FINANCE *How will we use our resources?*	Avoidance of financial loss is a key objective. We have no appetite for financial loss. We are only willing to accept the low-cost option as VfM is the primary concern. Tight controls in place with limited devolved decision taking authority.	We are only prepared to accept the possibility of very limited financial risk. VfM is the primary concern. Strong central control with limited devolved decision taking authority.	We are prepared to accept possibility of some limited financial risk. VfM is the primary concern but willing to consider other benefits or constraints. Resources are generally restricted to existing commitments. Strong central control is the default but some devolvement of decisions is accepted.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not being the overarching factor. Resources are allocated in order to capitalise on opportunities. We carefully balance central control with devolvement of decisions.	We will invest for the best possible return and accept the possibility of increased financial risk. Resources allocated without firm guarantee of return. We tend to devolve decisions with lower levels of inherent risk.	We will consistently invest for the best possible return for stakeholders, recognizing that the potential for substantial gain outweighs inherent risks. Our default is to devolve decisions where possible, only keeping central control for decisions with the highest levels of inherent risk.
REGULATION *How will we be perceived by our regulators?*	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of some limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to accept decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders
PEOPLE *How will we develop our people?*	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approached to workforce recruitment and retention are not a priority and will only be adopted if established and proved to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk as a direct result from innovation as long as there is the potential for improved recruitment and retention and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have impact on our people but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but is worthwhile due of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
QUALITY *How will we deliver safe services?*	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely necessary.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risks and possibility of improved outcomes and appropriate controls are in place.	We are prepared to accept the possibility of short-term impact on quality outcomes with potential for longer-term rewards.	We are willing to take decisions on quality where there may be higher inherent risks but potential for significant longer-term gains.	We seek to take high risk decisions on quality in pursuit of significant gains and mitigation to our other risks.
REPUTATION *How will we be perceived by the public and our partners?*	We have no appetite for any decisions that could lead to additional scrutiny or attention on the organisation. External interest in the organisation viewed with concern.	Our appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	We are prepared to accept the possibility of limited reputational risk as long as appropriate controls are in place to limit the risk.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
INNOVATION *How progressive and innovative do we want to be?*	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or established and proved to be effective in a variety of settings	Tendency to stick to the status quo, innovations in practice generally avoided unless really necessary. Systems/technology developments limited to improvements to protection of current operations & practice.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery.	Innovation is the priority– consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery.

Approved April 2026

Wells Jo
08/10/2026 16:12:40

Executive Risk Management (ERM) Committee Oversight

The Executive Risk Management Committee meets bi-monthly to review reports from Care Groups and Corporate Departments on the management of risks rated 12+ (high) and 15+ (extreme).

These reports are scheduled across the year so that each group or department presents regularly.

The reports include the results of a risk management deep-dive audit, which assesses performance on 15 risk management measures (a score of 12+ is rated green).

The Committee also receives reports on corporate risk management processes, such as policies and training, and agrees actions for further development.

The Committee regularly reviews the Board Assurance Framework and the full set of extreme risks.

The Committee is responsible for agreeing whether any risk may be categorised as 'accepted', which means that the risk will continue to be regularly reviewed but it is agreed that, at present, no additional mitigating actions would be possible or reasonable.

The review of risks rated 15+ (extreme) shows positive movement, with action resulting in reduced risk scores for 5 risk to below the 'extreme' level during the reporting period.

The following sub-committees report to the Committee through the presentation of minutes and the escalation of any issues: Health and Safety Committee, Fire Safety Committee and Emergency Planning, Resilience and Response Committee.

This summary is provided to give assurance to the Trust Board about the executive oversight of risks within the Trust and the quality of risk management by the Care Groups and departments.

		Risks					
ERM date	**Clinical Group/Dept**	**# live**	**# extreme**	**# accepted**	**Deep Dive score (out of 15)**	**Good practice noted**	**Escalations**
Jul.26	Surgery	58	8	0	12	Draft risks reviewed weekly to ensure they are complete and ready for approval.	Risk management training to risk owners is being expedited.
Jul.26	Diagnostics and Specialities	184	6	0	15	Improved processes for ensuring draft risks are reviewed and approved in a timely way.	Four risks were reduced from 'extreme' to 'high' since May 26.
Jul.26	Estates and Facilities	107	4	9	15	Divisional risk management group is well embedded and members constructively challenge each other.	Risks being allocated to division without notification and sometimes inappropriately
Jul.26	Finance	16	3	0	13	Improved deep dive score; improved logging of actions	Alignment of risk scores with BAF risk to be reviewed.
Jul.26	Infection Prevention & Control	8	1	0	14	All IPC risks on corporate and trustwide risk registers reviewed and duplications removed or merged, reducing total live risks from 27 to 8.	New risk regarding measles entered with a score of 20 and subsequently reduced to 12 to reflect actions taken.
Sep.26	Family Health	77	1	0	11	Housekeeping has improved: no overdue actions or risks, and the deep-dive rating improved to green.	Obstetric on-call gaps and maternity governance vacancies require close oversight.

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Sep.26	Medicine and Emergency Care	139	15	1	12	A comprehensive register cleanse corrected reporting gaps and overdue reviews; risks and actions were reported as back in date.	Mitigations for overdue follow-up patients require strengthening; postal delays may require a Trust-wide response.
Sep.26	Digital	51	6	0	15	A robust subcommittee structure and bi-monthly risk group achieved a clean 15/15 deep-dive result.	Capital is required for data-centre and bleep-system improvements.
Sep.26	People and Culture	31	2	1	13	People & Culture Committee and HR senior leadership routinely review risks; actions and supporting information have been comprehensively refreshed.	Emerging WLI risks to be considered separately from bank and agency workforce risks.
Sep.26	Health and Safety	66	1	0	15	Monthly review arrangements and fully populated risk records delivered 15/15 compliance, with all sampled risks green.	Interim ownership of fire-safety risks and the status of the violence and aggression risk require review.

