Joint forward plan – 25/26

Appendix 2: Strategic Enablers – Cross cutting themes

The section also identifies **how key enabling strategies** will be delivered to support the improved outcomes described in the core areas of focus section.

The section also describes the **strategic system developments** that will ensure that the system has the right structures, capacity and capabilities to deliver the plan.

Version: 2025 Refresh, June 2025

Strategic Enablers - cross cutting themes and strategic development areas

Cross Cutting Themes

Underpinning and supporting delivery of the core areas of focus outlined in Appendix 1 are a set of strategic enabling functions. These "cross-cut" all service areas and are fundamental components of delivering high quality, patient centred integrate services:

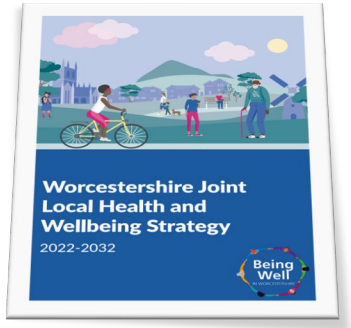
1. **Quality safety and patient experience**
2. **Clinical and care professional leadership**
3. **Medicines and pharmacy**
4. **Health inequalities**
5. **Prevention**
6. **Personalised care**
7. **Working with communities**
8. **Commitment to carers**
9. **Support veteran health**
10. **Addressing needs of victims of abuse**
11. **Digital, data and technology**
12. **Research and innovation**
13. **Greener NHS**

Strategic System Developments

In addition, there are a suite of strategic system developments that will support improved ways of working to maximise the opportunity for integration, enable greater focus on upstream prevention and delivery of best value health care in the right settings:

14. **Mental health collaborative**
15. **NHS Trust collaboratives**
16. **One Herefordshire Partnership**
17. **Worcestershire Place Partnership**
18. **Office for the West Midlands ICBs**

Together these supporting enablers provide the platform from which local NHS and Primary Care Partners can work together to deliver the priorities set out in the Integrated Care Strategy, the two Joint Local Health and Wellbeing Strategies and the NHS Long Term Plan



1. Quality, Safety and Patient Experience

Theme 1

Why is this important?

- What matters to people matters to us, listening to patients, their families and carers experience is essential to continuous improvement of services
- We have collective and individual responsibility to act in a manner that seeks ensure safe, effective and high quality care delivery and safeguard those in need of health and social care
- ICB has a Duty to ensure continuous quality improvement and as an ICS we are committed to this
- Learning and improvement cultures enable collaboration that leads to assurance of sustainable improvements in safety, clinical effectiveness and personalised experience

What have we delivered in 2024/25?

- Implementation and embedding of Patient Safety Incident Response Framework with continued growth of a system Patient safety specialist network and ICS Patient Safety Community of Practice to provide system opportunities for improvement and shared learning.
- This pilot project to safely develop, test and deliver an innovative approach of implementing AI into a patient management system to lead to better process flow and outcomes in CHC that is now being scaled up
- Improvement work related to Learning Disability and Autism including exemplary work around sensory friendly GP practices and children and adult admission avoidance. Surveillance status downgraded to 'by exception' which is the lowest level of surveillance the system can achieve.
- Establishment of ICS Collaborative for C-Diff Quality Improvement
- Oversight and governance processes established across the ICB to ensure patient safety quality and patient experience are central to ICB oversight

What are the priorities going forward?

- Improving indicators and experience of emergency care
- Improving system position for C-diff trajectories through quality improvement.
- Focus on implementation of Primary Care Patient Safety Strategy
- Further strengthen patient safety oversight with the development of patient safety dashboard
- Establish an ICS Deterioration Network and develop ICS strategy for PIER framework and Martha's Rule
- Delivering the national ambition to reduce still births, maternal and neonatal deaths and intrapartum brain injury Check planning guidance

ICS System Quality Group

The ICS System Quality Group met bi-monthly during 2024/25. The key aim of the group is to generate a shared commitment to improving quality and enable progress to be made on key system wide priorities.

The Group consists of key senior leaders from across the ICS and partner organisations who have a commitment to continuous quality improvement. Through discussion on key agenda items members have started to establish agreement about key cross cutting system priorities for improvement that are not otherwise managed through ICS Programme Boards.

During 2024/25 members have shared learning themes generated from organisation, 'place', system or Regional level processes, for the purpose of enabling system wide improvement.

What are we measuring?

During 2025/26 population health level dashboards will provide refreshed opportunities to understand what matters to people and track progress against priorities

- Rates of infection and antimicrobial prescribing
- Trends in mortality from specific causes and excess mortality
- Key metrics aligned to Saving Babies Lives Care Bundle
- Metrics agreed within each Trust and the ICS Patient Safety Incidents Response Plan
- Agreed quality, safety and experience Patient Safety Dashboard

Who is accountable?
ICS Forum for Healthcare acquired infection, Local Maternity and Neonatal System Board, ICS Mental Health Collaborative, ICS System Quality Group, Quality, Resources and Delivery Committee

Where can we see more detail?
System wide strategies on ICS webpage

Next steps
Continue working with partners across the system and regulators to agree, through the ICS System Quality Group, key system quality priorities that add value over and above the quality focus of each of the ICS Programme Boards.

2. Clinical and Care Professional Leadership

Theme 2

Why is this important?

As a system we are committed to embedding clinical and professional leadership throughout Primary Care Networks, neighborhood's, place and system structures and in our multidisciplinary forums across Herefordshire and Worcestershire. We have very string Clinical and professional Leadership forums in our two places, which are key but also are developing a culture of grass roots clinical engagement in service redesign and the "Building a Sustainable future" Programme, the system is held acocuntable to this through the Clinical Advisory Subcommittee which oversees Clinical transformation and policy.

Clinical and professional leaders

- Are trusted voices – connected with patients, communities and people working in health and care services
- Have the knowledge and expertise to make difficult decisions about how to use our limited resources most effectively, taking account of these int eh decisions they make
- Can use their diverse professional voices to create innovative solutions to problems
- Work effectively together across system and place, avoiding duplication, adding value, making a difference
- Are committed to collaboration and will seek to understand each others' professions and the unique contribution they make to improving health and care outcomes for local people – Including those who haven't been as involved in the past.
- Will make time for networking and building relationships across sectors
- Build on good practice and what works well, understanding that the transition to statutory ICS is an opportunity
- Embody leadership values and behaviours reflecting and connecting place and system

What will we deliver and when?

Clinical and Care leadership through delivering priorities: There is a strong clinical presence in the existing governance structures in H&W that support clinically led decision making

- Clinical leadership in the delivery of the **Getting it Right First Time (GiRFT) priority clinical areas**, focused on clinical productivity as a key enabler for reset and recovery and supporting the best use of resources programme.
- Clinical engagement and leadership of the **Building a sustainable future programme.**
- ICB Medical director, chair the **Quality, Delivery and Oversight** group and **Clinical advisory sub-committee,** providing support and challenge around solution focused decisions.

Who is accountable?

Clinical leader are in post to increase the capacity and capability in the ICB, driving improvement and transformation, Reporting to the CMO:

- Deputy Chief Medical Officers
- Interim Chief Clinical information officer
- Primary care, Veteran, military health and Vaccinations
- Clinical lead for social change
- End of life
- Ageing well and frailty

Where can you see more detail and get involved?

- The Clinical and Care Professional Leadership Framework describes the approach.

3. Medicines and Pharmacy

Theme 3

Why is this important?

- Medicines are the most common medical intervention in the NHS[1] and are an important part of preventing disease or slowing disease progression.
- In England in September 2024, 1,054,989 people received 10 or more medicines with 429,259 of them being aged 75 or over (8% of the population) and 143,982 aged 85 or over (8.9% of the population).[2]
- In December 2024[3], 7.2% of over 75s in H&W were prescribed 10 or more regular medicines in primary care which is a slight increase on December 2023 but lower than the national average.
- A person taking 10 or more medicines is 3 times more likely to suffer harm and 16.5% of unplanned hospital admissions are due to adverse drug reactions and polypharmacy. Over a 7-year period there was a 53% increase in the number of admissions caused by adverse drug reactions.[2]
- However, medicines are not always taken correctly, and it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.[1]
- The NHS in 22-23 spent £18.5 billion on prescribed medicines in primary care in England.[4] H&W annual spend on medicines is in excess of £230 million, with approximately £152 million in primary care.
- Antimicrobial resistance (AMR) which is the loss of antimicrobial effectiveness is increasing. The UK Government recognizes this and supports effective and careful use of antimicrobials (antimicrobial stewardship AMS) in the NHS. [5]
- Community pharmacy is an essential part of primary care, offering easy access to health services with 80% of people in England living within a 20-minute walk of a pharmacy.[6] Community pharmacy is delivering an increasing number of clinical services, supporting the primary care access recovery plan.
- The expertise of pharmacists and the role of pharmacy technicians has evolved and expanded significantly to deliver clinically focussed person-centred care integrated into multidisciplinary care teams and local systems across primary care, in general practice, in community care and in hospital pharmacy. This has led to pressures within the existing workforce which combined with the reforms to Foundation Year (FY) training for pharmacists makes workforce a key priority.[7]

Who is accountable?

- Medicines and Pharmacy Board, involving representatives from all sectors of the pharmacy profession across the ICS, with oversight of the Medicines and Pharmacy Strategy.

What will we deliver and when?

- Our vision is to ensure the population of Herefordshire and Worcestershire receive safe and effective access to medicines and technologies at the right time and in the right place. Working collaboratively, we will strive to improve and transform services, reduce health inequalities and deliver new ways of working, always keeping the population and patients at the heart of activity.

References

1. NICE Medicines Optimisation Quality standard Introduction | Medicines optimisation | Quality standards | NICE
2. Health Innovation Network: The mechanics of tackling overprescribing and problematic polypharmacy, February 2025
3. Data from Epact polypharmacy dashboard
4. NHSBSA: Prescribing Costs in Hospitals and the Community
5. NICE. Antimicrobial Stewardship
6. Delivery plan for recovering access to primary care. May 2023
7. NHSE. Initial education and training of pharmacists (IETP) reform. February 2024

3. Medicines and Pharmacy

Theme 3

	Our key priorities are:	What we have delivered in 2024/25	What we plan to deliver in 2025/26
Improve Health Outcomes	• Defined clinical use of medicines and technologies across the ICS through up to date and approved clinical policy, guidance and position statements.	• Horizon scanning and planning for new interventions anticipated during 2025/26. • Introduction of anticipated new medicines for endometriosis, kidney disease, migraine, and weight management. • Year 1 of a 5 year plan for hybrid closed loop systems for managing blood glucose in type 1 diabetes for those with greatest clinical need. • Extension of the eligibility for COVID-19 treatments • Ongoing work in relation to the National Patient Safety Alert on valproate	• Prioritising the introduction of new medicines for respiratory and kidney disease, skin problems, migraine, endometriosis, diabetes weight management and the menopause. • Year 2 implementation of hybrid closed loop • Further extension of eligibility for COVID-19 treatments.
Reduce Avoidable Harm	• Working across all sectors to co-ordinate work designed to improve medication safety focusing on high-risk medicines. • Focus on safety as patients move between organisations eg. discharge from hospital with changes to medicines supported by the Discharge Medicines Service (DMS) across the ICS. • Increase system awareness and undertaking in medicines audits. • Support and implement local antimicrobial stewardship (AMS) plans.	• Increasing the use of the Discharge Medicines Service • Introduction of an ICS Medicines Safety Group • Production of a primary care AMS dashboard to focus on total antimicrobial prescribing, course length and choice of antimicrobial agent.	• Re-launch of Community Pharmacy Intervention Scheme • Reduction in total antimicrobial prescribing • Production of structured medication review data to support the national drive to tackle over prescribing • Participate in national project work to address inappropriate antidepressant prescribing • Use the ICS Medicines Safety Group as forum to oversee implementation of National Patient Safety alerts and share learning.
Productivity & Achieving Best Value	• Working with clinicians to ensure cost effective medicines choice and reducing use of medicines or technologies considered ineffective or low priority.	• Improved use of technology e.g Electronic Prescribing and Medicines Administration system (ePMA) • Introduction of biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Updated pathways for use of medical retinal treatments. • Improved use of blood glucose testing strips with the lowest acquisition costs.	• Introduction of more biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Review use of first line biologic medicines used for chronic diseases • Improved use of Hybrid Closed Loop devices with the lowest acquisition cost • Normalising use of generic consenting principles to ensure early adoption of cost-effective agents
Service Delivery & Sustainability	• Develop a pharmacy workforce plan to help build a sustainable workforce across all sectors of pharmacy • Using community pharmacy professional expertise for common conditions management; safe medicines use following hospital discharge; blood pressure checks; contraception services; vaccination services and new clinical services as they are introduced. Ensure referral pathways are robust for complete episodes of care.	• Production of Pharmacy Faculty workforce newsletters, attendance at careers/recruitment events and supporting providers with the Foundation Year training reforms. • Introduction of Pharmacy First service; Blood Pressure Checks and Contraception services through community pharmacy. • Community Pharmacy Independent Prescriber Pathfinder Programme.is live in all HW approved sites • Working together locally and across the Region to understand and plan for future service needs to support the aseptic (sterile) preparation of medicines. • Community Pharmacy PCN Engagement Role employed to increase collaborative working between GP practices and pharmacies – focusing on and integrating work into the neighbourhood accelerator work • Delivered a Pharmacy Connect IP Teach and Treat programme to build independent prescribing in the community pharmacy setting	• Evaluation of Community Pharmacy Independent Prescriber Pathfinder Programme. • Development of strategies for workforce and community pharmacy to complement the overall Medicines and Pharmacy Strategy. • Explore options for improving the number of pharmacist FY placements in Herefordshire and Worcestershire e.g. by creating a database of Designated Prescribing Practitioners (DPP) and supporting existing pharmacist Independent prescribers to become DPPs • EPMA roll out should increase DMS referrals – work closely with Acute Trusts • Further increase vaccination programme delivery via community pharmacies
Greener NHS	• Promote the use of environmentally friendly medicines and packaging	• Ensuring sustainability considerations for all new medicine applications. • Promoting switches away from unit dose eye drops to alternative preservative free eye drop bottles. • Eliminating the use of desflurane by using lower carbon anaesthetic gases	• Improve use of inhalers with a lower carbon footprint • Consideration of available medicine/device recycling schemes. • Identifying solutions to reduce use and waste of nitrous oxide

4. Health Inequalities

Theme 4

Why is this important?

- ICB's and Local Authorities have legal duties to have regard to reduce health inequalities.
- The NHS Long Term Plan requires every local area to develop plans and take action to reduce health inequalities.
- The range in life expectancy across the social gradient of the region is 7.9 years for men and 5.6 years for women in Worcestershire; (Fingertips Public Health Outcomes Framework) and 5.4 years for men and 4 years for women in Herefordshire (Herefordshire JSNA Summary 2024).
- Marmot Review estimated that health inequalities cost society £31bn in lost production per annum, in 2010 prices. Whilst this is a national figure, its in local jobs and economies where this impacts.
- The additional treatment costs of health inequalities are estimated to be in the region of £5.5bn per year to the NHS. These will be replicated locally – equivalent to around £77m on a flat population share basis.

What have we delivered in 2024/25?

- Established the Health Inequalities Ambassador (HIA) Network comprising of 25 named individuals representing every ICS programme Board and enabler group, to apply a health inequalities to everything the system delivers. An innovative approach that has been recognised as best practice nationally.
- The ICS HIPP Board has received 12 health inequality focused discussions by HIAs across a range board and work areas.
- ICB allocated £4.4m to work programmes that have tackling health inequalities as their core purpose. With most funding allocated out to Primary Care Networks (PCNs) - over £3.9m to support the development and delivery of local health inequality plans and CVD targeted improvements as part of the Clinical Excellence and Investment Framework (CEIF).
- Development of a Core20PLUS5 dashboard by PH Herefordshire, using EMIS data for to support PCNs with the identification and development of projects to address health inequalities, as funded through CEIF.
- PH Worcs LSOA analysis of statistically high ED admissions to help inform targeting of preventative programmes of work to address unmet need.
- This includes the ICB and partner commissioned outreach prevention services in Herefordshire and Worcestershire, targeting our most underserved communities offering a range of services to meet individual needs. The Herefordshire service was shortlisted for a national award and the Worcestershire service has won an award.
- A mid-point evaluation has been completed independently by Worcester University which has provided a Plan, Study, Act, Do cycle ensuring the services continually improve and flex the local needs and insight.
- A pilot of the high intensity user programme with the British Red Cross in Worcester has been evaluated and will be rolled out across Herefordshire and Worcestershire in 2025/26. This will complement the upstream work of the LSOA ED analysis, to intervene earlier.
- The ICB was successful in a bid for Community Connectors across H&W. Employed and managed by the VCSE, the Connectors are engaging with GRT communities and Pakistani and Bangladeshi women to uncover the insights on barriers to healthcare. The valuable insights are being shared across the system services and programmes to make changes that improve access, experience and outcomes.
- This includes read across to the partnership cancer health inequality programme with Macmillan – which focuses on the same cohorts.