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Trust 'Extreme' Risks (score of 15+) on 9 September 2026

ID	Title	Care Group/ Division	Rating (current)	BAF Link
3603	CYBERSECURITY - by not securing our Digital estate, a significant Cyber attack will occur, leading to loss of patient info	Corporate	20	BAF07
5905	Delivery of Financial Plan	Corporate	20	BAF01
6189	No Trustwide assurance, that Medical Device Training is being completed, recorded, reviewed, audited effectively and efficiently	Corporate	20	none
5511	There is a risk of fire and smoke spread due to breaches in fire compartmentation. (Aging Mandolite or no compartmentation)	Corporate	20	BAF08
4205	A risk of not being able to prepare Systemic Anti-Cancer Therapy (SACT) within the Trust to meet patient needs.	Diagnostics and Specialties	20	none
5138	Due to equipment failure, there is potential risk and delay to treatment of patients presenting with AMI	Medicine and Emergency Care	20	none
5045	Risk to Patient Safety due to Corridor Care of Patients on Surgical Wards	Surgery	20	BAF05
6191	There Is a Risk to Patient Safety Due to no Formal Diabetologist or Orthopaedic Input for Inpatient Diabetic Foot Patients	Surgery	20	BAF03
5625	Agency workforce (Medical & Dental)	Corporate	16	BAF03
6243	Bank Workforce (all staff groups)	Corporate	16	BAF03
4084	DATACENTRES - by not replacing power or maintaining environment a severe failure will occur, leading to loss of Digital Services	Corporate	16	BAF06
6142	Failure to Maintain an Up to Date, Approved Business Continuity Plan (BCP)	Corporate	16	none
4816	Inability to process operational risk for the review and allocation of side rooms	Corporate	16	none
5546	Inadequate level of face fit testing service for Filtering Face Piece 3 (FFP3) masks.	Corporate	16	none
6207	Lack of space in providing an appropriate environment for psychological staff/safe psychological well being sessions	Corporate	16	none
6144	MULTITONE BLEEP SERVICE - by not replacing/maintaining the bleep server, emergency messages may not be delivered, patient safety	Corporate	16	none
5575	Potential delay to patient pathways due to Typing Backlog	Corporate	16	none
6050	Removal of the Deficit Support Funding	Corporate	16	BAF01
6105	As a result of reduced capacity on aged analysers, delays in sample processing will occur which would lead to patient harm	Diagnostics and Specialties	16	none
6240	There is a risk to the future Pathology Laboratory Information Management System due to contract expiry in January 2028	Diagnostics and Specialties	16	none
5819	Inadequate paediatric estate countywide	Family Health	16	none
6260	Reduction in bank rates resulting in inability to fill vacant shifts leading to negative impact on safety and patient care	Family Health	16	none

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6259	Reduction in WLI rates resulting in inability to fill WLI leading to negative impact on elective KPIs, activity and income	Family Health	16	none
5753	Risk of uncovered Consultant obstetric on calls due to staffing levels	Family Health	16	none
6001	Insufficient dietetic staffing levels are resulting in unmet need poor patient outcomes and deteriorating staff wellbeing/morale	Medicine and Emergency Care	16	BAF03
5458	Insufficient Speech and Language Therapy staffing is resulting in a skeleton service to inpatients across WAHT sites.	Medicine and Emergency Care	16	BAF03
4964	Patients and staff may come to potential harm due to ED Crowding and Exit Block	Medicine and Emergency Care	16	BAF05
6092	Risk of 52 week breaches in Gastroenterology due to long waits with investigations that are performed outside of the Trust	Medicine and Emergency Care	16	none
6093	Risk of 52 week breaches in Gastroenterology due to underpowered consultant workforce	Medicine and Emergency Care	16	BAF03
5076	Risk of harm to paediatric patients attending the ALEX hospital	Medicine and Emergency Care	16	none
6100	Risk of harm to patients attending the ALEX hospital with acute surgical presentations	Medicine and Emergency Care	16	none
6101	Risk of harm to patients attending the ALEX hospital with acute trauma presentations requiring admission	Medicine and Emergency Care	16	none
5848	Risk of Primary PCI service collapse due to short staffing and change of Trust On Call policy	Medicine and Emergency Care	16	none
5374	There is a risk of harm to patients who are overdue their follow up appointment	Medicine and Emergency Care	16	none
5931	Risk of insufficient Consultant on-call cover for Oral Maxillofacial Service (OMFS) due to shortage of Consultant availability	Surgery	16	BAF03
5545	Risk of Worcestershire Acute Hospitals Trust reputational harm with service delivery from an in-sourcing company in Dermatology	Surgery	16	none
5801	AHR - Nurse Call System - Static Systems 19 Pin	Corporate	15	none
4167	Cash Flow - risk that the Trust does not have sufficent cash	Corporate	15	BAF01
4773	CLINICAL APPLICATIONS - Timely implementation of EPR to realise quality and safety benefits	Corporate	15	BAF06
3648	Ageing infrastructure leading to machine failure in Hospital Sterile Decontamination Unit.	Diagnostics and Specialties	15	none
5124	Delay in service or cancellations as a result of equipment - washer disinfectors breakdown	Diagnostics and Specialties	15	none
6233	Non-fire-rated door leading into AGH Main Recovery may allow fire/smoke spread, leading to patient and staff safety risk.	Diagnostics and Specialties	15	BAF08
5593	Risk of harm to patients due to insufficient emergency theatre capacity (CEPOD) at the Alexandra Hospital.	Diagnostics and Specialties	15	none
5301	OPAT: Risk of increased patient length of stay due to workforce challenges and volume of referrals to OPAT service	Medicine and Emergency Care	15	BAF03

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5329	Patients may come to harm due to delays in specialty teams reviews following referral by the WRH Emergency Department team	Medicine and Emergency Care	15	none
4741	Patients may develop Hospital Acquired Functional Decline or infection due to long delays once medially fit for discharge	Medicine and Emergency Care	15	none
6205	There is a risk of AGH ED not meeting current legislation due to the inability to lock down the department	Medicine and Emergency Care	15	none
4873	Risk of Patient harm due to exceeding 36 hours to theatre for repair of fractured neck of femur	Surgery	15	none
4098	There is a risk of patient harm due to the historic unviewed & unfiled integrated clinical environment (ICE) results	Surgery	15	none
4998	There is a risk to patient safety due to delays and backlogs in contemporaneous and timely typing & actioning of clinic letters	Surgery	15	none

Risks Removed from Extreme Risk Register

ID	Title	Care Group/ Division	Rating (current)	BAF Link	Reason for Change
6124	Risk of harm to patients cared for in the 3rd bay in resus at the Alex due to lack of essential equipment.	Medicine and Emergency Care	20	none	Risk score reduced to 9
5807	Inappropriate and inaccurate wound assessment documentation upon the Trust's EPR system; increasing the risk of patient harm and	Corporate	16	BAF06	Risk score reduced to 9
6055	There is a potential risk of harm to patients who are referred and accepted by surgical specialties at AGH ED	Medicine and Emergency Care	16	none	Risk closed as duplicate of 6100
5173	Tissue viability documentation on Sunrise EPR , increased risk of staff inability to document safe care	Corporate	15	BAF06	Risk score reduced to 9
5204	Overdue complaints in Surgery - unable to meet standards and gives patients a poor experience	Surgery	15	none	Risk score reduced to 12
5802	AHR- Emergency Sounders in Theatre suite (Theatres 1- 7)	Corporate	15	none	Risk score reduced to 10

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Board Assurance Framework Risk Summary	
Risk Reference	BAF01
Strategic priorities and objectives	Effectiveness: enhancing our efficiency and effectiveness Deliver the financial plan, achieving our CPIP target in full

Date	October 2026
Risk Headline	Financial delivery
Risk owner	Chief Finance Officer

Risk	Cause	Impact
Risk of failure to deliver the Trust's agreed financial plan and achieve long-term financial stability.	The 2026/27 financial plan is dependent on delivery of a challenging cost and productivity improvement plan (CPIP) of 6.8%.	Regulatory intervention. Negative reputation. Impact on ability to achieve wider strategic priorities. Impact on delivery of ICS financial delivery

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=16	4x4=16	↔	1x4=4	Moderate-cautious
	June 2026	4x4=16	4x4=16			

Current Controls and Mitigations	
1. Financial Recovery Board oversight	2. People and Culture Committee oversight
3. Enhanced financial controls	4. Enhanced vacancy controls
5. Enhanced controls of temporary staff usage	6. New weekly Executive Financial Recovery meeting
7. New Operational & Assurance Committee	8. New Agency Reduction Programme Board
9. Strengthened forecasting	10. Adoption of national financial controls and toolkits
11. New recovery framework in place	12. Support from NHSE to deliver financial improvement plan
13. Close monitoring of cash position and cash controls	14. Strengthened debtor recovery
15. Closed additional capacity (Pathway Discharge Unit)	

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continued use of agency staff	Reduce agency staff usage and expenditure	CPO	March 27	Reduced in August. Revised rates and strengthened break-glass controls were implemented from 1 September 2026.
Continued reliance on bank staff	Reduce bank staff usage and expenditure	CPO	March 27	Bank rates and controls have been reviewed; further action is required to reduce usage driven by sickness and vacancies.
High proportion unidentified CPIP schemes to meet target	Develop CPIP plans to achieve full CPIP target	CFO	Aug 26	Financial check-and-challenge sessions have commenced. Scheme maturity improved at M5, with recovery focused on clear ownership and conversion to recurrent savings.
Under performance of financial plan impacting receipt of deficit funding, driving adverse cash position	Submit application for cash support	CFO	~~June 26~~ Aug 26	Provider Revenue Support was secured for July and August; a further request was submitted for September.
Capacity to delivery financial improvement plan	Establish financial improvement taskforce (FIT)	CFO	TBC	Terms of reference and local leads are in place.
Additional operational capacity open beyond planned timescales due to operational pressures	Close Pathway Discharge Unit	COO	July 26	Complete and added to controls

Key Assurance Indicators	Date Reported	Performance	Change
Delivery of financial plan 2026/27	Aug-Oct 26	Performance deteriorated at M4 and behind plan year to date (YTD).	↓
CPIP performance	Aug-Oct 26	YTD performance behind plan. Improvement in M4 and M5 on development of schemes and scheme maturity.	↓

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Cash position	Aug-Oct 26	Cash position at risk due to performance resulting in loss of Q2 and M4 deficit funding. Cash remained dependent on revenue support at M5.	-
Agency expenditure reduction	Aug-Oct 26	YTD above plan and deteriorated since month 2. Reduction at M5 but still above plan.	↓
Bank staff expenditure reduction	Aug-Oct 26	YTD above plan. Increase in M4 and marginal reduction in M5.	↔
Productivity cost per unit of clinical output (WAU)	Aug-Oct 26	YTD better than 2025/26 and on an improvement trend.	↑
Delivery of financial plan 2025/26	April 26	Not delivered	↔