What are the priorities going forward?

- The aim of the ICS Herefordshire & Worcestershire strategic intent remains to make addressing health inequalities everyone's business,, through the continuation of a range tangible actions:
- A review of the HI Ambassador Network will provide a series of recommendations to enhance and strengthen the network.
- Maximising on our outreach prevention services by removing barriers to access to secondary prevention services, by targeting areas using data, engagement and evidenced based interventions.
- Delivery of the DWP Workwell programme through PCNs, supporting people who at risk of leaving employment due to ill health, to remain or return to work.
- Continuing to build awareness and skills within the workforce of the practical and relevant actions that can be taken to reduce health inequalities, to make it everyone's business.
- Evaluation of the outreach prevention services and a view on long-term sustainability.

What are we measuring?

- Development of a Health Inequalities, Prevention and Personalised Care dashboard, by bringing together HIPP related metrics from across all ICS Boards into a single view to track progress.

Who is accountable?

- Health Inequalities SROs have been identified within ICB and across all provider Trusts.
- Responsibility and delivery of reducing health inequalities sits at system, Place, PCN and neighbourhood level – as such it should cut across all work.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health.

Where can you see more detail and get involved?

CORE20PLUS5 (england.nhs.uk)
CORE20PLU5 Children and Young People(england.nhs.uk)

5. Prevention

Theme 5

Why is this important?

Integrated Care Boards have a duty under Section 14Z34 of the Health and Care Act 2022:

"Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness".

What have we delivered in 24/25?

- Tobacco Dependency services fully implemented across all acute inpatient, mental health inpatient and maternity services in H&W as of June 2024. This achieves the Long Term Plan (LTP) deliverable of all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- There have been 2,012 eligible referrals into the Digital Weight Management Programme (DWMP) between April 24 and January 25, achieving 80% of the target so far. H&W have consistently been in the top 10 referring ICBs nationally for the DWMP for this financial year so far as of January 2025 data, as well as having the highest number of practices referring into the programme (91%).
- There have been 4,198 referrals into the NHS Diabetes Prevention Programme (NDPP) between April 24 and February 25.
- There have been 225 accepted referrals into the Type 2 Diabetes Path to Remission Programme between April 24 and January 25. There is an 80% acceptance rate for referrals into the programme. 127 service users have reached 6 months and have an average weight loss of 12.5kg. 38 service users have reached 12 months and have an average weight loss of 9.6kg.
- Continuation of the prevention outreach response services in both Herefordshire and Worcestershire, providing opportunistic testing of AF, blood pressure and lipid optimisation to our most underserved communities.
- CVD strategy has been drafted. An ICB Workshop was held in November 2024 to discuss opportunities to raise profile of national CVD high impact interventions.
- The development of a local dashboard and intelligence to map the patient journey. This work will complement the CVD Prevent Dashboard and information on this has been shared to promote engagement.

What are the priorities going forward?

- A broader review of the weight management pathway e.g. needs assessment, ICS system engagement.
- Exploration of targeted work with the National Diabetes Prevention Programme local provider, and GP practices to encourage referrals from PLUS groups (GP unregistered and rural communities) and exploring opportunities for LD/A groups.
- Delivery of prevention outreach service – targeting of GP unregistered citizens and the most underserved populations.
- Continuing to support Public Health colleagues and partners with the Loneliness and Isolation work within Worcestershire e.g. community grants.
- Monitoring of the delivery and implementation of the Joy Social Prescribing App across Worcestershire PCNs.

What are we measuring?

- A key element to the NHS LTP is tackling tobacco dependence, as tobacco smoking is the largest modifiable risk factor for health. The NHS will contribute to reducing the number of people smoking tobacco by delivering on the commitments outlined in Chapter 2 of the document: Prevention and Health Inequalities.
- To help tackle obesity, the LTP states that the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ *(also outlined in the above link to Chapter 2 of the LTP).*
- These metrics will be encompassed as part of the development of a Health Inequalities, Prevention and Personalised Care dashboard bringing together the agreed deliverables into a single view to track progress against trajectories (Q2 2025)

Who is accountable?

- Prevention SROs in place across the system provider organisations.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health. This Board's function is to ensure the strategic intent of making health inequalities everyone's responsibility is realised through the application of health inequalities lens to all the work that we deliver to realise a close in the gap in healthcare inequalities through targeted prevention work.

Where can you see more detail and get involved?

- Information relating to the Long Term Plan priorities can be found here.
- Data is collated on the Regional Dashboards which can be accessed through the FutureNHS Collaboration Platform.
- Details around Your Health and Talk Wellbeing can be found on the ICS website. Information around what the service entails and upcoming events are included:
- Your Health – Worcestershire
- Talk Wellbeing – Herefordshire

6. Personalised Care

Theme 6

Why is this important?

Personalisation means health and care services delivering what matters most to each individual in a way that meets them where they are at. Engagement with our local population has told us that this relies on people having clear expectations of what is expected of them and what they can expect of their health and care professionals and services. Services are then able to offer support that is appropriate to the individual's level of need, making the best use of resources and getting the individual to the right support at the right time.

The Comprehensive model of Personalised Care outlines a three-tier approach to implementation: Universal (whole population) interventions; interventions targeted at those with Long-Term Conditions (LTCs) (30% of the population) and specialist interventions (5% of people with complex needs) (NHS, 2019). The NHS Long Term Plan outlines six interlinked components which underpin delivery: Shared Decision Making (SDM); Enabling Choice; Social Prescribing; Supported Self-Management (SSM); Personalised Care and Support Plans (PCSPs) and Personal Health Budgets (PHBs).

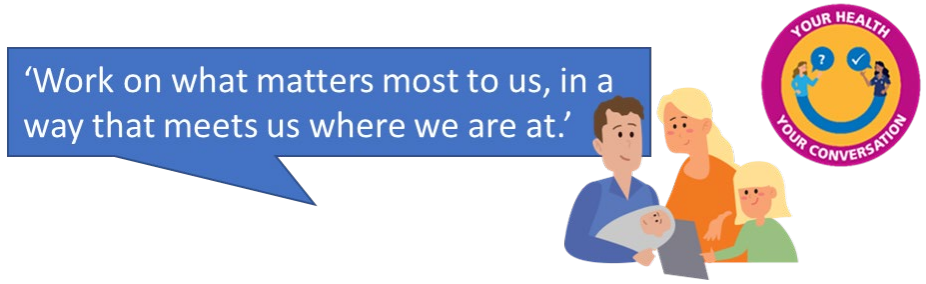
Supporting people with LTCs to self-manage is critical to addressing the rapidly growing demand this population represents . Our approach to supporting people to live well with their LTCs is to to raise awareness of how an individual's knowledge, skills and confidence, also termed activation, impacts on their ability to self-manage.

What have we delivered in 24/25?

- Developed and enhanced our training offer through the ICS Exchange platform. This now includes a Health Literacy training package and more modular and practical training.
- A health literacy network has been established, which is developing system wide health literacy commitments and a self-assessment tools to assess organisational maturity.
- A Personalised Care Toolkit has been developed to support system wide colleagues to implement personalisation approaches.
- There have been multiple examples of patient information improvements across the system, e.g. a Pulmonary Rehabilitation Guide, Endometriosis and Frailty videos.
- We continue to promote and develop our Long Term Condition video library, which provides health literate information on a range of topics.
- We piloted a Family Coaching service for children who are overweight, demonstrating positive outcomes from a whole family approach, the learning from this pilot has informed the children's hubs in Worcestershire and the service has been embedded in Herefordshire.
- We have piloted a service for high intensity users of urgent and emergency care services, SupportingYou. This is demonstrating a reduction in A&E attendances.

What are the priorities going forward?

- Continuation of the Supporting You Service in Worcestershire.
- Continuation of the Health Literacy programme.
- Continued development and delivery of the Health and Wellbeing and LTC video library.
- Promotion of the Peer Support Worker offer.
- Embedding use of Patient Reported Experience and Outcome measures across priority LTC services.



What are we measuring?

The dashboard that is in development is anticipated to measure: numbers of PHBs, number of personalised care and support plans (PCSPs), numbers of ARRS role team members and referrals to their services, the number of people accessing personalised care training and the number of registered carers. There are also specific outcome measures in place for the services that are being piloted and for the video library.

Who is accountable?

The Health Inequalities, Prevention and Personalisation Board is responsible for delivery of Personalised Care. This is a system wide meeting, with membership across health, the local authority and the Voluntary, Community Social Enterprise. The SRO is the ICB Chief Nursing officer.

Where can you see more detail and get involved?

Health Literacy - https://teamnet.clarity.co.uk/Topics/ViewItem/5813997c-1f90-477c-9de9-b10e00e42f56

Personalisation Toolkit - https://teamnet.clarity.co.uk/Topics/ViewItem/1680689e-80fe-4368-898e-b086007d97da

Any queries, please email: hw.personalisedcare@nhs.net

7. Working with Communities

Theme 7

Why is this important?
Our ambition is to place greater emphasis on early engagement and ongoing dialogue and partnerships with people and communities. From these early, open and genuine conversations we can work together with local communities, who are often better placed to create solutions to the health challenges we face.

What have we delivered in 24/25?
During 204/25 we have worked with all of our partners across the system to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This has included supporting people to sustain and improve their health and wellbeing, as well as working with people and communities to develop our plans and priorities, address health inequalities, and co-design services that equitably address the health challenges that our population faces.

Our key deliverables are detailed within the People and Communities Annual Reports and the Insights Reports:

1. People and Communities Annual Report – These reports are published annually and detail how the ICB has worked with ICS partners to engage with people and communities at a system, place and local level.
2. People and Communities Voices Report – Published quarterly, these reports collate soft intelligence and highlight key themes from the feedback garnered from people, communities and ICS partners, from across Herefordshire and Worcestershire. These insights are fed back to the key ICS and ICB decision makers for their consideration and to highlight any cross-cutting themes between services and areas of focus.

Some examples of our work include:

- NHS 10 Year Plan – Facilitated and ran two engagement events on the NHS 10 Year Plan. Representatives from Patient Participation Groups (PPGs) and health services from across Herefordshire and Worcestershire, joined us for two sessions. The interactive and informative sessions focused on national and local health priorities. Attendees had the opportunity to network, have their say on the NHS 10 Year Plan, engage on local plans, share best practices, and learn from each other's experiences. There was a lot of in-depth discussions and feedback generated from the two gatherings. The ICB has fed all the comments generated into the national NHS Change consultation, as well as internally using feedback to improve local health services and work on Integrated Neighbourhoods.
- Palliative and End of Life Care – This engagement exercise sought the views, stories and experiences of people who live, work or receive care in Herefordshire and Worcestershire, specifically targeting people who were receiving palliative or end of life care, those in the last year of life, and including carers. The feedback received was fed back to the programme board and will be used to shape the new Palliative and End of Life Care Strategy.

Priorities going forward
We intend to:

- Listen more and broadcast less, and where engagement is an ongoing and iterative process focused on what matters to people, not something 'done once'
- Hold ongoing conversations with communities about healthcare, built around community groups, forums, networks, social media, and any other place where people come together as a community
- Provide clear and timely feedback to local people about the impact of their involvement
- Develop plans and strategies that are fully informed by engagement with the public and patients
- Use insights and data to improve access to services and support reduction of health inequalities
- Focus on early prevention and supports communities to develop their own solutions to improving their health and wellbeing

Specific programme areas of focus are the NHS Ten Year Plan, Building a Sustainable Future (BSF) Programme and stroke services reconfiguration.

What we're measuring
- The ICB's compliance with undertaking our legal duties to involve the public in decision-making about NHS services.
- The feedback, sentiment and key themes that we have gathered from undertaking engagement with people and communities in Herefordshire and Worcestershire.
- The demographic details of the people and the communities we engage with. This is to ensure that we are listening to a wide and diverse range of people, and to highlight where more engagement needs to be undertaken with specific people, groups and communities.

Who is accountable?
- NHS Herefordshire and Worcestershire Integrated Care Board is responsible for ensuring that the statutory duty to involve are met across the system.
- The ICB is responsible for arranging effective health and care services for the Herefordshire and Worcestershire population; demonstrating that decision-making is clearly informed by insight
- Herefordshire and Worcestershire Integrated Care Partnership Assembly is responsible for ensuring that strategies for health and wellbeing are based on the needs and aspirations of local communities, and open to scrutiny and challenge
- The One Herefordshire Partnership and Worcestershire Executive Committee are responsible for delivering health and care services shaped by local need

Where can you see more detail and get involved?
Please see our strategy 'Working with people and communities in Herefordshire and Worcestershire' or for more information or contact the ICB Engagement Team.

8. Commitment to Carers

Theme 8

Why is this important?

Carers are a diverse group, and every caring situation is unique. Carers are people who care for a family member, a friend, or another person in need of assistance or support with daily living. They include those caring for children who have a disability or additional needs, older people, people living with long-term medical conditions, people with a mental illness, people with a disability, people with addiction, people experiencing substance misuse and those receiving palliative care.

The degree to which a carers own life is impacted by their caring role will vary. Parent carers are most likely to be caring the longest and experience the greatest financial impact. Some carers may find themselves caring for more than one person. The physical demands of caring may be greatest for those whose cared for is disabled or is frail. The emotional demands on carers may be greatest for those caring for someone at end of life or caring for someone with poor mental health.

According to the last Census (2021), there were 16,501 and 52,547 carers in Herefordshire and Worcestershire respectively, of which 7,701 (47%) and 25,171 (48%) care for more than 20 hours a week. This represents a rise in proportion of carers providing higher levels of care than in the previous census (around a third). Carer support organisations are in touch with 5,500 carers in Herefordshire, and 14,547 in Worcestershire. Worcestershire Association for Carers receives around 600 referrals per month, 85% of which result in 1 to 1 support. Local intelligence tells us that the complexity of caring roles is increasing. This includes carers maintaining responsibility for increasingly complex clinical needs against increasingly stretched finances. The number of carers is expected to rise by at least 60% by 2030 (Carers Trust).

By supporting carers, we enable people to remain living well within their communities, reducing the demand on health and social care and improving the health and wellbeing of both the carer and the cared for.

What have we delivered in our second year 2024/25?

1. Continued to support system partners to progress against Commitment to Carers statements.
2. Facilitated regular ICS Carer Reference Group (CRG). Key areas progressed include:
    - Empowering Carers at Discharge – working with pilot inpatient wards as part of the Accelerating Reform Fund project to identify and support carers, capturing learning to share systemwide
    - Improved recording of carer status across system partners.
    - Herefordshire carers strategy refresh and introduction of the Herefordshire Carers Partnership forum
3. Enabled opportunities, through the CRG and place-based forums, for carers to share their views and lived experience, and contribute to co-production of improvements in carer support.
4. Incentivised the following areas in primary care through the 2023/24 CEIF contract:

- Identification of GP practice carers lead.
- Delivery of carer awareness training.
- Drive to increase the number of carers identified and recorded in EMIS.
- Signposting to local carers support.
- Proactive offer of other support to carers, e.g., social prescribing.

What are the priorities going forward?

1. Continue the drive to recognise and support more carers across the system.
2. Capture and share Accelerating Reform Fund learning to enable improvement in carers support across Herefordshire and Worcestershire.
3. Continue to support carers forums across the two counties, strengthening the carer voice in planning and provision of services.
4. Work with system partners to develop carer awareness training package for staff.
5. Work with system partners to ensure carers voices are heard and the profile of work in support of carers is raised.

What are we measuring?

1. The number of carers identified across the system.
2. Qualitative progress towards the system Commitment to Carers by each provider organisation.
3. Feedback on patient and carer experience of services via periodic Healthwatch surveys.

Who is accountable?

The Carers programme is a component of the Personalised Care programme and accountability sits with the Health Inequalities, Prevention and Personalisation Board. The Carers Reference Group was established to develop and enable delivery against our system commitment to carers. These commitments are integral to place-based Carer Strategies held by our County Councils, which are supported by carer partnerships in both Herefordshire and Worcestershire.

Where can you see more detail and get involved?

Visit the ICB carers resource hub: [Resource Hub for Family, Carers and Loved Ones :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)]

9. Supporting the Armed Forces Community

Theme 9

Why is this important?

The Armed Forces community is made up of serving personnel, veterans and their Family's and carers. There are an estimated 2.4 million veterans living in the UK. Within Herefordshire and Worcestershire there are currently approximately 30,000 military veterans. Herefordshire and Worcestershire ICB has a high density of veterans making up about 4.7% of the patient base. The Armed Forces Act 2021 makes it a legal duty on specified public organisations to have due regard to the principles of the Armed Forces Covenant when exercising their functions. These duties apply to ICBs. As an ICB we are working with system partners to give due regard to the health and social care needs of the Armed Forces Community in the planning and commission of services. We are working on building our engagement with this community to build our understanding for how we can support their health and wellbeing.

What have we delivered in our second year 2024/25?

Within the first two years alongside signing the armed forces covenant, the ICB has been an integral part in supporting this cohorts through both primary and secondary care. Leads from the system were invited to an Armed Forces Health Symposium where there were valuable conversations to take away to help deliver the promises to the Armed Forces Community.
With the introduction of the Talk Wellbeing Service in Herefordshire, they have reported a large number of veterans engaging with their services and through the training which has been undertaken by the team has supported clinicians in engaging with this group.
More practices in Worcestershire are signing up to the veteran friendly practice scheme too with compared to the first year we are nearly 10% higher in sign up rates.

What are the priorities going forward?

Within the next year it is key to ensure that we can continue to keep signposting the Armed Forces community to healthcare available within the system and to continue the identification of them within the healthcare system.
We will continue to encourage practices to sign up to the veteran friendly practice scheme.

What are we measuring?

There are two key measurables which we are working towards.

1. Increasing the number of veteran friendly practices across Worcestershire (as Herefordshire are already 100%). This is being collated by the Royal College of General Practioners
2. Increase the number of coded veterans on clinical system, initially in Primary Care. This is being supported by local BI teams to assist in sourcing the data.

Who is accountable?

The Clinical Lead on the project is Dr Jonathan Leach OBE, with project management in place to support. This will be delivered through following the key commitments from the Armed Forces Forward View that ICBs use indicators to measure progress. We will work with partner and provider organisations to develop and deliver objectives and actions to reduce any health inequalities and improve healthcare for this population. We will work closely with the service users to understand their needs and requests within the services.

Where can you see more detail and get involved?

If you have any questions or for more information on how to get involved or how this community could benefit your work, please email: hwicb.partnerships@nhs.net

10. Addressing the specific needs of victims of abuse

Theme 10

Why is this important?

The ICB has a duty to address the particular needs of victims of abuse, including an assessment of need. Working with health, social care and statutory partners to support victims, tackle perpetrators and prevent abuse. This includes reducing the health inequalities faced by victims of abuse.

There are a range of initiatives and services in place that will be built upon over the lifetime of the joint forward plan, these include:

- The Serious Violence Duty (SVD) is based on a public health approach which requires co-operation and collaboration including data across a range of partners. This approach to tackling violence means looking at violence not as isolated incidents or a sole police enforcement problem. It is about taking a multi-agency approach to understanding the causes and consequences of serious violence and focusing on prevention and intervention.
- Training plan to support upskilling of talk wellbeing and your health outreach services to spot those vulnerable to domestic abuse / serious violence etc
- Collaboration between Policing partners and roving vaccination teams in areas of deprivation and inequality.
- Pan West Mercia data group in place – With leadership from Herefordshire Council.
- District collaboratives – working between district councils, primary care networks, community support officers, voluntary sector to identify needs in the local community
- Funding secured by Herefordshire PCN's to collaborate with 3rd sector organisations supporting victims of domestic abuse, exploitation and youth crime.

What have we delivered in our second year 2024/25?

Services have been developed and commissioned responding to identified cohorts or individuals to support prevention and reduction in serious violence, these are listed below:

- Serious violence duty actions including strategic needs assessment to support action.
- SVD - Develop system wide data group in partnership with Police, Local Authority, West Midlands Ambulance Service, CSPs and other relevant organisations.
- Worked with partners in preparation for implementation of the Victims and Prisoners Act (2024).
- Delivered trauma informed care training, supported by the Integrated Care Partnership Assembly.
- Commitment to integrate the Workwell programme, supporting people to get back to and stay in work, with the IRIS programme in 2025/26.
- Supported the White Ribbon Campaign across system partners, seeking to end male violence against women and girls.

What are the priorities going forward?

There are a number of services and programmes in place to ensure that we are addressing the needs of victims of abuse, these include:

- **Domestic Abuse and Sexual Violence:** Working with the Police and Crime Commissioner as interim convener of the Victims and Prisoners Act 2024, implementing required actions.
- **IRIS:** A specialist domestic violence and abuse training support and referral Programme for General Practices that has been positively evaluated in a randomized controlled trial. Iris is a collaboration between primary care and third sector organisations specialising in domestic abuse. This service will continue in 2025/26 in Herefordshire, supported by Herefordshire Council and NHS Herefordshire and Worcestershire.
- **Climb:** A service which delivers early intervention and prevention for those at risk of criminal exploitation.
- **Purple Leaf and West Mercia Rape and Sexual Abuse Support:** A charity providing specialist front line support independent advocacy counselling and those affected by any form of sexual violence
- **Drive perpetrator programme:** A project which aims to reduce the number of child and adult victims of Domestic Abuse by deterring the perpetrator (in Place).
- **Steer Clear:** Prevention Programme working with young people who have been or could be involved in knife crime, continuing in 2025/26.

What are we measuring?

The overall approach is to ensure that all partners are sharing data and intelligence to build up a comprehensive picture of individuals and communities at risk of serious violence, domestic abuse or sexual violence. Those key hotspots across the system are being looked at and appropriate interventions will be put in place. This will be developed during 2025/26, working with West Merica Police and broader partners through Community Safety Partnerships.

Who is accountable?

The integrated care board (NHS Herefordshire and Worcestershire) has a specific duty to address the particular needs of victims of abuse. This will be delivered at place through the Herefordshire community safety partnership, Worcestershire community safety partnership and the crime reduction board.

11. Digital, Data, Analytics and Technology

Theme 11

Why is this important?

We cannot improve health outcomes and reduce health inequalities without data and technology, which is key to making health and care services more accessible to parts of our communities. This can be via remote and virtual care, better planning of services and enhanced sharing of patient information. Technology and data can play a core role to reduce elective backlogs, mitigating urgent care pressures, continuing to deliver responsive and timely community and primary care. Digital products can enable personalised preventative care by giving people more control over their lives by providing self-assessment, education, motivation and monitoring to help them manage their own health. We must ensure digital services are inclusive and provide for everyone's needs by listening to and designing with communities with seldom heard voices more closely.

What have we delivered in 2024/25?

- Written and published the system's Digital and Cyber Strategies to outline our ambitions and direction of travel.
- Continued the work on optimisation and increasing adoption of the Shared Care Record. This included a comprehensive evaluation of the service to date and taking action on the findings.
- Developed and enhanced our patient facing digital offer and Patient Portal to provide a front door to patients under our care.
- Worked closely with our system partners in work towards levelling up digital maturity.
- Embedded the enhanced BI and analytics service, delivering more aligned and standard performance and BI reporting and tools. Continuing to progress with the capabilities needed for effective population health management.
- Continued to work on refreshed technology to support staff capacity, efficiency and organisational productivity specifically unified communications, telephony and networks.
- Commenced work on Artificial intelligence pilots and initiatives to support productivity.

What are the priorities going forward?

Pillar 1: Getting the right infrastructure in place

- Sourcing and developing the essential operating systems, technology and software to enable us to deliver the best outcomes
- Levelling up the digital maturity and architecture of organisations

Including: Shared Care Record, Electronic Patient Records, Frontline Digitisation.

Pillar 2: Enabling integration of our data sources

- Ensuring systems and applications can talk seamlessly to each other – maximising interoperability
- Improving information to support decision-making

Including: Data Sharing Agreements, Agreed Standards, Data Security/Protection, Groundwork for Population Health Management and Federated Data Platform.

Pillar 3: Creating an environment to enable people to self-serve

- Providing our people with easy-to-use apps and systems, where they can access their information and help manage their own care and needs, closer to home where possible

Including: Patient Portal/NHS App, Patient access to their records, Improved and accessible information

Pillar 4: Supporting the transformation of services 'around the user'

- Ensuring all NHS staff have access to and are trained in the use of the right tools and systems to deliver the best care to and outcomes for our people

Including: AI and Automation Principles, Continuing Health Care, Piloting newer technologies

What are we measuring?

Each project measures outcomes and success. This will include improvements in productivity, efficiency, usability and usage. For example the number of people across our system using the Shared Care Record.

Who is accountable?

One of the ICS Programme Boards focuses on Digital, Data, Analytics and Technology and brings in the ICS Digital Clinical Leads, these two groups will be responsible for setting the digital agenda and collective vision. Their work will be informed by the ICS Analytics Board, Technical Design Authority and Clinical Safety Officer Group on digital transformation and improvement.

There are a number of Groups and Boards focusing on the technicalities of the deliverables including Shared Care Record, Cyber and Data Security and Primary Care. Based on the structures already in place in the NHS Trusts and primary care system in Herefordshire and Worcestershire, the ICB Digital Leaders will work closely with the organisation Boards and Steering Groups. There are strong links to the other five ICS Forums where digital plays a central role and vice versa delivery teams are accountable for the outcomes they are set up to deliver.

Where can you see more detail and get involved?

There is a digital section on the ICB website

Digital innovation :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

12. Research and innovation

Theme 12

Why is this important?
As a system we recognise the importance of promoting research an innovation in the provision of healthcare. The ICB Medical Director holds the responsibility for promoting this, ensuring it is clinically led and underpins the delivery of the Joint Forward plan.

What will we deliver and when?

- **Assets:** ICS Academy, Knowledge and research school, The Herefordshire and Worcestershire research consortium. Worcester University - Allied health professional school. I&I Bid – Engaging underrepresented communities. (Personalised care.) Innovation – Pods. Research network.
- **Resources:** Increase access to funding, ,E.g. NHIR and working in partnership with the academic health science network.
- **2024/25 priorities:** Delivering the new **5 year research and innovation strategy** developed and published last year. This will be led by the Herefordshire and Worcestershire research consortium, reporting into the ICS academy steering group.

Innovation - What are we building on?
To help promote innovation across the system, the ICB has created an Innovation Hub called: The CO-LAB www.icscolab.org.uk We believe this is the first example of an ICB-led Innovation Hub. It exists both virtually and physically, located deliberately in a rural community hospitals (Kidderminster Treatment Centre), where we know innovation traditionally receives less focus, but has real chance of improving health services. Approaching it's first year operating, it has had a number of successful initiatives and adoptions of innovation, including:

New Ways of Working and developing new knowledge:

- In partnership with Warwick University's "West Midlands Health and Wellbeing Innovation Network WMHWIN", The CO-LAB ran a 5-day Agile approach for one of our Trusts to help them co-design a new Heart Failure @ Home pathway with a "User focus". The co-design event included staff, commercial innovators and patients. Outputs included a framework for staff to use if interested in this type of approach, supplemented by education webinars.
- It is regularly used as a space anyone in the ICS can use for free to re-imagine pathways and processes. For example, it is used monthly by one of the trust's Transformation guiding board as part of it's Virginia Mason Programme.

Trial and Adoption of Innovation:

- The CO-LAB hosted certified VR anti-anxiety headsets and approached teams to trial. Following a successful trial on our Pediatric Oncology wards, where they reduced anxiety in children needing cannulas, improving patient experience and reducing clinic time, a number of headsets have been purchased for long-term use on those wards and are being trialed across multiple other wards within two Trusts (one within our ICS and one in a neighboring ICS)
- As the host for the first teleconsultation pod from a French-based innovator, The CO-LAB has worked extensively with the company on feasibility, demoing and real-world testing. The pods are now being used in the South East of England and is being deployed in system as part of an NIHR bid for the ICS.

Partnerships:

- The CO-LAB has partnered with innovative organisations to understand opportunities and art-of-the-possible to highlight to workstream leads, these include:
    - ICS Partnership with Amazon Web services, where the ICB participates in their Global Healthcare Incubator.
    - Satellite Catapult, currently arranging a trial of drone technology
    - IASME, working with a local innovator to train unemployed Neurodiverse young people for employment in cybersecurity
    - Partnership with multiple Universities, including a successful partnership with the University of Manchester on a systematic review of literature on the implementation of AI in health and care

Staff and wellbeing:
Early on in the hub's life it became apparent there was a significant ask for finding and spreading innovation practice for wellbeing of staff. Initiatives have included:

- Partnering with a Hypnotherapy provider, we setup an agreement to offer the hub's use whilst closed in return for free provision of sessions to front-line staff to address anxiety, sleep deprivation and relaxation. Sessions typically have 20 attendees, with great feedback
- The Hub is provided free of charge to ICS groups who want to host staff celebration or wellbeing events. For example, it is used as part of the International staff process, providing an area for them to come together, and celebrate pre-exam.
- NHSE provided sessions for Wellbeing in Leadership Roles, is being hosted at hub for several trusts in and out of the ICS.

Herefordshire and Worcestershire Research consortium

- Is the system wide group overseeing research in the system, we are looking to widen its brief to look at innovation too as part of the strategy refresh.
- It monitors performance / recruitment across the system, but also looks to broaden the scope of our research beyond organisational boundaries, looking at how we work with the local university as it develops
- Will hold oversight of delivery of the new strategy.
- Now reports into the ICS academy steering group, where previously it was not part of any formal governance.

13. Greener NHS

Theme 13

Why is this important?

The climate emergency is also a health emergency.

Poor environmental health contributes to major diseases including cardiac problems, asthma and cancer. Unaddressed, it will disrupt care and affect patients and people at all stages of their lives. Climate change impacts every single person and as such we all have a duty and responsibility to do something about it.

Herefordshire and Worcestershire ICS are committed to embedding environmental and sustainable practices into all areas of our work, as an enabler for better health. We see the work of the green agenda aligned to our principles of delivering high quality care; reducing health inequalities and improving the health and wellbeing for the communities we serve.

Reducing emissions will mean fewer cases of asthma, cancer and heart disease. Many of the drivers of climate change are also the drivers of ill health and health inequalities. In the UK, air pollution is attributable for 1 in 20 deaths, making it the greatest environmental threat to health. We can all play our part in tackling climate change through reducing harmful carbon emissions, which will improve health and save lives.

Environmental health impacts are often unfairly weighted in areas of deprivation and minority ethnic groups. For example, Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.

What have we done in our second year, 24/25?

- Deepened relationships with public sector partners to support strategic developments and build awareness to our populations
- Continued to embed the system-wide ICS wide Sustainability Impact Assessment (SIA) into decision making.
- Increased the number of virtual appointments and virtual wards available to our patients thereby reducing carbon emissions through travel.
- Continued to reduce the amount of nitrous oxide used through identifying leaks within our system and changes to manifolds.

What are the priorities going forward?

- To refresh the HWICS Green Plan for 2025-8.
- To continue to increase the use of low carbon inhalers.
- To continue to strengthen our networks and connections to create greater impact.
- To strengthen our focus on Clinical Transformation pathway opportunities.
- To support our efficiency and productivity agenda by reducing waste across the system.
- To support delivery of social value

Who is accountable?

- Greener NHS SROs have been identified within ICB and across all provider Trusts
- Responsibility and delivery of Trust Green Plans sit at Trust provider level.
- Collectively agreed ICS Greener NHS actions sit at ICB level, working collaboratively with Providers to deliver through their existing governance groups.
- Engagement is undertaken directly with SROs, and operational working and engagement through a system Sustainability Leads group.

Where can you see more detail and get involved?

- ICS Green plan
- ICB Green Board papers

14. Mental Health Collaborative

Theme 14

Where we are now? – What we have achieved together

The Mental Health Collaborative met the national targets for:

- perinatal mental health
- access to mental health services for children and young people
- access to community mental health services
- recovery and improvement rates for people who have received talking therapies
- health checks for people with severe mental illness

The Collaborative recognised the challenge of Dementia diagnosis in our system, establishing a separate programme board with exclusive focus on Dementia care. A plan to improve dementia diagnosis is now in place that is tackling raising awareness and improving support for people living with Dementia.