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHS Oversight Framework Segmentation	June 26	Segment 4 (quarter 4)	Segment 4 (quarter 3)	↔
NHS Oversight Framework Segmentation	Sept 26	Segment 3 (quarter 1)	Segment 4 (quarter 4)	↑
Internal Audit: payroll	2024/25	Significant assurance	n/a	n/a
Internal Audit: Accounts receivable/payable	2024/25	Significant assurance	n/a	n/a
Internal Audit: expenses	2024/25	Significant assurance	n/a	n/a
Internal Audit: bank and agency staffing	2024/25	Moderate assurance	n/a	n/a
External Audit Value for Money assessment	2025/26	3 significant weaknesses	2 significant weaknesses	↓
Internal Audit: financial ledger and reporting	Mar 26	Significant assurance	n/a	n/a
Internal Audit: procurement	Nov 25	Significant assurance	n/a	n/a
Provider Capability Assessment Rating	Feb 26	Amber/Red (2025/26)	n/a	n/a
Internal Audit: financial systems	2026/27	TBC	n/a	n/a
Internal Audit: Bank and agency staffing: high earners	2026/27	TBC	n/a	n/a

Summary Update
Since July, delivery of the financial plan has remained very high risk, with performance behind plan and CPIP under-delivery the principal driver, despite improving scheme maturity. Closure of the PDU and tighter controls reduced agency use, but bank expenditure remained pressured by sickness and vacancies. Productivity remained positive year to date but deteriorated in August. With deficit support withheld, cash remains dependent on Provider Revenue Support. Recovery actions are focused on CPIP delivery, temporary staffing, cash resilience and clear accountability.

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Board Assurance Framework Risk Summary	
Risk Reference	BAF02
Strategic priorities and objectives	People: Experience, Workforce Transformation • Supporting colleagues to remain well at work, helping those who are unwell to return • Deliver measurable improvement in staff survey results

Date	October 2026
Risk Headline	Staff wellbeing
Risk owner	Chief People Officer

Risk	Cause	Impact
There is a risk to the health and wellbeing of our staff	• Operational pressures • High workload • Industrial action • Societal pressures – economic and rising poor mental health	• Sickness absence • Low morale • Burnout • Inability to provide the highest quality care

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=16	4x4=16	↔	2x4=8	High-open

Current Controls and Mitigations	
1. Occupational health service	2. Health and wellbeing communications and resource signposting
3. Clinical psychologist support	4. Health @ Work service
5. Menopause Support Group	6. Oversight by Staff Experience Delivery Group
7. Employee Assistance Programme	8. Annual flu vaccination programme
9. Targeted intervention meetings with managers in sickness hotspots	10. Sickness management support by HR advisory team
11. Digital financial support package	12. Mental health expertise within occupational health service
13. Health and wellbeing passport	14. Staff wellbeing and relaxation rooms
15. Menopause toolkit	16. Refreshed SOP for reasonable workplace adjustments
17. Neurodivergent toolkit	18. Board level oversight by Financial Recovery Board

Gaps in Control	Related Actions	Lead	Due Date	Progress
Strategy for reducing sickness	Implement Sickness Reduction Programme	CPO	March 27	Sickness policy review commenced.
High rates of seasonal sickness	Deliver winter flu plan	CPO	Dec 26	Campaign has commenced
Disability discrimination and poor experience for neurodivergent staff	Implement neurodivergent toolkit	CPO	March 27	Neurodivergent toolkit in place and further elements in development, including manager training.

Key Assurance Indicators	Date Reported	Performance	Change
Flu vaccination rate	TBA	Flu campaign just commenced; data to be reported	
Monthly sickness absence	Oct 26	Increased by 0.11% from last month to 5.74% - 0.29% worse than the same month last year. The % of absence attributed to stress has remained at 36% of total sickness	↓
Percentage of sickness absence attributable to stress/anxiety	Oct 26	36% (increase since May 26)	↓

Independent Assurance	Date	Rating/Outcome	Change
Staff Survey 2024 results: 'we are safe and healthy'	March 25	Score of 6.09: Improvement compared to 2024 and equal to average result for peer group	-
Staff Survey 2025 results: 'we are safe and healthy'	March 26	Score of 6.30: Improvement compared to 2025 and above national and peer group average	↑
Internal Audit: sickness absence management	May 26	Significant assurance	n/a
Internal Audit: Working life improvement plan	May 27	Planned	n/a

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NHS Oversight Framework People Domain	Sept 26	Segment 3; score 2.64	n/a

Summary Update
Sickness reduction performance deteriorated in month, driven by hot spots but programme remains on track to achieve 4% or less target by end of 2026/27

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Board Assurance Framework Risk Summary	
Risk Reference	BAF03
Strategic objectives and priorities	People: Workforce transformation

Date	October 2026
Risk Headline	Workforce transformation
Risk owner	Chief People Officer

Risk	Cause	Impact
Failure to deliver workforce transformation and achieve a sustainable workforce	• Recruitment challenges in some services and staff groups • Operational pressures impacting timely recruitment • Agenda for change terms not competitive for some roles. • Demand exceeds capacity in some departments • Requirement to reduce temporary staffing • Requirement to reduce non-clinical headcount • Staffing required for temporary operational capacity, which has remained open longer than planned	• Need for continued reliance on temporary staff in additional capacity areas. • Staff unable to achieve full operating capability • Failure to achieve full productivity • Failure to deliver national and local standards

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 25	4x4=16	4x4=16	↔	2x4=8	High-open

Current Controls and Mitigations	
1. Agency Programme Board	2. Job planning consistency panel
3. Vacancy controls	4. Quality Impact Assessments for workforce transformation programmes
5. Enhanced agency and bank staffing controls	6. Target Operating Models for corporate services
7. PMO Improvement Team support for workforce programmes	8. Workforce Transformation & Modernisation Programme
9. Board level oversight by Financial Recovery Board	

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continued reliance on temporary staff	Deliver the 2026/27 nursing workforce and temporary staffing reduction programmes	CPO	March 27	• Agency HCSWs removed from ward cascade (Feb 2026); break-glass only. • Agency RN reduction started June; review due mid-Oct. • August temporary staffing increased, but HCSW use was 36.1 WTE below Aug 2025. • PDU closed end-June.
Vacancy numbers above target	Undertake targeted recruitment and review hard to fill vacancies	CPO	March 27	• 27 nursing offers and 75 HCSW offers made following recruitment events • Detailed HCSW vacancy review under way.
High sickness levels	See BAF02			
100% compliant and accurate job plans for medical staff	Complete roll-out of medical e-roster	CMO	March 27	Programme continues for all medical staff
Effective, efficient, sustainable admin and clerical workforce structures	Admin and clerical workforce review	CPO	March 27	Good progress on programme actions but WTE reductions behind plan.

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Key Assurance Indicators	Date Reported	Performance	Change
Agency staff expenditure (% of gross pay bill)	Oct 26 (Aug data)	Reduced to 2.5% (within 4% target)	↑
Agency staff usage	Oct 26 (Aug data)	WTE agency usage above plan (55.37 - compared to 38.47 in June)	↓

Bank staff usage	Oct 26 (Aug data)	WTE bank usage above plan (222.31 compared to 148.08 in June)	↓
Vacancy rate	Oct 26 (Aug data)	7.88% against target of 6.5%	↑
Annual staff turnover	Oct 26 (Aug data)	7.7% compared to 11.5% target (a slight increase)	↓
Consultant job planning	Aug 26 (June data)	89% against target of 95%	↑

Independent Assurance	**Date**	**Rating/Outcome**
Staff survey 2024: "there are enough staff"	Mar 25	Above national average score and an improvement on 2023
Staff survey 2025: "there are enough staff"	Mar 26	Above national average score and a 4% improvement on 2024
Internal Audit: Bank and Agency Staffing	2024/25	Moderate assurance
Internal Audit: Payroll (contracted out)	Mar 26	Significant assurance
Internal Audit: NHS Professionals Pre-employment checks	Sept 26	Significant assurance
Internal Audit: bank and agency staffing – high earners	2026/27	Planned
NHS Oversight Framework People Domain	Sept 26	Segment 3; score 2.64

Summary Update
Progress continues in strengthening workforce oversight, reducing reliance on temporary staffing and supporting targeted recruitment. Key workforce indicators show a mixed position, with some areas performing positively while vacancies and temporary staffing usage remain subject to focused management action.

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Board Assurance Framework Risk Summary	
Risk Reference	BAF04
Strategic objectives and priorities	People: Experience, Leadership, Development

Date	October 2026
Risk Headline	People Culture
Risk owner	Chief People Officer

Risk	Cause	Impact
Risk of a failure to sustain a positive change in organisational culture	• Multiple changes in senior leadership over time • Organisational change • History of low staff engagement • Examples of poor culture within workforce	• Poor staff experience • Failure to attract and retain the best people • Inability to deliver high quality care and treatment

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
5x3=15	Feb 24	5x3=15	4x3=12	↓	2x3=6	High-open
	June 25	4x3=12				

Current Controls and Mitigations	
1. FTSU Guardian and Champions	2. Refreshed Trust values based on staff engagement
3. Staff Networks	4. Sexual safety charter and toolkit
5. Cultural Ambassadors	6. National Mandatory Training MOU
7. Mandatory Training Oversight Group	8. Refreshed appraisal documentation and system
9. People Strategy based on staff engagement	10. Increased communication of staff survey actions to improve staff engagement
11. NHS Elect online training and development available to all staff	12. Anti-racism charter in place
13. Refreshed induction and mandatory training programmes	14. Appraisal and Revalidation Lead in post
15. Improved appraisal processes	

Gaps in Control	Related Actions	Lead	Due Date	Progress
Effective policies and processes for conflict resolution	Develop respectful resolution policy, framework, toolkit and manager training	CPO	Oct 26	Good progress with positive Staff Side engagement
Incidents of racism	Implement Anti-Racism Charter	CPO	Oct 26	Signed November 25, 12-month programme now in progress
Low appraisal rates	Improve appraisal process	CPO	Mar 26	Completed and added to controls
Compliance with new NHS Staff Standards	Implement NHS Staff Standards	CPO	July 27	Self-assessment and delivery plans in progress with oversight by People and Culture Committee

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Mandatory training rates	Oct 26 (Aug data)	Performance increased 3% since last report to 86% against 90% target	↑
Appraisal rates (non-medical)	Oct 26 (Aug data)	Performance improved to 85% against 90% target. Corporate is the principal outlier at 72%.	↑
Appraisal rates (medical)	Oct 26 (Aug data)	91% against the 90% target; deterioration compared to last period	↓

Independent Assurance	Date	Rating/Outcome	Change
Staff Survey 2024: Response rate	Mar 25	46%	↑
Staff Survey 2024: Engagement score	Mar 25	6.82: Slightly below average but better than 2023	↑
Staff Survey 2024: We are always learning	Mar 25	5.61: Slightly below average but better than 2023	↑
Staff Survey 2024: We are compassionate & inclusive	Mar 25	7.31. Above average and better than 2023	↑
Staff Survey 2025: Response rate	Mar 26	48%	↑
Staff Survey 2025: Engagement score	Mar 26	6.84: Above average and better than 2024	↑
Staff Survey 2025: We are always learning	Mar 26	5.69: Above average and better than 2024	↑
Staff Survey 2025: We are compassionate & inclusive	Mar 26	7.36. Above average and better than 2024	↑

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NHS Oversight Framework People Domain	Sept 26	Segment 3; score 2.64	↓

Summary Update
Mandatory training remains below target, partly reflecting the expansion of safeguarding adults level 3 training eligibility. A new area of focus is the implementation of the NHS Staff Standards.