A revised model of children and young people's emotional wellbeing and mental health service was procured, resulting in Melo being launched in April 2025.

The Collaborative conducted a governance review in 2024/25 to ensure there was greater focus on programme delivery, clearer accountability to the ICB and stronger collaborative strategic leadership.

Where next? – Areas of focus

The Collaborative will focus on five key delivery areas for 2025/26:

- Improving children and young people's mental health so there is multi-faceted and stratified support offer to children and families. This will include embedding the new Melo service, further expansion of MH in Schools and roll-out of Primary Partnership in Neurodivergence in Schools initiative. Additionally, the Collaborative will commission a support service for neurodivergent children and their families. The Collaborative wants children to be supported in a more timely manner and will focus on bringing down CAMHS waiting times.
- Inpatient care in acute psychiatric units. The Collaborative has put in place financial risk/share arrangements to remove the use of inappropriate out of area beds, so that people are cared for closer to their local communities and their families. Alongside this, length of stay will be reduced so that patients have a better opportunity for timely recovery. This will allow resources to be re-purposed for community mental health.
- The redesign of adult mental health acute and rehabilitation clinical pathways (using the GiRFT approach). This will deliver more modern, sustainable and appropriate recovery pathways, and the design will be undertaken with extensive consultation with patients, staff and wider community.
- Review of Adult Community Mental Health Services. This comprehensive review will ensure services provide the right support at the right time, and where necessary assertively, so that there is no risk of the homicides in Nottinghamshire occurring locally.
- Post-diagnostic dementia support. The offer will be recommissioned and will take account of feedback from Healthwatch consultation.

Strategic Focus:

For 2025/26, the Collaborative's strategic focus will be to:

- Ensure it is ready for the implementation of the Mental Health Bill
- Develop and agree a Mental Health Strategy for the local system. This will take account of the new 10 year NHS strategy and ensure that mental health remains a system priority.
- Review arrangements to ensure they are fit for purpose for the changing operational model for ICBs

15. NHS Trust Collaborations

Theme 15

Where we are now?

- Wye Valley NHS Trust (WVT) has been a full member of The Foundation Trust Group since 2016.
- Worcestershire Acute Trust (WAHT) became a full member of The Foundation Trust Group from July 2023 resulting in a joint Chief Executive and Chair across the four Foundation Group Hospitals.
- From April 2025, both trusts have a joint Acting Chief Executive Officer.
- WAHT and WVT has completed a service sustainability analysis, which influences areas of collaboration between the two trusts. There is continued mutual aid for vulnerable services with WVT being lead provider for dermatology and WAHT for MaxFax. Other areas identified as priority services for collaboration include ophthalmology, haematology and Interventional Radiology.
- WAHT and Herefordshire and Worcestershire Health and Care Trust – A Memorandum of Understanding is in place and a work programme agreed. Current work areas include international nurse recruitment, workforce wellbeing and vaccination, the systemwide stroke pathway and urgent care pathway (including frailty and virtual wards). Practical coordination of services between the two trusts is helped by colocation of the acute trust Single Point of Access team in HWHCT premises alongside their Care Navigation Team.
- WAHT and University Hospitals Birmingham – a range of tertiary services provided for Worcestershire residents including some cancer services, renal services, cardiothoracic and trauma services.
- WAHT and University Hospitals Coventry and Warwickshire – MDT working on clinical services in head & neck cancer, Improvement partner for Virginian Mason methodology.
- WAHT and Birmingham Women's and Children's Hospital- collaborative work around paediatric services and work ongoing to collectively support further delivery of paediatric surgery in-county and the expansion of paediatric High Dependency Care at Worcestershire Royal Hospital.
- South Midlands Pathology Network – board approvals received for LIMs outline business case and SM Pathology network collaborative.
- Continued member West Midlands Cancer Alliance.
- Foundation Group collaboration includes work to consolidate pharmacy aseptic medicines preparation facilities across the Group.
- At Place level in Worcestershire, provider collaborative work also includes services within primary care, with close collaboration managed through the Interface group.
- The West Midlands Mental Health and Learning Disability and Autism Provider Collaborative was informally formed in 2021 bringing together 7 Trusts in the West Midlands, including Herefordshire and Worcestershire Health and Care NHS Trust. The specialist inpatient pathways of forensic, LDA< CAMHS, adult eating disorders and mother and baby services are under this Collaborative arrangement and the collective leadership has also developed a governance structure to work on the greatest challenges in the H and LDA and opportunities to address these through working at scale. This has included supporting local systems (ICSs) to improve population health outcomes, building on best practice and developing a regional approach developing innovative clinical and workforce solutions, horizon scanning to maximise WM PC influence and implementation of changes.

Where next? – Areas of focus

- Shared Executive leadership between Acute Trusts will help to continue to strengthen collaborations during 2025
- Within Worcestershire, it is recognised that there is potential to improve patient pathways through increased collaborative working between the acute and community trust.
- The ICB-led Building a Sustainable Future program has identified key services for collaborative working across the ICS.
- Provider review of areas of opportunity around corporate support functions at Foundation Group, system or Place as appropriate
- Taking forward the review of options for Stroke services across H&W
- Continuing the development of a Pathology Network across the South Midlands

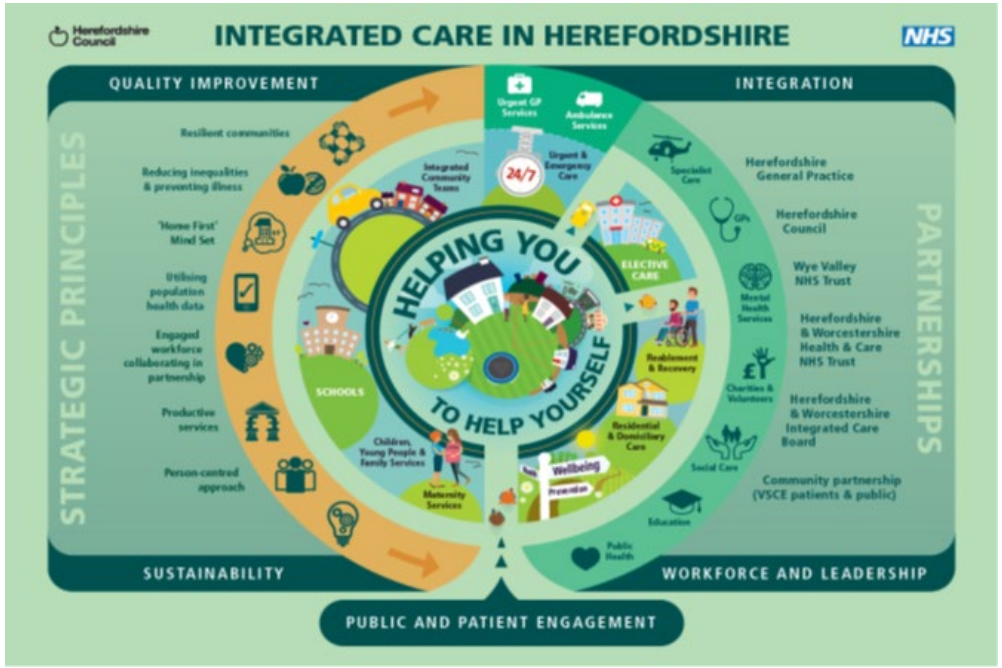
How we will get there? – Development steps

- Stratify provider collaborative arrangements based on service and population needs.
- Progress collaborative working through the Building a Sustainable Future program
- ICB-led methodology for vulnerable services is twofold:
  - At operational level to manage existing or at risk vulnerable clinical services with identified models to support in the short term.
  - Strategically a provider led self-assessment of all clinical services to theme by sustainability / resilience and / or growth domains as part of potential collaborative service model.

16. One Herefordshire Partnership

Theme 16

The One Herefordshire Partnership (1HP) drives the co-ordinated planning and delivery of the Herefordshire health and care system in order to deliver improvements in health and care outcomes through integrated working. 1HP partners share strategic objectives and reviews business cases, provides a forum for discussion on care pathway changes, oversees the Better Care Fund (BCF)and approves the objectives set by the Primary Care networks (PCNs).



Where we are now? What have we delivered in 2024/25

- Making a variety of improvements across the Best Start in Life programme
- Improving the primary/secondary care referral interface with direct access and internal referrals
- Providing improved value for money through the BCF with 22% more D2A purchases in 2024 than in 2023
- Improved collaboration with the Talk Community Healthy Lifestyle Service and delivering Talk Wellbeing Health Checks
- Developed a co-located Community Referral Hub with a SPA and virtual ward, delivering a material increase in WMAS referrals taken from the CAD

Where next? – Areas of focus

1HP 2025/26 priorities will remain as in the previous year.

- **Best Start in Life (HWBB Priority)**
- **Good Mental Wellbeing (HWBB Priority)**
- **Primary/Second Care Interface**
- **Integrated Urgent and Emergency Care**
- **Integrated Neighbourhood Development**
- **Driving Value Through the BCF**
- **Herefordshire Together (supporting VCSE schemes that deliver against 1HP priorities)**

In terms of improvements to outcomes, the partners are finalising a framework based around:

- Prevention and Population Health (HWBB Priorities) including child health, talking therapies and social isolation
- Management of complex community based care, including emergency admission reduction, discharge delay reduction and residential and care home admission reduction
- Improving access to services and early identification, including reduction of elective waiting times and increasing cancer identification

How we will get there? – Development steps

- Develop and agree the outcomes framework that sets out the improvements we will expect to see against the priorities
- Continue to refine the BCF and seek opportunities to improve value for money
- Consider how we might incentivise the urgent and emergency care pathway for general practice in order to prevent acute admissions
- Consider the structure of the partnership in light of the major changes to both the wider NHS structure and local authority boundaries and responsibilities

17. Worcestershire Place Partnership

Theme 17

The Worcestershire system spans many partner organisations and sectors. Whilst many have been working together for years, this is now being extended to deliver even greater collaboration as we strive to fully integrate health, public health and social care.

We recognise the required shift to achieve greater integration and have been working to establish a framework for the culture within which we will work, between key partners, by agreeing and centring on our **shared vision and values** and putting people in our communities at the heart of everything we do. We understand that an **equal partnership** between NHS and health, local government and our VCSE sector is vital, and we have been developing shared health and wellbeing principles as follows:

Together we will:-

- Place equal value and emphasis on the **physical health and mental health** and wellbeing
- **Protect health** and focus on supporting the **conditions for good health**
- **Focus on prevention**; to prevent, reduce or delay need for care and support
- **Improve health disparities** particularly for those who are vulnerable, disadvantaged or living with a disability
- **Listen** to people who use our services and strive to improve, ensuring a **quality experience**
- Deliver **proactive and better coordinated** care to help people to stay healthy and independent**,** based on each person's needs
- Work together in an **evidence-based way** to take to **system wide approaches** to improve health across the life course
- Maximise **shared funding opportunities** to achieve **best value** (including social value)
- Develop and support our **workforce**

District Collaboratives: District Collaboratives bring together statutory health and care services, District Councils, the Voluntary, Community and Social Enterprise (VCSE) and wider partners to deliver against shared priorities with their communities. This is a new way of working and represents a shift in how communities and health and care providers work together. This should see greater local autonomy and resources directed into communities to enable greater control over addressing the underlying causes of ill health through interventions people design for themselves. There is a focus upon building strong, resilient communities, understanding and being able to optimise local assets, whilst articulating gaps and opportunities available to further improve the local offer. We are increasingly seeing that local partnerships are most effective in improving population health and tackling health inequalities.

Where next? – Areas of focus

- Priorities identified by the Worcestershire Health and Wellbeing Board: Good mental health and wellbeing, supported by (1) Healthy living at all ages (2) Safe, thriving and healthy homes, communities and place (3) Quality local jobs and opportunities
- Place based integrated performance report to drive assurance and prioritisation of activities.
- Strong integrated GP leadership across whole county and ensure full support to mature and develop
- Identification and building on local place-based assets to provide foundation for further 'left shift'
- Shared delivery plan across local NHSE Provider Alliance; shared delivery demonstrates maturity of relationship
- Support development and sustainability of VCSE Alliance as an equal partner
- Deliver agreed model of integrated urgent care and frailty action plan, further reducing pressure on ED front door and thereby supporting flow.
- Increasingly looking at shared resources, building on the work of place-based intelligence, engagement and communication cells.
- Support improvements to Stroke pathway to ensure sustainability and high-quality outcomes
- Consider wider integration with other statutory partners eg police, fire

How we will get there? – Development steps

- Developing relationships of trust through working together to deliver place priorities, as listed above.
- Develop systems thinking to enable shared understanding of challenges and solutions across providers.
- Consider implications of adopting Community Paradigm approach and how we can harness local assets to support District Collaborative objectives
- Maximise impact of the reinvigorated Place Leadership, collaboration between HWB and other place-based governance infrastructure to deliver sustainable improvements.

Worcestershire Place Partnership – Progress

The following 3 priorities have been identified and agreed by Worcestershire Place Partnership:

- **Frailty:** move to a systemwide model of care where people identified as living with frailty are proactively and reactively cared for at home, in their local neighbourhoods, and in hospital, by members of the integrated Worcestershire place-based teams.
- **Long Term Conditions:** priority areas of work - heart failure, diabetes and COPD (respiratory).
- **Integrated Neighbourhood Teams/Neighbourhood Health:** prototyping work is progressing in 3 Integrated Neighbourhood Teams Accelerator Sites across Worcestershire. The three sites have identified their priority areas which are to progress proactive care for frail patients in the community (2 sites) and focus on improving the proactive management of diabetes in the community (1 site).

18. Pan system collaboration – The Office of the West Midlands Integrated Care Boards

Theme 18

The six ICBs in the West Midlands are collaborating to form an Office of the West Midlands. NHS Birmingham and Solihull ICB will host the staff performing these functions from 01 April 2023 and staff will transfer to the BSOL ICB in July 2023.

From April 2024 BSOL will also host for the Midlands team supporting all 11 ICBs for the delegated specialised commissioning portfolio.

Herefordshire and Worcestershire ICB will be leading a project on development and delivery of the dental access recovery plan.

The VISION:

Through at scale collaboration and distributive leadership, the Office of WM will add value and benefit to a shared set of common goals and priorities for West Midlands citizens and patients.

Purpose:

The core purpose is to :

- To commission a set of agreed functions at a West Midlands level on behalf of 6 ICBs through shared leadership and joint decision making
- To identify shared priorities and goals and clear projects and work programmes to deliver them
- To bring together in a single host ICB the shared teams and staff supporting the Office of the West Midlands and their ICBs.
- To develop distributive leadership and expertise across an agreed range of functions/teams for the benefit of all ICBs
- To provide a single coherent voice for the West Midlands ICBs where appropriate /a single point of contact/shared voice for change
- To share learning and support improvement across the ICBs
- To achieve best value and efficiency by working at scale where appropriate

Work Programme	Host ICB	Lead CEO
POD / GMaST / Complaints / Secondary Dental – Dental access recovery plan	Herefordshire and Worcestershire	Simon Trickett
Operating Model Development	Coventry and Warwickshire	Phil Johns
Collaboratives		
Integrated Staff Hub and OWN hosting	Birmingham and Solihulll	David Melbourne
Specialised commissioning		
Commissioning Support Service Review	Shropshire, Telford and Wrekin	Simon Whitehouse
NHS 111/999 Services	Black Country	Mark Axcell
West Midlands Combined Authority		
Immunisations and Vaccinations	Staffordshire and Stoke	Peter Axon

NHS
Office of the West Midlands
Partnership of Integrated Care Boards

Herefordshire and Worcestershire Integrated Care System

Joint forward plan – 25/26

Appendix 3: Statutory Requirements checklist

This section includes a **cross reference to the two Health and Wellbeing strategies** for Herefordshire and Worcestershire, to identify the extent to which the JFP addresses the priorities set out therein.

The section also identifies which section of the JPF (or other documents) **show how the ICB will meet its statutory duties** as laid out in Appendix 2 of the mandatory guidance.