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Board Assurance Framework Risk Summary	
Risk Reference	BAF05
Strategic objectives and priorities	Collaboration: All Patients: safe, high-quality care; Home First

Date	**September 2026 draft**
Risk Headline	Urgent & Emergency Care
Risk owner	Chief Operating Officer

Risk	Cause	Impact
Risk of failure to improve urgent and emergency care (UEC)	• Increased demand in both volume and acuity for urgent and emergency care. • High demand for elective care. • Discharge pathway delays.	• Continued high demand for acute inpatient beds. • Longer waits in Emergency Department • Long delays for ambulance patients • Longer waits for elective care • Continued use of temporary escalation spaces • Increased risk of patient harm • Poor patient experience • Pressured working environments • Financial pressures • Failure to meet local and national targets. • Regulatory intervention.

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
5x4=20	March 2025	5x4=20	5x4=20	↔	2x4=8	High-open

Current Controls and Mitigations	
1. Oversight of improvements by new UEC Recovery Board	2. Standard Operating Procedures for key UEC pathways and use of Temporary Escalation Spaces to improve flow and maintain patient safety and experience.
3. UEC navigators	4. Continual monitoring of and response to daily UEC and patient flow dashboards
5. Stress-tested winter plan	6. Call Before Convey now mandated part of WMAS ambulance conveyance process.
7. PMO support for multiple deliverables	8. NHSE GIRFT support Ambulance pitstop
9. Regular engagement meetings with WMAS	

Gaps in Control	Related Actions	Lead	Due Date	Progress (Aug 26)
High attendance numbers at ED	Work with partners to develop ED avoidance plan	CCSO	Mar 26	GP front-door pilot commenced at Alexandra Hospital, redirecting patients to primary care. Admission avoidance pathways continue to be developed.
Long waits in ED and poor patient flow due to high attendance numbers	Implement Front Door Improvement Workstream	COO	Mar 27	Weekly improvement meetings established. ED workforce plan completed and recruitment under way; daily review of ambulance handovers reinstated.
	Implement Effective Site Management workstream	CPO	Mar 27	Digital patient flow system on track for 19 October implementation. Site meetings streamlined and enhanced daily oversight introduced to strengthen patient flow.
Por patient flow due to late discharges.	Implement Effective Discharge workstream	CNO	Mar 27	Weekly ward discharge targets remain in place. Daily trauma huddles identify patients suitable for earlier discharge; wider flow remains constrained by bed pressure and discharge delays.
Poor patient experience and impact on patient care due to long waits in ED	Implement Acute Care Standards workstream	CDIO	Mar 27	Care Groups now receive performance information on compliance with acute care standards. Monitoring through ward accreditation is planned.
	Implement Frailty workstream	CMO	Mar 27	Phase 1 frailty model continuing, with early positive impact reported. Frailty

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				Same Day Emergency Care remains operational; model redesign continues.

Key Assurance Indicators	Date Reported	Performance	Change
ED 4-hour standard (78%)	October 26 (August data)	Performance deteriorated from 69.3% in July to 65.5% in August, below the 78% standard	↓
ED 12-hour standard (10%)	October 26 (August data)	Performance deteriorated from 12.3% in July to 14.3% in August, above the 10% standard	↓
Ambulance handovers <45 mins (80%)	October 26 (August data)	Performance deteriorated from 79.4% in July to 71.7% in August, below the 80% standard	↓

Independent Assurance	Date	Rating/Outcome	Previous rating/s	Change
NHS Oversight Framework Segmentation Q1	Sept 26	Segment 3 (Q1 26/27)	Segment 4 (Q4, 25/26)	↑
NHS Oversight Framework: Access to Services Q1	Sept 26	Score: 3 Quartile: 4	Score: 2.94 Quartile: 4	↓
Internal Audit: Performance & Accountability Framework	2024/25	Significant assurance	n/a	n/a
Care Quality Commission: UEC at WRH	Apr 24	Requires Improvement	Inadequate (2020)	↑
Internal Audit: Patient transfers/handovers (joint review with partner trust)	Mar 26	Limited assurance	n/a	n/a
Provider Capability Assessment Rating	Feb 26	Amber/red	n/a	n/a
Internal Audit: Temporary Escalation Spaces	Mar 27	Planned	n/a	n/a

Summary Update
Progress has been seen through a range of initiatives but these have not yet produced sustained improvement. Performance in August remained challenged amid significant pressures. The risk remains high and unchanged.

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Board Assurance Framework Risk Summary	
Risk Reference	BAF06
Strategic objectives and priorities	Excellence: Technology and digital

Date	October 2026
Risk Headline	Digital Strategy
Risk owner	Chief Digital and Information Officer

Risk	Cause	Impact
Risk of failure to develop, modernise and improve information technology through timely delivery of the digital strategy.	• Scale, number and complexity of individual projects create pressure on delivery and coordination • Workforce capacity and capability • Competing digital priorities across clinical, operational and corporate services • Dependence on legacy systems, limiting pace of improvement and innovation • Wealth of products and solutions on the market make evaluation, selection and standardisation for Trust needs challenging.	• Planned service/ quality benefits not achieved • Risk to patient safety and quality • Planned qualitative and financial savings not achieved • Increased operational inefficiency • Opportunities for productivity improvements not realised • Poor staff morale • Maximum digital maturity not achieved. • Increased cyber resilience risk • Reputational impact

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score		Risk Appetite
4x4=16	February 2024	4x4=16	3x4=12	↔	Mar 2027	2x4=8	Significant-seek
	May 2025	3x4=12			Mar 2028	1x4=4	