Mapping to the Herefordshire Health and Wellbeing Strategy

Herefordshire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this
Core Priority Areas	Best Start in Life For Children	• **Appendix 1, Theme 1** (Maternity and Neo-natal Care), **Appendix 1, Theme 2** (Early years, children and becoming an adult): The core focus of these two areas is directly aligned to the Health and Wellbeing priority or providing the Best Start in Life for Children.
	Good Mental Wellbeing throughout life	• **Appendix 1, Theme 6** (Learning Disability and Autism Care), **Appendix 1, Theme 7** (Mental Health and Wellbeing), **Appendix 2, Theme 15** (Mental Health Collaborative): The core focus of these three areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life.
Supporting Priorities	Improving access to local services	• **Appendix 1, All Themes** – Improving access to core NHS services is a priority running through the work programmes of all core themes, including through the development of virtual wards and an overall ambition to invest more in preventative activities and to provide best value healthcare in the right setting. • **Appendix 1, Themes 11, 12 and 13** (Primary Care Themes): Improving access for primary care services will be a specific focus through implementation of the National Access Recovery Plan. Furthermore, the ICB is responsible for commissioning Dental Services from April '23 and is prioritising work to improve access, particularly for those with greatest need. • **Appendix 2, Theme 11** (Digital data and technology): A key theme of our digital strategy is to enable greater access to service through digital platforms and to support the development of virtual wards.
	Support people to live and age well	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, All Themes** – Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities • **Appendix 2, Theme 5 (Prevention):** This sets out how NHS services will work to support local prevention strategies through specific interventions.
	Good work for everyone	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.
	Support those with complex vulnerabilities	• **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 6** (Learning Disability and Autism Care), These sections outline out work to support people with complex needs. Other services, particularly Primary Care also tailor their approaches to support complex needs. • **Appendix 2, Theme 4** (Health Inequalities), **Appendix 2 Theme 6** (Personalised Care), **Appendix 2 Theme 8** (Commitment to carers), **Appendix 2, Theme 9** (Support to veteran health), **Appendix 2, Theme 10** (Addressing the needs of victims of abuse): These sections outline specific local actions that will ensure that NHS partners support those people with complex vulnerabilities.
	Improve housing, reduce homelessness	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes.
	Reduce Carbon Footprint	• **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.

Mapping to the Worcestershire Health and Wellbeing Strategy

Worcestershire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this	
Core Priority: Good Mental Health and Wellbeing	**Whole Population Approach**	• **Appendix 2, Theme 17** (Worcestershire Place Partnership): This section outlines how partners will work together at county and district collaborative level to put integration at the heart of our service delivery.	The core focus of these areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life: • **Appendix 1, Theme 6** (Learning Disability and Autism Care) • **Appendix 1, Theme 7** (Mental Health and Wellbeing) • **Appendix 2, Theme 14** (Mental Health Collaborative)
	Align and Support Local Strategies	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 11** (Digital, Data and Technology):	
	Commitment to reducing health inequalities	• **Appendix 2, Theme 4** (Health Inequalities), • **Main Document, Population Health Management section (p27)**	
	Engage local communities over the lifetime of the strategy	• **Appendix 2, Theme 7** (Working with Communities) • **Appendix 2, Theme 8** (Commitment to Carers)	
Supporting Priorities	**Healthy Living at All Ages**	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 4** (Frailty), **Appendix 1, Theme 8** (Long term conditions): Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities. • **Appendix 2, Theme 5** (Prevention)**:** This sets out how NHS services will work to support local prevention strategies through specific interventions.	
	Quality local jobs and opportunities	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.	
	Safe, thriving and healthy communities and places	• **Appendix 2, Theme 7** (Working with Communities): This section outlines how we will listen to our communities and use this intelligence to make sure we focus on doing the right things. • **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.	

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Describing the health services for which the ICB proposes to make arrangements.	**Chief Executive**	**Appendix 1, Core Areas of Service** provides an overview of the range of services that the ICB is making arrangements for. The ICB Operating Model and System Development Plan provides more detail on specific areas to demonstrate how services are organised and developed.
Duty to promote integration	**Executive Director of Strategy, Health Inequalities and Integration**	The duty to promote integration is inherent to the **design of the whole local system, as demonstrated in**: Integrated Care Strategy, JPF Main Document, JFP **Appendix 1 (Core areas of focus) and Appendix 2 (Enablers)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. Additionally, there are a myriad of other documents that outline this, including: ICB Operating Model and Organisational Structure, Better Care Fund, ICB Contribution to the Health and Wellbeing Strategies, Place Partnerships and HIPP Board, Fragile Services Framework, Clinical and Care Professional Leadership Networks
Duty to have regard to the wider effect of decisions	**Executive Director of Strategy, Health Inequalities and Integration** **Director of Corporate Services**	**The Four Pillars of Integrated Care Systems**, built up from the Triple Aim were the **basis of the strategic planning framework** that was used to develop the ICS Strategy, the Joint Forward Plan and the linkages they have to the Health and Wellbeing Strategies. The ICB Governance Design, as set out in the ICB Constitution and Governance Handbooks outlines how the Governance Structure of the ICB is designed to ensure that the ICB meets its duty to have regard to the wider effect of its decisions. The main committee for ensuring this happens is the ICB Quality, Resources and Delivery (QRD) Committee, which is supported by the ICB Quality Delivery and Oversight of System Group (QDOS), which pulls together the activities of all the ICS Programme Boards and Forums.
Financial duties	**Chief Finance Officer**	**Main Document, pages 18 - 19** outline the 25/26 Financial Plan. It also outlines arrangements for developing a Medium-Term Financial Strategy, which will be used to set out the plan for returning the system to financial balance. The ICS Finance Forum (chaired by Wye Valley NHS Trust Chairman) is the strategic group that bring finance professionals together to build consensus around the financial plan.
Implementing any Joint Local Health and Wellbeing Strategy	**Executive Director of Strategy, Health Inequalities and Integration**	**The JFP has been developed to specifically demonstrate how NHS partners will contribute to the delivery** of the Integrated Care Strategy and the two Joint Local Health and Wellbeing Strategies. The overall approach to the development of the Integrated Care Strategy and the Operating Model for the system (build around place) has been created to ensure alignment between all strategic plans.
Duty to Improve quality of services	**Executive Chief Nurse**	**Appendix 2, Theme 1 (Quality, Safety and Patient Experience)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to reduce inequalities	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 4 (Health Inequalities) and Theme 5 (Prevention)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to promote the involvement of each patient **Duty to involve the public**	**Director of Operations – System Programmes** **Director of Communications & Engagements**	**Appendix 2, Theme 6 (Personalised Care)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Appendix 2, Theme 7 (Working with Communities)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty as to patient choice	**Managing Director**	**Patient choice is a key focus for the ICB.** There is a plan for an accreditation process for new providers in development that will be ready in late 2023. Addition, there will be revised patient information to promote choice and support patients decisions. Progress against Patient Choice will be reported through the Elective, Diagnostic and Cancer Programme Board through the SRO for patient choice.
Duty to obtain appropriate advice	**Chief Executive, through individual Executive Leads**	**There are a myriad of different arrangements** in place for ensuring that the ICB obtains relevant advice when making decisions. This includes arrangements with a legal firm to provide legal advice, and MOU with public health to provide support for undertaking needs assessments, arrangements with the CSU for provide procurement advice etc.

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Duty to promote innovation	**Chief Medical Officer & Director of Workforce and Digital**	The Chief Medical Officer is responsible for coordinating work across the ICB for promoting Innovation and the ICB employs and Officer within the Digital Team to support this work. **Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty in respect of research	**Chief Medical Officer / LTC and Personalised Care Lead**	
Duty to promote education and training	**Chief People Officer**	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Duty as to climate change	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 13 (Greener NHS)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of children and young people	**Director of Operations – System Programmes**	**Appendix 1, Theme 2 (Early Years, children and becoming an adult)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of victims of abuse	**The Chief Nursing Officer**	**Appendix 2, Theme 10 (Addressing the specific needs of victims of abuse)** The Director of Partnerships and Health Inequalities and Chief Nursing Officer is coordinating work to link in with external partners to ensure that the ICB fulfils across these areas, in addition to the services in place across Herefordshire and Worcestershire.

Other Recommended Content	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Workforce	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Performance	**Main Document Page 13** sets out the specific short term performance trajectories that are being aimed for. Longer term trajectories will be developed as part of the new approach to Strategic and Operational Planning and will be incorporated in the first refresh of the JFP.
Digital / Data	**Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Estates	**The System Development Plan and ICS Operating Model documents** outline more detail on how the ICB and System Partners meet their statutory requirements in these areas.
Procurement / Supply Chain	
Population Health Management	**Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
System Development	**Appendix 2, Theme 14 to 18** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Supporting Wider Social & Economic Development	The ICB fulfils its statutory duties through **membership of the Health and Wellbeing Boards** and engagement and contribution to the two Joint Local Health and Wellbeing Strategies, which both have a focus on tackling the wider determinants to health.
Veteran's Health	**Appendix 2, Theme 9** for detail on our approach to supporting veteran's health

Minutes for Quality Governance Committee

Thursday 29th May 2025 at 10.00 am
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director (Chair)	**Y**
Required Attendees	Sarah Shingler	Chief Nursing Officer	**Apols**
	Rachel Dunne	Deputy Chief Nursing Officer - ICB	**Apols**
	Justine Jeffery	Director of Midwifery	**Y**
	Baylon Kamalarajan	Consultant Paediatrician and POSCU Lead	
	Chris Douglas	Interim Chief Operating Officer	**Apols**
	Simon Murphy	Non-Executive Director	**Y**
	Michelle Lynch	Associate Non-Executive Director	**Y**
	Edwin Mitchell	Associate Divisional Director - SCSD	
	Nicholas Purser	Surgery Governance Lead	**Y**
	Stephen Collman	Managing Director	
	Alison Robinson	Deputy Chief Nursing Officer	
	Rosemary Smart	Public Patient Forum	**Y**
	Susan Smith	Deputy Chief Nursing Officer	Y
	Sue Sinclair	Associate Non-Executive Director	
	Jules Walton	Chief Medical Officer	**Y**
	Jo Ringshall	Healthwatch	
	Gwenny Scott	Company Secretary	**Y**
	Liz Watkins	Associate Chief of Nursing / Director for Infection Prevention and Control	
	Rebecca Brown	Chief Digital Information Officer	**Y**
	Chris Bryne	Healthwatch	**Y**
	Emma King	Director of Estates and Facilities	**Y**
Attending			
	Samantha Bucknall	EA to Chief Nursing Officer (minutes)	**Apols**
Guest			
	Dan Hastie	Associate Chief Nurse for UEC Place based Transformation	**Y**
	Helen Harris	Associate Director of Nursing and Quality ICB	**Y**
	Tracy Pearson	Deputy Chief Operating Officer	**Y**

Item	Title

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QGC/25/1	**Welcome and Apologies for Absence**
	Ms Moore welcomed all present at the meeting. Apologies from Sarah Shingler, Sue Sinclair and Samantha Bucknall.
QGC/25/2	**Declarations of Interest**
	There were no new declarations of interest raised.
QGC/25/3	**Minutes of the last meeting**
	The minutes of the meeting held on the 24th of April 2025 were confirmed as a factual representation of the meeting and approved.
QGC/25/4	**Action Schedule**
	Progress on the outstanding actions were reviewed and updates received.
QGC/25/5	**Escalations from Chief Nursing Officer, Chief Medical Officer & Director of Midwifery for items outside of standard report / not on the agenda**
	Ms Walton highlighted an emerging concern in dermatology regarding a missed cancer diagnosis due to process issues. A retrospective review of patient cohorts was ongoing, with a report expected by the end of June. Ms. Smart highlighted a concern about a patient with a disability having to travel outside their local area for a routine blood test and is worried this may be happening to several patients. Ms Smith informed the committee was informed of a wrong-site eye injection, now under investigation. Previous corrective actions will be reviewed, with findings expected in July. Additionally, NHS England and the ICB visited regarding infection prevention, identifying manageable issues. A wider action plan is in development, and updates will follow. The transfusion policy has been approved, closing the related national patient safety action. Ms. King reported concerns about the state of the ED fire doors at Worcester, including damage and the need for repairs. Immediate actions were taken, and educational efforts were made to inform staff about the importance of looking after the fire doors. Plans were discussed to replace the doors with hold opens, with an estimated cost of £450,000 to £500,000. **ACTION: Ms Harris (ICB) and Ms Smart to discuss why blood samples cannot be accessed locally, sent to the appropriate facility, and have results delivered to the necessary recipient.**
QGC/25/6	**Quality & Safety**
QGC/25/6.1	**Perinatal Incident Report**
	Ms Jeffery reported on the perinatal incident report for April. No cases met MSI referral criteria, and a previously reported incident was progressing. A baby drop during birth led to a transfer for observation, but the baby was discharged well. A rapid review identified learning points on equipment use and vigilance in upright birthing. A stillbirth, suspected due to fetomaternal haemorrhage, will be reviewed through the perinatal mortality tool. Incident reporting remained high, reflecting a strong reporting culture. An avoidable neonatal admission due to low temperature and blood sugars was linked to delayed monitoring, now being addressed through a quality improvement programme. Key learnings were shared, with ongoing improvements tracked.
QGC/25/6.2	**Maternity Safe Staffing**

	Ms Jeffery reported to the committee of the positive developments in midwifery staffing, with all shifts being safely covered and a reduction in required mitigations. It was noted that there were zero vacancies in the midwifery workforce, though some support staff vacancies remained, with recruitment underway following the advert closing on 2nd June. Staff turnover in midwifery was declining, but vacancies among support staff remained relatively high. No harm was reported from medical staffing incidents. The draft Birth Rate Plus audit report had been received, with the final report expected in June. Initial findings suggested that the staffing levels were appropriate, though adjustments may be needed to reallocate staff based on activity levels. Further updates would be provided to the committee as the final report is received, and staffing adjustments are considered.
QGC/25/6.3	**Nurse Safe Staffing**
	Ms. Smith reported staffing in paediatrics, neonatal and adult inpatient areas was maintained at safe levels throughout April. Boarding and additional capacity spaces continued to be used due to increased demand. The end-of-year report highlighted decreases in RN vacancy and turnover, along with reductions in healthcare support staff vacancies. Engagement with NHSC price cap compliance was ongoing, with 97% compliance for general RN coding and 93% overall RN compliance. Efforts to reduce agency rates had been successful, with agency usage decreasing by 39% over the year and framework compliance reaching 92%, with no off-framework usage since December. Bank staffing had increased as agency use declined, with a 9.35% reduction in banking and agency spend. Work will continue into the next financial year to sustain these improvements.
QGC/25/6.4	**Emergency Quality & Safety Report**
	Ms Smith reported on the emergency department quality and safety report, focusing on the fundamentals of care. Regular audits were ensuring these standards were maintained, even in overcrowded conditions. It was noted that eight reds were still being reported, primarily related to documentation. From next month, these issues would be reviewed by the Fundamentals of Care Committee for targeted actions and support, with tracking for assurance. Improvements were expected in the coming months, with efforts directed at resolving documentation concerns. The committee discussed concerns about patients being nil by mouth for extended periods. Healthcare assistants now include this status in handovers to ensure regular reviews and appropriate escalation. It was clarified that patients are generally assumed able to drink unless explicitly instructed otherwise.
QGC/25/6.5	**Patient Experience: Patient Carer, Community Experience Report**
	Ms. Smith assured the committee that efforts were underway to improve patient experience across services. She reported that the Patient Voice and Involvement Strategy had been approved at board in April, with implementation options currently being explored. Ms. Smith highlighted positive feedback on discharge and response volunteers, who were assisting with medication collection and discharge logistics. The initiative had been well received, and plans were in place to continue the service. It was noted that NHS England had withdrawn funding for NHS responders, which had supported out-of-hours work between 5:00 and 7:00 PM. Ms. Smith stated that discussions were ongoing to explore ways to maintain coverage during these hours, as some discharges still occur later in the day.

	The committee acknowledged the importance of these initiatives and would continue to monitor their development. Ms. Smith confirmed that the discharge response volunteer service was gaining momentum, with wards actively requesting volunteer support for medication collection, reducing the need for staff to leave the ward. Mr. Murphy noted that the initiative was being rolled out to The Alex on 9th June.
QGC/25/6.6	**Blood Transfusion**
	Ms. Walton flagged two ongoing issues for the committee's attention. Firstly, a solution was needed for blood transfusion training requirements, particularly during doctor rotations in August. The transition to blood track training and National Patient Safety Agency expectations meant there was a risk of insufficiently trained doctors on shift to comply with transfusion regulations. Options, including remote pre-training, were being explored to address this gap. Secondly, the committee was informed of Amber Alerts on O group red blood cells and B negative blood, with a potential escalation of the O group alert to red. These shortages were particularly significant for women of childbearing age. Plans were in place, in line with transfusion recommendations, to mitigate the risks. The committee would be updated as solutions progressed.
QGC/25/6.7	**The Deteriorating and Sepsis Pathway**
	Mr. Hastie updated the committee on sepsis management challenges. Internal KPI reporting showed areas for improvement, though clinical treatment remained effective. Efforts were underway to refine pathways in EPR Sunrise, addressing inaccurate NEWS scoring. Best practices from other NHS sites were being reviewed, with a working group meeting on 16th June to finalise improvements. Training teams were integrating the ATTENSI package and developing a trust-wide SOP. Given data inaccuracies, Mr. Hastie proposed pausing internal KPI reporting until the new process was in place, with a structured plan expected by June's end and a target launch later in the year. Ms. Brown acknowledged the need for a standardised process before digitisation to ensure accurate reporting. She expressed confidence in Mr. Hastie and the team, highlighting the financial impact of repeated EPR adjustments and the importance of getting it right first time. **ACTION: IPR to include Sepsis update in the next Trust Board meeting on the 10th of June.**
QGC/25/7	**Performance Reports**
QGC/25/7.1	**Integrated Performance Reports**
	Ms. Pearson reported a 10% reduction in the overall waiting list compared to April last year. However, a small number of patients were still waiting over 65 weeks, with April's performance falling short of the plan. Areas of concern remained in skin and breast pathways, with tele dermatology starting next month and expanded breast clinics underway. Cancer performance showed some progress, with the 31-day standard at 86% and 62-day at 64%. Elective recovery and outpatient productivity were being supported by the Octopus room scheduling system, aiming to reduce cancellations and delays. Emergency departments saw record-high attendances, causing a drop in ambulance handovers and an increase in 12-hour waits. Occupancy reached over 110% during parts of April. Simple discharges exceeded targets, though pathway discharges remained low. Improvement plans included digital tools like the Discharge to Assess app. The UEC Steering Group had been established and was progressing work on triage, trauma, and surgical bed reconfiguration, with early signs of improvement in urgent care metrics. Further updates would follow.
QGC/25/7.2	**Research and Development (R&D)**

	Ms. Walton provided an update on research and innovation activity across the trust, highlighting the continued delivery of high-quality research. She noted ongoing collaboration with the Foundation Group and the development of an ICS-wide research strategy. Over the next 12 months, the focus will be on better integration of research and innovation within clinical teams and across the wider organisation. Work is also underway to improve divisional engagement, including introducing research and innovation more effectively during induction for new doctors. The aim is to embed these activities more deeply across the trust, moving away from their current isolated position.
QGC/25/8	**Governance and Risks**
QGC/25/8.1	**Risks (15 & above)**
	Ms. Smith provided an update on the trust's high-level risk reporting. Currently, there are eight risks scored at 15 or above under the monitoring of the QGC, with the Chief Nursing Officer and Chief Medical Officer assigned as executive leads. Seven risks have remained steady, with one reduced in the past month. Ms. Smith confirmed that these are routinely reviewed by the Executive Risk Management Committee, and the agenda is being revised from July 25 to ensure a more comprehensive review structure.
QGC/25/8.2	**Escalations from the Improving Safety Action Group**
	Ms. Smith provided an update from the Improving Safety Action Group, asking the committee to note the current patient safety issues under discussion. She highlighted ongoing work on nutritional needs, with a business case under development and further input from finance regarding benefits realisation. This is now ready for review. Updates were also shared on deteriorating patient and sepsis pathways, electrolyte and fluid management, and progress made in those areas. The anaemia guideline has been approved, allowing closure of a related national patient safety alert. Finally, the complaints policy is under review, with proposed changes being prepared for submission to TMB. Ms. Smith confirmed these key points as the focus of the report.
QGC/25/8.2.1	**ISAG ToRs**
	Noted for information, no issues addressed.
QGC/25/8.3	**Clinical Audit & Effectiveness**
	Ms. Walton presented the annual report for the Clinical Effectiveness Team, noting significant and positive changes in team structure and processes. She highlighted the establishment of the Clinical Effectiveness Group, which now meets bi-monthly and has driven improved delivery against the audit forward plan — an area that had previously been a challenge. The focus is now shifting toward using audit outputs to drive quality improvement and enhance patient care. Ms. Walton also acknowledged ongoing work to update key clinical documents, noting delays due to original authors having left the trust or changed roles. Efforts are underway to assign new owners and improve compliance, ensuring documents are current and fit for purpose. She confirmed this remains a priority area for continued development.
QGC/25/8.4	**Children & Young Peoples Board ToRs**
	Noted for information. Ms. Moore raised concerns regarding the clarity of reporting arrangements for the group, noting that the current description creates confusion. She

	emphasised the need for a clear and agreed reporting pathway, including escalation through the Improving Safety Action Group, with meeting minutes to be tabled at the Trust Management Board and shared with the Quality Governance Committee. Ms. Moore proposed that an annual report should be submitted to the Trust Board and that this requirement should be explicitly agreed from the outset, rather than left to committee discretion. Ms. Smith acknowledged the concern and agreed to take the matter back for further consideration.
QGC/25/9	**Regulatory and Accreditation Reports**
QGC/25/9.1	**Professional Bodies Update**
	Ms. Smith provided an update on the current position of referrals to the NMC and HCPC for noting by the committee. There are nine open nursing cases, which is within expected levels, and all are being appropriately managed within reasonable timeframes. She noted that the trust is part of the NMC task and finish group established in December following the NMC culture report. NHS England has since issued best practice guidance, which aligns with the trust's recently approved local policy. Required data returns to NHS England have been completed and are now in process. No further action was requested from the committee at this stage.
QGC/25/9.2	**Health & Safety Report**
	Ms. King summarised the Q4 Health and Safety Report. Incident reporting increased to 158, viewed positively as it supports learning. There was a rise in inoculation incidents due to increased awareness following safer sharps work. Two Health and Safety Executive improvement notices have now been closed. Work continues on fire safety, with progress on enforcement notices 1503 (operational management) and 1508 (structural compliance). The trust is developing costed options, including possible rebuilds, to demonstrate the complexity of full compliance. A recent fire inspection of the Charles Hastings Education Centre was positive, with only non-statutory recommendations. Security reports also rose slightly to 45. A new local security management specialist has been appointed, and focus remains on addressing violence and aggression. The Health and Safety Committee continues to mature, with improvements in reporting and escalation.
QGC/25/9.3	**Quality Account 2024/25**
	Ms. Smith presented the draft quality accounts for noting, confirming the trust remains on track for submission to the Secretary of State by 30 June. The draft had been reviewed by TMB in May, with further amendments incorporated. It is scheduled for submission to Trust Board on 10 June. Ms. Smith noted that the Chief Executive's welcome message had now been approved. She thanked the Patient Public Forum, particularly Rosemary, for submitted comments, which would be included in the final version. In response to previous feedback about accessibility, a new summary version of the report had been produced, reducing the length from 92 pages to just a few, to support easier reading.
QGC/25/10	**Any Other Business**
	Ms. Jeffery flagged an emerging issue in the triage department, where increased patient attendance—linked to the telephone triage midwife—has led to delays. This concern has been echoed in staff and patient feedback. The team is aware and planning mitigation, including staffing adjustments, particularly for late shifts. A full update will be included in the July safety report. Ms Jeffery to report in the escalation title.
QGC/25/10.1	**Next Meeting Date 26th June 2025**

QGC/25/11	**Reflections on the meeting**
	Ms. Moore praised the meeting's overall progress, particularly the work on sepsis following several years of challenges. She acknowledged continued efforts needed on areas like neck of femur and C. difficile but noted steady improvements in staffing and quality. She thanked the team and closed the meeting on a positive note.
QGC/25/12	**Meeting closed at 11:42am**

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 8 May 2025
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: Complaints (follow-up)**
Rating rationale	The review had a moderate assurance rating indicating there were remaining areas for improvement. There had been progress since the 2023 review, though only one recommendation had been fully implemented. A new process and policy had been developed and would shortly be implemented. Recent improvements in the timely closure of complaints and the delivery of training were noted. The remaining backlogs had also been substantially reduced. In addition, an oversight group would be established to provide enhanced scrutiny of compliance with the policy (including timescales) and the quality of complaints management.
Outcome	While the Committee was disappointed with slow progress since the last review, it was assured by the management response under new leadership and the actions planned for further improvement. Board committee oversight would now be aligned with the Quality Governance Committee.
Item/Topic	**Contract Management**
Rating rationale	The report sought to provide assurance on the procurement process to replace contracts ahead of expiry. 154 contracts had been identified as requiring replacement within the next 12 months, which provided clarity on planned expenditure. A contract management dashboard had been built and a contract manager had been appointed to ensure improved oversight, forward planning and reduced late and retrospective approval. Where delays were likely due to unavoidable issues, the new system enabled these to be anticipated, planned for and escalated. Any delays would be clearly described in contract award governance reports. Work with the divisions was in progress to ensure better planning and oversight at divisional level. A Foundation Group task and finish group was focused on opportunities for efficiencies across Group and the development of an optimum Group structure to secure savings over the coming year.
Outcome	The Committee welcomed the positive and evolving improvements to a challenging position.

Assure: Including assurance items rated green	
Item/Topic	**Draft Head of Internal Audit Opinion 2024/25**
Rating rationale	The rating was 'significant assurance' demonstrating improvements, particularly on the board assurance framework, the timely completion of reports, implementation of recommendations and escalation of issues. The Committee was pleased to note the improved opinion compared to the previous year and was satisfied that it appropriately reflected progress.
Outcome	The draft opinion was accepted. The final opinion would be presented within an annual report at the next meeting, incorporating the outcomes of the final reviews within the plan.
Item/Topic	**Internal Audit: Pre-employment Checks – Doctors and Consultants**
Rating rationale	The rating was 'significant assurance' with one low risk recommendation. The process was robust and had been shared with another trust as good practice. It was recognised that the process took time and could delay recruitment though there was no data to indicate this was a significant issue within the Trust.
Outcome	The Committee was assured by the report and the management response.

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: 8 May 2025
Report to: Trust Board

Item/Topic	Internal Audit: Board Assurance Framework
Rating rationale	The report was rated 'significant assurance' reflecting improvements since the previous year. The recommendations were all accepted, reflecting plans already in place associated with the new format and process.
Outcome	The Committee was assured by the report, which was an important element of the annual Head of Internal Audit Opinion.
Item/Topic	**Internal Audit: Payroll - Expenses**
Rating rationale	The report was rated 'significant assurance' reflecting a robust process. There were two low-risk recommendations, one of which was complete.
Outcome	The Committee was assured by the report and the management response.
Item/Topic	**Counter Fraud, Bribery and Corruption Annual Report**
Rating rationale	The report included the annual counter fraud functional standards return, which had an overall green rating, reflecting improvements since the previous year. Two amber standards related to staff awareness and understanding of the conflicts of interest policy, reflecting the need to embed the new process (see below), and the reporting and management of counter fraud risks based on the annual risk assessment. Plans were in place to address both. A verbal report was provided on progress of the annual counter fraud work plan: • The National Fraud Initiative (NFI) checks had been completed satisfactorily. • Some salary overpayments were under review for potential fraud. • No significant fraud risks had been identified.
Outcome	Accepted
Item/Topic	**Annual Trust Board Register of Interests Review**
Rating rationale	The Committee was assured that the Register highlighted no concerns and that there had been appropriate cross-checking as part of the National Fraud Initiative. The Register had been published on the Trust's website and the 2025/26 register was now being used as a live document ahead of the next annual declaration process. The new system for annual declarations for decision making staff and ad hoc declarations for all staff was now live on ESR, enabling improved monitoring and reporting and supporting full compliance with the relevant counter fraud functional standards.
Outcome	Accepted
Item/Topic	**Implementation of Recommendations from Value for Money (VFM) Assessment 2023/24**
Rating rationale	The report provided assurance that all recommendations from last year's External Audit VFM assessment had been implemented, with assurance in some areas that these had resulted in positive outcomes, including improved financial and CPIP delivery and improved assurance on internal controls from the Internal Auditor. It was noted that no concerns had been highlighted during the VFM assessment for 2024/25, which was ongoing.
Outcome	Accepted

To Note: Items received for information or approval	
Item/Topic	**Draft Annual Governance Statement 2024/25**
Summary	The Annual Governance Statement (AGS) formed part of the Accountability report within the Trust's Annual Report and had been prepared in line with DHSC guidelines and a model AGS published by NHSE. The AGS was designed to provide assurance on the Trust's system of internal control and was supported by the work of the Committee. Evidence relied upon in determining the conclusions regarding internal control included the work of the Internal Auditor and progress on implementing the recommendations arising from the previous year's External Audit. The Committee considered whether the AGS sufficiently described issues of internal control and whether any could be described as 'significant' in line with the guidance. It was agreed that the statement was clear and transparent about internal control issues and improvement actions, and that the conclusion was appropriate.
Outcome	The AGS was commended for approval by the Trust Board

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: 8 May 2025
Report to: Trust Board

Item/Topic	Draft Annual Accounts 2024/25
Summary	The draft, unaudited accounts were considered by the Committee prior to audit and final approval in June. The report highlighted key areas for the Committee's consideration. There was regular engagement with the Auditor during the continuing audit and no concerns had been raised to date.
Outcome	The Committee was satisfied with the accounts, subject to some additional information to be added to a note and subject to audit.

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: 23 June 2025
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	**Auditor's Annual Report**
Rating rationale	The annual report provided an assessment of the Trust's value for money arrangements, with opinions on the following: • Financial sustainability: one significant weakness was identified and a key recommendation made in respect of the Trust's efficiency savings plan for 2025/26, plus an improvement recommendation in respect of the financial position. • Governance: no significant weaknesses identified; two improvement recommendations made. • Improving economy, efficiency and effectiveness: one significant weakness identified and a key recommendation relating to agency spend. One improvement recommendation relating to PFI contract management. This reflected an improvement on the previous year's opinion, with two significant weaknesses compared to four the previous year. The Auditor highlighted a generally positive direction of travel. The Committee considered the significant weakness related to preparedness for delivering the 2025/26 efficiency plan, notwithstanding the Trust achieving the 2024/25 plan and a break-even position. The audit found that the savings plan for 25/26 should have been further progressed at the end of 24/25. The Committee observed the challenge of developing the 25/26 plan while ensuring delivery of the 24/25 plan.
Outcome	The Committee welcomed the more positive report compared to previous years. Action: CEO and CFO to comment at the next meeting on the findings of a significant weakness on the 25/26 efficiency plan.
Item/Topic	**Audit Opinion (Financial Statements)**
Rating rationale	Subject to some final work on the Audit, the opinion would be unmodified. Several low priority recommendations (not all agreed) and 2 medium priority recommendations were made; management response set out in action plan. The Audit process had been smooth, with appropriate support from management.
Outcome	The Committee accepted the report. The Management response would be reviewed in more detail at the next meeting.

Assure: Including assurance items rated green	
Item/Topic	**Head of Internal Audit Opinion**
Rating rationale	The draft report was presented at a previous meeting of the Committee and there had been limited changes in the final report. Only one report from the annual plan was incomplete (the Safeguarding report was in draft and would be presented at the next meeting) but this would not affect the overall opinion. The opinion was of 'significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently'. The opinion recognised the moderate opinion reviews provided during the year and acknowledged that in the main the Trust was aware of the issues highlighted. KPIs for both the Trust and the Internal Auditor were generally positive. Strengthened partnership arrangements between the Trust and the Internal Auditor and an improved approach to developing and agreeing the plan for 2025/25 would ensure continued improvement in the current reporting year.
Outcome	The Committee was assured by the annual Opinion, which was reflected in the Trust's Annual Governance Statement, and commended the improvements, including in the Trust's response to recommendations.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 23 June 2025
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**Annual Accounts 2024/25**
Summary	The draft accounts were presented to the Committee in May. Key changes in the final version were highlighted. It was noted that there was a change to the audit completion certificate process. Over 500 queries had been received from the Auditor, all of which had been answered, demonstrating the depth of work involved in the Audit. There were no unexpected or unusual issues within the Audit from the Trust's perspective.
Outcome	The Committee endorsed the Accounts for Trust Board approval. Action: Learning from the Audit process to be reported at the next meeting.
Item/Topic	**Annual Report 2024/25**
Summary	The Report included the Annual Governance Statement, which had previously been reviewed by the Committee, with no material changes subsequently. The Report had been reviewed by the Auditor for compliance with the DHSC Group Accounting Manual and the Remuneration Report had been subject to Audit.
Outcome	The Committee endorsed the Annual Report for Trust Board Approval.