Current Controls and Mitigations	
1. Digital governance framework	2. Annual business planning cycle
3. Programme and project governance	4. Monitoring and oversight through Trust governance structure
5. Regular review and alignment of digital resource plans	6. Funding secured for Digital Patient Flow solution
7. Benefits and outcomes realisation programme – monthly oversight and challenge	8. Demand to Delivery (D2D) Framework

Gaps in Control	Related Actions	Lead	Due Date	Progress
Change management	Embed Optimisation process through the full Digital Programme of work.	CDIO	Sept 2027	In place for Sunrise, now rolling out through all Digital programmes.
Digitally capable workforce	Implement Digital Skills Framework (DFS) and Digital Literacy improvements	CDIO	Mar 2027	Development of DFS is in progress
Delay due to extraneous factors	Embed relationships with partner NHS and commercial organisations	CDIO	Mar 2027	Progressing well
Prioritisation of digital programmes and projects can affect delivery of EPR Programme	Clinically led prioritisation of programmes and projects	CDIO	Mar 2027	A new prioritisation mechanism is being trialled via Design to Delivery framework Embed Clinical Design Authority
Workforce change aligned to digital improvements	Support better use of technology in administrative functions	CPO	Mar 2027	In progress – reported to People & Culture Committee

Key Assurance Indicators	Date Reported	Performance	Change
Progress against agreed programme milestones	Rolling	Monthly through Digital Programme Board	↔
Digital training and competency assessment	July 26	Workstream established, now progressing to Trust wide assessment	n/a
Benefits Realisation and reporting	Rolling	Reporting to Digital Programme Board in line with forward plan	n/a
Clinical Safety Assurance – DCB0129 / DCB0160 compliance	Rolling	On track	n/a

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Financial control – actual spend / budget	March 2027	Monitored for programmes and projects through Digital Programme Board	n/a

Independent Assurance	Date	Rating/Outcome	Previous Rating	Change
Digital Maturity Assessment Score (well led)	Sept 26	3.8/5	3.2/5	↑
Data Security and Protection Toolkit	July 26	Standards met	Standards met, with action plan	↑
360 Audit Report on DSPT	Aug 26	High assurance, low risk	High assurance, low risk	↔
NHSE external assurance report (EPMA)	Oct 25	Amber/green (safe to go-live)	n/a	n/a

Summary Update

- The 2026 Digital Maturity Assessment tool has just been released by NHSE. Completion of this tool kit will illustrate progress being made by the Trust.
- The new Digital Patient Flow solution is on track to go live October 2026. This is slightly later (2 weeks) than planned due to rigorous testing identifying 3 supplier defects which are now fixed.
- The Trust has invested significantly in T-Pro Dictate (Voice Recognition) and Scribe (Ambient Voice Technology) products and deployment continues at pace. Both of these products will be important tools in driving quality and efficiency gains across our clinical services
- The Demand to Digital (D2D) continues to mature and enables all requests of Digital to be captured, assessed and prioritised for delivery. Continuous feedback is provided to users now enabling tracking of their individual requests. The D2D framework

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Board Assurance Framework Risk Summary	
Risk Reference	BAF07
Strategic objectives and priorities	Excellence: Technology and digital

Date	October 2026
Risk Headline	Cyber security
Risk owner	Chief Digital and Information Officer

Risk	Cause	Impact
Risk of a successful cyber-attack on the Trust's systems.	• Increasingly frequent and sophisticated attacks on internal and external digital systems containing critical Trust data. • Large and diverse user base with access to Trust's digital systems • Increasing reliance on digital systems for clinical care, operational processes and decision-making • Reliance on third party suppliers and shared services. • Supply chain remote connectivity to Trust systems • Advances in Artificial Intelligence increasing the frequency and improving the quality of future attack attempts • Insufficient core standards/framework alignment and compliance (e.g. DSPT Cyber Assessment Framework)	• Data security breaches • Loss or corruption of data • Lost or delayed access to patient care records • Disruption to clinical services • Patient safety incidents • Business interruption • High cost of rectification • Reputation damage • Regulatory intervention

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x5=20	Feb 2024	4x5=20	4x5=20	↔	3x5=15	Significant-seek

Current Controls and Mitigations	
1. Perimeter level cyber security mechanisms	2. Risk-based approach to cyber and infrastructure funding
3. User knowledge assessments (e.g. phishing)	4. Supplier and third-party controls and oversight
5. Business Continuity plans	6. Capital planning programme
7. Mandatory information governance training	8. Security Operations Centres (NHS England and Wavenet)
9. Cyber Health Dashboard monitoring, and Board 'Safer Cyber' report	10. Identity and access controls
11. Regular audits (e.g. Annual penetration testing, cyber health checks and internal DSPT audits)	12. National CIO weekly briefing on cyber security threats

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continual development to meet changing risk environment	Implement DSPT CAF-aligned Digital workplan	CTO	Nov 2026	High level DSPT project plan in place. Business cases and resource allocation activities in flight to support 'Top 3' initiatives.
Staff understanding and awareness of cyber risks	Maintain mandatory training compliance at 90%	DPO	Rolling	Monitored monthly through Information Governance Steering Group
Digital Team Structure and Funding	Digital Team Structure Review, Inc. Business case for enhanced Cyber team	CDIO	March 2027	In progress. Initial phase 1 Digital re-structure work complete. Cyber resourcing business case in development.
Gaps in compliance with DSPT CAF framework	Implement an updated plan to mature the Trust in line with 2026/27 CAF v4/DSPT v9 requirements	CDIO	Rolling	High level project plan in place. Business cases in development to support 'Top 3' initiatives.
Supply chain assurance improvements	Update contracts with IG and Cyber clauses, maintain robust contract management and	CDIO	March 2027	Approach linked to DSPT CAF project workstream.