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

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Teaching room 2, CHEC
Tuesday 1st April 2025 at 10:00

Present		
Chair	Karen Martin (KM)	Non-Executive Director
Members	Ali Koeltgen (AK)	Chief People Officer
	Jules Walton (JW)	Chief Medical Officer
	Sue Sinclair (SSi)	Non-Executive Director
	Neil Cook (NC)	Chief Finance Officer
Attendees	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Justine Jeffery (JJ)	Director of Midwifery
	Liz Faulkner (LF)	Deputy Chief People Officer
	Alison Robinson (AR)	Deputy Chief Nursing Officer
	Rich Luckman (RL)	Assistant Director of People & Culture
	Richard Haynes (RH)	Director of Communications & Engagement
	David Southall (DS)	Chaplaincy Team Leader and Equalities Engagement Lead
	Mark Stanley (MSt)	Organisational Development Practitioner
	Reena Rane (RR)	EmbRACE Network Chair
	Rachael Hayter (RH)	Director of AHPs
Apologies	Stephen Collman (SC)	Managing Director
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Sarah Shingler (SSh)	Chief Nursing Officer
	Colin Horwath (CH)	Non-Executive Director
	Chris Douglas (CD)	Acting Chief Operating Officer
	Julie Moore (JM)	Non-Executive Director
	Simon Murphy (SM)	Vice Chair

	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 4th February 2025 were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly.	
	Staff Story – Ramadan	

Dr Munir Ahmed shared his experience of fasting during daylight hours and working in the hospital during Ramadan.

A workday during Ramadan includes a 3am wake up, time for prayer and to eat before sunrise. Dr Munir arrives at the hospital for 8:45 on a clinic day seeing around 8/10 patients between 9am and 1pm. Muslims are then not allowed to eat or drink between sunrise and sunset, which can make speaking difficult.
At the end of clinic, Dr Munir assists with Friday prayer, which is divided into 2 separate congregations and attended by around 40 people. After this Dr Munir attends a consultant meeting and then has some time for admin before going home around 5pm. After sunset, they can then eat and have evening prayer, then sleep before waking again at 3am.

AK asked what the Trust can do to better support Muslim colleagues to stay safe and well in Ramadan. Dr Munir explained that increasing awareness among other staff would be beneficial, and that some Trusts donate food and drink for Muslims who are on-call so that it is readily available when they have a short break, in between their duties. Dr Munir extended his thanks and appreciation to the Trust for their support, as well as to the Faith and EmbRACE networks.

Staff Network Updates: EmbRACE Network

Over the past year, the Network has celebrated Diwali and Ramadan to increase awareness and has also provided ongoing support a member of staff's bereaved family. The proactive support and engagement from the Executive team during the riots was greatly appreciated in the community.

A Network engagement survey has taken place to learn how the Network can improve, and the results of the Staff Survey are being reviewed alongside this. Feedback showed that work commitments were the biggest barrier in members participating in the Network with only 11% of respondents reporting that they attend Network meetings often. However, the biggest motivator for participating was feeling support from other members. Feedback also showed Network members perceive a lack of engagement from Executives and the Network will be looking to increase participation to drive change from the top, as well as enhancing collaboration and engagement through increased networking events and inviting guest speakers. The Network will also focus on addressing workplace inequalities and career progression which will include signposting staff to the OD team and increasing attendance at Network meetings by alternating the location across the 3 sites and exploring the possibility for protected time. The possibility of having an EDI member of staff to attend Network meetings and cascade information out was also discussed. Regarding Board visibility and commitment, the Trust will sign the Anti Racism Charter to reaffirm its 0-tolerance commitment. Both Unison and the RCN are supportive of this. There is potential for a Task and Finish group to launch the work and materials provided include the charter, an action plan, pledge cards and presentation.

KM asked how the Trust can better manage inclusivity so that all celebrations such as Christmas, Eid and Diwali are recognised equally. RR advised that the Network is conscious of this and is wanting to ensure that all minority groups are seen, for example, looking into how different communities celebrate Easter, and Harvest festival celebrations not relating to a specific religion but being celebrated by all. JW suggested the Trust could consider offering staff the choice of which statutory days they would work, for example, for a clinical member of staff would need to take Annual Leave if rostered to be working Eid, whereas non-clinical staff would receive bank holidays off such as Christmas. RR noted the logistical difficulty with Eid being celebrated on different dates each year.

AR explained that Senior Nurses have recently been discussing what further support they can offer international students, following the suicide of a student nurse due to financial difficulties. Some students will doing extra jobs and eating very little, with some also needing to send money back home. A foodbank has been started on SAU however the Senior Nurses are keen to do more, acknowledging their duty of care, and extended an invitation to speak at one of their meetings. RR advised that she has been working closely with the university and international students to understand their situations better, for example that some enter the country already having debt. RR felt that the reality of their wage had not been explained to the students properly and that they may still struggle financially. SS shared that the Trussell Trust are based in Worcester and support for people in hardship and acknowledged that the international students would not be aware of the resources available or how to access support.

Chief People Officer Report

AK reflected on the general unrest following the announcement regarding NHS England. This year's annual plan sets a clear target for infrastructure and headcount reductions. A large proportion of this can be changed through natural turnover and transformation, however careful communication will be needed with individuals. The definition of infrastructure remains broad; however, the Trust is conscious that there has been significant growth in corporate headcount over several years, and that this could be an opportunity to ensure the growth is in the right place, and that efficiency savings have been made.

The new target for agency reduction is roughly 40%, and the Trust is currently benchmarking nationally as one of the worst for medical agency use. The Trust is aware that agency use is outstripping vacancies, with much of the usage due to additional staffing in urgent care. There is also high sickness absence due to stress and anxiety and the Trust is liaising with system partners on how they can work together to provide support.

The introduction of a new Neonatal Care act will mean that statutory rights for leave and pay are increasing; Trust policies will be updated accordingly.

Discussions have taken place across the Foundation Group regarding alignment of workforce KPIs; the sickness, appraisal and statutory and mandatory training targets will remain as they are, but the turnover target will be reduced to 10% from 11.5% .

Kate Haddigan has been elected Chair of the new Women's Network which will focus on issues that specifically impact women and acknowledge the rising trend in misogynistic behaviour and experiences. The launch of the Sexual Safety Charter in 2024 will tie in closely, and inspirational stories will be shared at the Network meetings.

People Strategy Build

Feedback has been sought from stakeholders regarding the new People Strategy which will align to the new organisational values and behaviours. Approval is requested to commence the actions planned for year 1.

AK added that culture will be a key element that weaves throughout the strategy. The strategy remains high level to allow for adaptability, and the potential for a Board Workshop was discussed.

NC asked where the strategy explores whether the Trust has the right shape and size workforce, and LF explained that this will be included in detail in the Trust-wide organisational change programme, including the workforce infrastructure reductions.

The next stage will be to review the governance framework under the strategy to ensure there are no gaps, which information is escalated to other People meetings, or to meetings with wider Divisional representatives. **Item at the next meeting for assurance. It was suggested to focus on one programme per Committee meeting, with a wrap up at the end of the year.**

Strategy approved by the Committee.

Trust Values & Behaviours

The 4Ward branding is gradually being removed across sites and resources containing the new visual identity will be filtered out. This has been tested, and some tweaks have been made following feedback ready for launch.
The Behavioural Charter needs to also be sunset, but the Trust needs to maintain the 0 tolerance, challenging staff to speak up, linking to the new Anti-Racism Charter and with an additional focus on behaviours online via Facebook and WhatsApp. Socialisation of the new values and communications assets will begin, and a draft design of the new charter will be presented at the next Committee meeting. The 4Ward behaviours are included on a variety of documents, in the PDR and recruitment processes, and referenced in policies so the removal will take place gradually over several months.
The new behaviours will officially be launched at an upcoming Exec Live and staff encouraged to update any documents that can easily be amended to remove the 4Ward branding. The Trust will be working with A Kind Life and repurposing the materials provided so that they focus on bringing the new values to life as well as creating a kinder culture. Some Staff Survey feedback indicated that departmental leads may need more focus with the Kinder Culture work.

RH explained that the Communications team will liaise with Morgan to develop a style guide and other assets, to then be able to commence work on centrally produced projects such as the Trust's website and intranet. Other Trusts in the Foundation Group generally only have Group branding when participating in group events such as the AGM. MSt suggested that 4Ward branding is removed from areas when conducting quality assurance visits.

Staff Survey Results

MS outlined the Staff Survey highlights:

- The response rate increased to 46%, from 31% the year prior.
- Nationally, WAHT is the 8th most improved Trust
- Scores showed improvement across all elements of the People Promise, and 6 out 7 themes showed a significant improvement.
- Staff engagement and morale also improved, and the Trust scored above the national average for morale and flexibility.
- Nationally, People Promise scores have stagnated or decreased.
- Overall, 42 of the 60 questions scored significantly better than previous, with only 4 showing a minor decrease.
- The results are average when compared nationally, so improvements still need to be made.
- Some Divisions and specific areas have been highlighted as hotspots of concern.
- Scores recommending the Trust as a place to work are on 5% upward trend, and nationally WAHT is the 3rd most improved Trust.

- In the survey provider group, Picker, WAHT is the 2nd most improved Trust, with some showing stagnated or even declining.

RL explained that WRES AND WDES are informed by Staff Survey results and by data systems like ESR. There have been some improvements in WRES, however further focus is needed in some WDES indicators that have not shown improvement. Some WRES indicators have decreased, and others improved.

Key feedback received from staff was that they don't find out the results of the survey and don't see the difference it makes. The Intranet has been used to display the results for each area, as well as provide a resource pack containing the overall results for the Trust, and action plan templates to encourage teams to take ownership and start identifying actions. Leaders have been asked to have conversations with their teams in the coming weeks to identify priority actions to focus on. Momentum needs to be maintained now, so that teams can recognise the outcomes from their feedback.

Planning for next survey will commence soon. "You said, we did" have been changed to "you said, we listened, together we did" and it is hoped that capturing and showcasing examples like these will encourage people to participate again.
KM shared an example of a ward manager's viewpoint on the Staff Survey changing; from not feeling that it was confidential, to encouraging their team to complete it.

AK advised that competitiveness has been observed between Divisions regarding their response rates, who are now keen to act on the results and improve their scores next year. **It was suggested for an example of this to be brought to a future meeting.** MS added that he has already been working with HRBPs to support action planning for Estates and Facilities and areas of SCSD. **Action: To share Staff Survey results video link with the committee.**

AHP Workforce Update

An engagement survey was carried out in June 2024, and this feedback along with the Staff Survey results has informed several projects. When commencing in post, RH met in person with many teams to understand and get to know them which has been key.

Quality is difficult to define from an AHP perspective due to the diversity of the group, spanning different specialties and divisions. An AHP Dashboard has been launched nationally, and 2 key elements of this relate to workforce: optimising the workforce and supporting staff. RH asked teams their thoughts on these two elements to learn what the organisation is doing well, and what it could do better. Two posts have been fundamental to the AHP workforce; Head of AHP Workforce to work closely with their Nursing counterpart, and a band 7 Professional Development Lead, to support teams to explore what the future workforce looks like, including student pipeline and retention.

AHP preceptorship is being launched nationally and has been shown to have a positive impact on staff wellbeing and retention. A steering group has been organised to explore what resources would be needed. The Safe Learning Education charter has also been considered to create a safe space for learning. Other areas have been reviewed for improvement such as student capacity, retention and sustainability and green space.

An AHP Workforce strategy has been drafted, and the team have also been providing input in the development of the People Strategy to ensure alignment. The most recent Staff Survey showed an increase in AHP response rate by 47%; 83 questions showed an improved result, and 15 were slightly worse. Feeling safe to speak up regarding concerns has now scored 66%, compared to 36% the year before, and 41% are

confident that their concerns would be addressed. The results showed that the workforce is feeling positive about opportunities to develop their careers and feels that they are strong as a team. However, there needs to be a focus on workforce planning, for Therapies in particular, as staff have reported they do not feel there are enough staff for them to do their jobs properly. Some teams will also need to explore better flexible working and wellbeing. Governance and representation of AHPs has been improved through attendance at NWAG, NMAB, Education Board and JNCC.

AHP integration programme was launched in June 2024, so the Trust has been working closely with Worcestershire County Council and the Health and Care Trust to create one single workforce that includes Physiotherapists, Dietetics, Speech and Language Therapists, and Occupational Therapists. Barriers that prevent collaborative working across organisations have been reviewed and the University will collaborate to provide qualitative data from staff regarding how they feel the programme has been and how it should continue moving forwards. Turnover has decreased from 16% to 13%, so the programme seems to have had a positive impact on retention.

Nationally, waiting lists are high for community AHP children's services, and learning will be taken from improvements already carried out in Neonates. Musculoskeletal pathways and weight management services are overwhelmed, and the service will be looking into how this can be improved by working with partners. Looking into developing the leadership offer with Professional Advocacy and creating more learning opportunities with the University.

NC commented it would be beneficial to have the links to productivity and efficiency visible. SS suggested AHP representation to become regular at this committee.
RH advised that she could feel a change in the culture, and felt that coming into post, staff were ready for the improvements to be made but were waiting for the leadership to do so. Some cultural challenges have been noted, for example many Physiotherapists feeling their acute skillsets are more valued in transitioning from a band 5 to a 6, rather than their leadership skills.

Medical Agency Reduction

LF advised that the Trust has moved on from the suggestion of an agency deep dive and highlighted the ambitious targets in the Trust's new Annual plan of a 40% reduction in agency costs, and a bank reduction of 15%.

A weekly approvals meeting will be arranged for medical agency. For Nursing agency, a daily call is in place to review the rosters and any requests; whilst a daily call is not necessary for medical agency, some lessons can be learnt from this process and applied to the weekly medical call so that requests are prospective rather than retrospective.

The roll-out of eroster for Medical colleagues is progressing with more than 50% expected to be setup on the system in the next few months. This will provide better visibility of shifts required, and which are due to vacancy, sickness or additional capacity.

Job planning compliance is now at 76% and LF noted the correlation with up-to-date job plans and the amount of bank and agency usage. A consistency panel is now in place for approval of job plans over the core 10PAs. Although this is related to substantive Medics, a positive impact is anticipated on bank and agency too.

A Price Cap Compliance programme was implemented by NHSE in September, which launched with Nursing, and then AHPs and Medics. The plan is to adopt the cluster

rates across the Midlands, which will provide a regional approach. Organisations in the region will share information with each other, allowing better visibility and transparency, so that the Trust can push back on some rates where appropriate.

KM asked whether there can be confidence in maintaining this approach across the region, and LF responded that this will be built into the weekly panel for visibility. For some specialty areas, the Trust may still need to go above the cluster rate, but this information will provide a benchmark and opportunity for pushback in other areas. AK shared that Consultants in ED had been advised of the new contracts and had received pushback with 52 gaps on the rota. All acknowledged the need to balance the risk. LF added that there is evidence from other organisations that shows that WAHT is the only Trust offering non direct engagement.

NC noted the success on CPIP savings last year, however shared concern regarding the coming year. Most of this years' savings are due to be from reducing bank and agency, and NC did not feel that there is currently sufficient assurance, and that detailed due diligence was needed on each position.

KM asked if the impact of job planning on bank and agency can be quantified, and JW responded that 95% of consultants having an approved job plan was not likely to reduce bank and agency alone; there is a significant amount of activity taking place, and the job plans will allow better understanding of whether this is happening in the right place at the right time. SS cautioned that historically, examining Consultants' workloads can cause unrest and the potential to work to rule.

JW advised that most almost all consultants will have an approved job plan by 31st April 2025 but noted that this is unlikely to provide much in extra resource or savings. Finance colleagues will be involved in the weekly oversight meetings as well as HR to monitor closely. ***Agreed to schedule an update to Committee of the Job Planning Audit action plan***.