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	monitoring mechanisms, retrospectively perform DPIAs on legacy systems			
Digital Systems DR, BCP and scenario testing	Review current plans and policies and ensure appropriate updates are made and regular assurance testing scheduled	CTO	Dec 2026	Updated Digital BCP now in final draft, with all core Digital annexes signed off. DR plan update work has commenced with workshops to commence late Sept/early Oct. Scenario testing will be completed before the 31st Dec 2026.

Key Assurance Indicators	Date Reported	Performance	Change
Malware protection – servers	Aug 2026	100%	↔
Malware protection - endpoints	Aug 2026	99.99%	↔
Data security mandatory training	September 2026	91%	↔

Independent Assurance	Date	Rating/Outcome	Previous Rating	Change
Internal Audit: Cyber Assessment Framework (CAF) – aligned Data Security & Protection Toolkit (DSPT)	June 26	Risk: Low Confidence Level: High	Risk: Low Confidence Level: High	↔
Digital Maturity Assessment Score (well led)	2026	3.7	3.2	↑
Emergency Planning, Resilience & Response (EPRR) Core Standards compliance	2026	Substantial assurance	Substantial assurance	↑

Summary Update

- New DSPT CAF v9 (based on NCSC CAF v4) framework guidelines released into the Trust.
- New bi-monthly DSPT planning and governance meetings in place, led and sponsored by Nikki O'Brien (Deputy Chief Performance and Information Officer)
- 'Top 3' critical initiatives and workstreams defined. mobilised and tracked – Identity and Access Management, Supply Chain Assurance and BCP/DR/Assurance Testing
- Change in due dates reflect the more in-depth level of planning required to ensure the Trust addresses the top 3 appropriately given budgetary and resource constraints.

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Board Assurance Framework Risk Summary	
Risk Reference	BAF08
Strategic objectives and priorities	Effectiveness: Buildings and infrastructure

Date	October 2026
Risk Headline	Fire Safety
Risk owner	Managing Director

Risk	Cause	Impact
There is a continuing fire safety risk to patients, staff and visitors at the Alexandra Hospital (Alex) resulting in two Enforcement Notices from the Fire Authority.	• Fire compartmentation work required. • Fire door replacement required • Fire detection system improvements required. • Control of contractors requires improvement. • Cost of full rectification is unaffordable	• Regulatory enforcement action, including potential closure of areas of building, impacting service delivery. • Building damage in the event of fire • Injury in the event of fire

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x5=20	January 2025	4x5=20	3x5=15	↔	2x3=6	High-open
	February 2025	3x5=15				

Current Controls and Mitigations	
1. Updated staff fire safety training	2. Evacuation plans
3. Regular engagement with Fire Authority	4. Fire drill schedule
5. Monthly fire safety audits	6. Ongoing remedial works pending permanent design solutions
7. Increased alarm response from fire service	8. Increased vigilance by security and porter staff
9. Updated role specific fire incident training	10. Heightened staff awareness
11. Updated fire risk assessment	12. Dedicated Fire Safety Manager
13. Updated Fire Strategy aligned to evacuation plans	14. Enhanced fire detection in place (above British Standard)
15. Phase 1 betterment works complete	16. Funded plans in place for phase 2 capital works

Gaps in Control	Related Actions	Lead	Due Date	Progress
Full implementation of Schedule of Works -Enforcement Notice 1508	Implement Fire Remedial Works Project	DoE	~~Aug 25~~ ~~Feb 26~~ July 2026	Phase 1 is complete. Phase 2 capital works are planned, and the Fire Authority extended Enforcement Notice 1508 to August 2026. A response from the Fire Authority is awaited.
Gaps identified via fire risk assessments (Alex)	Implement fire risk assessment action plans	DoE	Sept 26	Six actions from the 2025 fire risk assessments remain. These are expected to be addressed through planned assessments and Phase 2 capital works, with progress monitored by the Fire Safety Team.

Key Assurance Indicators	Date Reported	Performance	Change
Fire safety training compliance rates	Quarter 1 2026/27	80% across 8,218 staff	↑
Fire warden and Fire Response Team training rates	Quarter 1 2026/27	100%	↔
Fire safety drills completed	Quarter 1 2026/27	41 drills completed, reaching 460 staff (40 in Quarter 4 2025/26)	↑
Unwanted fire alarm activations	Quarter 1 2026/27	29 unwanted fire signals, a 21% increase from Quarter 4	↓
Number of fires	Quarter 1 2026/27	Zero	↔

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Independent Assurance	Date	Rating/Outcome	Previous Rating	Change
Fire Authority Enforcement Notice 1503	Feb 25	Closed	Enforcement	↑
Fire Authority Enforcement Notice 1508	August 2026	Notice extended; Fire Authority response awaited	Enforcement	↔

Internal Audit: Fire Safety Enforcement Notices Action Plan	Mar 26	Substantial assurance	n/a	n/a

Summary Update
The risk score remains 15. Enforcement Notice 1503 is closed; Notice 1508 remains open, with Phase 2 works planned and a Fire Authority response awaited. Assurance includes improved training compliance, 41 fire drills and no actual fires. Six fire risk assessment actions remain, and unwanted fire signals increased to 29.

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Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
ATAIN	Avoidable Term Admissions into Neonatal Units
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CCOSMOS	CNST, CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2 and Saving Babies Lives
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
CNST	Clinical Negligence Scheme for Trusts
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council

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

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PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PMR	Perinatal Mortality Rate
PROMs	Patient Reported Outcome Measures
PROMPT	PRactical Obstetric Multi-Professional Training
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review
RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SDP	Single Delivery Plan (maternity)
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur

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