Freedom to Speak Up (Quarterly report)

Staff Survey results showed that staff are feeling safe to speak up, however do not feel that the organisation addresses concerns, and this is the trend nationally. FTSU concerns have increased by over 32% within the last 12 months, and the number of those that are anonymous continues to reduce. Compliance with Speak Up training is now 91% and Listen Up has also launched. Follow Up training will launch soon for senior leaders. There has been a slight increase in sexual safety concerns, and this may correlate to an increased awareness in the Trust.

Several people are volunteering to become FTSU Champions, and discussions have taken place to transition the existing 4ward Advocates into the new Values Champions. MSt is now trained to deliver Active Bystander training, and this will link to the review of Trust Induction to incorporate the new values, early resolution and work with Kind of Life.

SS raised that young male staff may struggle to come forward with sexual safety concerns. MSt advised that contractors like ISS and Equans may employ more young males, and training may be needed for them to ensure they feel safe and supported to speak up.

Governance

People & Culture Risk Register

The risks rated above 15 remain as job planning and regarding temporary workforce. No change is reported and these are reviewed regularly.

	There has been assurance on the Job Planning position, but this remains a risk until the improvement is sustained. Temporary staffing will remain a high risk until more assurance can be provided regarding CPIP plans for the year. AK noted concern regarding managing the ambitious targets in the Annual Plan to reduce agency usage as well as sickness and keep culture improving throughout. The Board Assurance Framework is also being reviewed and will be linked to this and be submitted to People & Culture Committee for recommendations to Board.	
	Terms of Reference Review There have been general changes to the language used in the document, and some suggested changes to Committee membership. As the Committee could have delegated authority from the Board, it is essential that the quorum consists of Board members. Noted a desire for Divisional attendance, however recognised issues with the practicality of this; it was suggested this could be through COO attendance or a rotation of Divisional representation. **Action: AK to discuss with COO.** Further to discussions earlier in the meeting, it was agreed for an AHP representative to be invited as a regular attendee. *Terms of Reference approved with amendments above.*	
	Any Other Business (AOB)	
	None raised.	
	Date of Next Meeting	
	The date of the next meeting is Tuesday 3rd June, Crompton A, CHEC.	

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**08/07/2025**
Title of Report:	Infection Prevention and Control Annual Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Liz Watkins. Director for Infection Prevention and Control
Reporting Route:	TIPCC, Quality Governance Committee
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The purpose of this report is to provide assurance to The Worcester Acute Hospital NHS Trust (WAHT) Board of Directors, Governors and the public for the reporting period 1 April 2024- 31st March 2025 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (update December 2022) (commonly known as The Hygiene Code) and with regard to appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

The report also reflects the IPC Board Assurance Framework (IPC BAF). It is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework and sets out our priorities and plans to achieve further improvement and reductions in infection during 2025-26 and achievement of the quality priorities.

Recommended Actions required by Board

The Trust Board is invited to:

1. Review the information contained within this report, to ensure it provides sufficient detail for assurance on the range of issues covered and request any additional information necessary.

2. Note the continuing performance in relation to CDI and other key infection targets, the associated impact on patient safety, and measures being progressed to mitigate risks.

3. Approve the report for presentation for publication on the Trust website.

Executive Director Opinion[1]

This annual report fulfils the Trusts' statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (update December 2022),which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual programme which is monitored at the Trusts' quarterly Infection Prevention and control committee (TIPCC) meeting. Infection prevention and control is the responsibility of everyone in

[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.

our healthcare community and is only truly when everyone works together. The aim of the of the IPC team is to increase organisational focus and collaborative working to ensure continues compliance and continuous improvement.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2024-2025

Authors:

Sarah Shingler - Chief Nursing Officer Executive Director Infection Prevention and Control

Liz Watkins - Associate Chief Nursing Officer/ Director of Infection Prevention & Control

Dr Emma Yates - Consultant Microbiologist and Co-Infection Control Doctor

Dr Eftihia Yiannakis - Consultant Microbiologist and Co-Infection Control Doctor

Sadiya Hussain - Antimicrobial Pharmacist.

Emma King – Interim Director for Estates and Facilities

Helen Wealthall - Occupational Health

Julie Noble – Head of Health & Safety and Fire Safety

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Foreword

"As the Chief Nursing Officer and Executive Director of Infection Prevention and Control, I would like to take this opportunity to say thank you to all the staff, colleagues, and partners for welcoming me to the organisation. Infection Prevention and Control is pivotal in ensuring that our patients and citizens receive safe and high-quality care, and it is everyone's responsibility.

Resetting our focus and raising the importance of fundamentals post the Covid-19 pandemic, has been a real focus for us here at The Worcester Acute Trust (WAHT). As the Trust's Executive Director of Infection Prevention and Control I am proud to be able to present this Annual Infection Prevention and Control Report for 2024/25, which has been developed in collaboration with the Deputy Director of Infection Prevention and Control and the Infection Prevention and Control (IPC) Team. This report outlines the activities relating to infection prevention and control for the year from April 2024 to the end of March 2025, presenting the arrangements the Trust has in place to reduce the spread of infections. It outlines our accountability arrangements, policies and procedures relating to infection prevention and control, audits, and the education necessary to support the prevention and control of infections.

Our focus on cleanliness, antimicrobial prescribing and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care from us.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to *Putting Patients First.* The Quality Governance Committee continued to scrutinise our infection prevention progress quarterly on behalf of the Board throughout 2024-25.

Our key achievements for 2024/25 include:

- The Trust reported zero MRSA bacteraemia which was a reduction from 7 reported in 2023/2024.
- Reporting below threshold for mandatory blood stream (BSI) infections including E. coli and *Pseudomonas aeruginosa*,
- Mandatory Infection Prevention and Control training completed by 90% of clinical staff.
- 96% of non-clinical staff up to date with Infection Prevention and Control (IPC) e-learning.
- Recruitment to the IPC team under very challenging circumstances.
- IPC promotional activities included IPC week and World Health Organisation Clean Your Hands Day.

Looking forward to 2025/26, the IPC team and all WAHT staff will continue to work towards the prevention of all healthcare acquired infections. This will be guided by our overarching

IPC annual programme of work and strengthening our relationships with our system partners."

I trust you will find this report informative.

Sarah Shingler

Chief Nursing Officer and Executive Director of Infection Prevention and Control (DIPC)

Definitions/ Glossary

ACP	Advanced Care Practitioner
AE	Authorising Engineers
AER	Automated Endoscope Reprocessor. A specialised machine for washing and disinfecting endoscopes
AHP	Allied Health Professional
AmpC beta lactamases producing Enterobacteriaceae	Produce enzymes which mediate resistance to a wide variety of B-lactam antibiotics e.g., amoxicillin
ALEX	Alexandra Hospital Redditch
AMS	Antimicrobial Stewardship
ANTT	ANTT® / Aseptic Non-Touch Technique: A specific type of aseptic technique with a unique theory and practice framework (NICE 2012).
ASG	Antimicrobial Stewardship Group
AP	Authorised Persons
Bacteraemia	A bloodstream infection
BSI	Bloodstream Infection
CDI	*Clostridioides difficile infection. Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
CMT	Certified Medication Technician
CNO	Chief Nursing Officer
COHA	Community Onset Healthcare Acquired
COIA	Community Onset Indeterminate Association
COVID-19	Coronavirus disease
CPA/ UKAS	*Clinical Pathology Accreditation (CPA* UK) is a subsidiary of United Kingdom Accreditation Service *(UKAS)*
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
D&V	Diarrhoea and vomiting

Datix	Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DDD	Defined Daily Doses. The DDD is a standardized measure used to determine the average daily dose of a medication used for its main indication in adults.
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E. coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ED	Emergency Department
EDIPC	Executive Director for Infection Prevention and Control
EOLAS	Eolas streamlines access to knowledge for use at the point of care, ensuring all healthcare professionals can make the right decision for every patient, every time
EPMA	Electronic Prescribing and Medicines Administration
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
EPP	Exposure Prone Procedure
EPR	Electronic Patient Record
ESR	Electronic Staff Record
GAP	WAHT Audit Tool
GNBSI	Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas.
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HOHA	Hospital Onset Healthcare Associated
HPV	The ProXcide® System uses innovative hydrogen peroxide vapour (HPV) technology for a rapid decontamination process tailored to each room's requirements, ensuring log-6 kill efficacy on all surfaces
HSDU	Healthcare Sterilisation Decontamination Unit
HSE	Health and Safety Executive
HTM	Health Technical Manual. These documents give comprehensive advice and guidance on the legal requirements, design implications, maintenance and operation in healthcare premises providing acute care.
ICB	Integrated Care Board replaced Clinical Commissioning Boards July 2022

IC NET	IPC Surveillance software and database
ICS	Integrated Care System
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPCT	IPC Team
IQPR	Integrated Quality Performance Report
IV	Intravenous
KPI	Key Performance Indicator
KTC	Kidderminster Treatment Centre
LHE	Local Health Economy
MD	Managing Director
MDT	Multi-disciplinary Team
MHRA	Medicines and Healthcare Products Regulatory Agency
MICAD	MICAD Trust Audit Reporting System
MPOX	Mpox, previously known as monkeypox, is a viral illness caused by the monkeypox virus, a species of the genus Orthopoxvirus
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus.* *Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g., inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NED	Non-Executive Director
NEWS 2	The latest version of the National Early Warning Score (NEWS), which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NNU	Neonatal Unit
Norovirus	Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults.
OH	Occupational Health
Outbreak	One or more persons with the same signs, symptoms in time place and space.
OPAT	Out-patient parenteral antimicrobial therapy
OPD	Outpatients Department
PCR	A polymerase chain reaction (PCR) test detects genetic material from a pathogen or abnormal cell sample
PEWS	Paediatric Early Warning Score
PFI	Private Finance Initiative
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment

PPE	Personal Protective Equipment e.g., gloves, aprons, and goggles
PPS	Point Prevalence Survey
PSIRF	The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety
PVD	Peripheral Vascular Device
QGC	Quality Governance Committee
RAG RATING	Red, Amber, Green rating system
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RSV	Respiratory Syncytial Virus (RSV) is a common viral infection that primarily affects the respiratory tract, particularly in infants and older adults, and can lead to severe respiratory illnesses
SARS-CoV-2	COVID-19
SCSD	Specialised Clinical and Services Division
SEPSIS	A potentially life-threatening condition caused by the body's response to an infection.
SOP	Standard Operating Procedure
SSI	Surgical Site Surveillance
SSISS	Surgical site Infections Surveillance Service
SWFT	South Warwickshire University NHS Foundation Trust
TB	Tuberculosis
The Source	Staff Intranet Site
TIPCC	Trust Infection Prevention and Control Committee
TOR	Terms of Reference
UK HSA	UK Health Security Agency formally Public Health England (UK HSA)
UVc	Ultra-V Connect™ discreetly emits high-intensity UV-C light for efficient routine surface decontamination.
WAHT	Worcester Acute Hospitals NHS Trust
WHO	World Health Organisation
WREN	Worcestershire Reporting System for audit
WRH	Worcester Royal Hospital
WSG	Water Safety Group
WSP	Water safety Plan
WTE	Whole Time Equivalent
WVT	Wye Valley NHS Trust

SECTION ONE:

INTRODUCTION

The purpose of this report is to provide assurance to The Worcester Acute Hospital NHS Trust (WAHT) Board of Directors, Governors and the public for the reporting period 1 April 2024-31st March 2025 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (update December 2022) (commonly known as The Hygiene Code) and with regard to appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils the Trusts' statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Updated December 2022), which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual programme which is monitored at the Trust's quarterly Infection Prevention and Control committee (TIPCC) meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase organisational focus and collaborative working to ensure continued compliance and continuous improvement.

The report also reflects the IPC Board Assurance Framework (IPC BAF). It is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework and sets out our priorities and plans to achieve further improvement and reductions in infection during 2025-26 and achievement of the quality priorities.

Liz Watkins. Associate Chief Nursing Officer/ Director of Infection Prevention & Control (DIPC)

Table 1

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

Infection Prevention and Control is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers (WHO) it is essential to ensure that the safety and quality of care for our patients can be provided. At Worcester Acute Hospitals NHS Trust (WAHT) infection prevention and control is a key priority.

Our Trust is committed to delivering the highest infection prevention and control standards to prevent avoidable harm to patients, visitors, and staff from healthcare associated infection. It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times.

The infection prevention and control agenda faces many challenges including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing service development in addition to national thresholds and outcomes. The Trust Infection Prevention and Control Team experienced several changes in personnel over the last year and recruitment into the team has been challenging. This has resulted in periods of reduced staffing levels and reduction in the service provided to clinical teams.

The Board of Directors and ultimately the Managing Director, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year, the 2024/25 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia and *Clostridioides difficile* infection (CDI) as areas for improvement. Within Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm of the Outcomes Framework reducing all HCAIs remained a priority.

As previously reported, the extension to the mandatory surveillance to include Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Escherichia coli (E. coli) Bacteraemia infections since 2011 together with the MRSA Bacteraemia and CDI national reduction thresholds set for Integrated Care Systems (ICS) reflects the zero-tolerance approach for all avoidable HCAIs.

This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2024 -31 March 2025 by WAHT. The report is aligned to the 2024/25 IPC Programme, informing progress against the objectives set and outlines performance of WAHT against the MRSA Bacteraemia and CDI reduction thresholds.

In addition, the report aims to reassure the public that reducing the risk of infection through robust infection prevention and control practice is a key priority for WAHT and supports the provision of high-quality services for patients and a safe working environment for staff.

SECTION TWO:
WHO ARE WE, OUR DUTIES, ARRANGEMENTS AND ASSURANCE

2.1 Who are we?

As a Trust, the Worcester Acute hospitals provide health services to around 450,000 people in Worcestershire. These include three hospital sites, Worcester Acute, the Alexander Hospital in Redditch and Kidderminster Hospital and Treatment Centre as well as some community-based services.

We provide a wide range of services to a **population of over 603,000** people in Worcestershire as well as caring for patients from surrounding counties and further afield.

In a year we…

- Over the last year, we provided care for:

  - **549,464** outpatients (face-to-face appointments)
  - **121,015** outpatients (video or phone appointments)
  - **143,002** inpatients
  - **125,549** walk-in patients in A&E
  - **45,390** patients arriving by ambulance.
  - **4,710** births

We also carried out:

- **20,554** elective operations
- **4,300** emergency operations
- **2,826** trauma operations
- **197,904** plain film x-rays
- **79,333** CT scans
- **23,759** MRI scans
- **73,782** non-obstetric ultrasound scans
- **22,012** endoscopies

We employ over 7,500 people and **over 380 local people volunteer** with us. We have an annual **turnover of nearly £600 million**.

Our catchment population extends beyond Worcestershire as our patients also come from neighbouring areas including South Birmingham, Warwickshire, Shropshire, Herefordshire, Gloucestershire, and South Staffordshire. This results in a catchment population which varies between 420,000 and 800,000 depending on the service.

In 2017, a 'Foundation Group' was created in partnership with South Warwickshire University NHS Foundation Trust (SWFT) and Wye Valley NHS Trust (WVT). In 2018, George Eliot Hospital NHS Trust (GEH) joined the Group.

WAHT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the

best outcome for patients. The IPC team utilises both a reactive and proactive approach with the emphasis on being visible so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e., being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems.

Looking forward, it is critical that WAHT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations, commissioning Integrated Care Board (ICB), and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England.

2.2 Our Duties & Arrangements

Infection Prevention and Control Service:

- Executive Director of Infection Prevention and Control (Chief Nursing Officer)
- Associate Chief Nursing Officer/ Director of Infection Prevention and Control
- Infectious Diseases Doctors / Consultant Microbiologists
- Antimicrobial Pharmacist
- Infection Prevention and Control Nurse Specialists
- Infection Prevention and Control Nurses
- Fit mask testing Team
- Infection Prevention and Control Team Admin support
- Mattress cleaning teams

The Executive Director of Infection Prevention and Control (EDIPC) is a role required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008, updated 2022). The EDIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable HCAIs at all levels within the organisation.

The EDIPC is the public face of IPC and is responsible for the Trust's annual report, providing details on the organisation's IPC programme and publication of HCAI data for the organisation.

The EDIPC leads the commitment to quality and patient safety, effective communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. Additional support is provided by the antimicrobial pharmacists, IPC Doctor/ Consultant Microbiologist, and Director of Infection Prevention and Control (DIPC). All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Hygiene Code.

At WAHT, the Chief Nurse holds the role of EDIPC supported by the DIPC who has the responsibility of providing expert advice and day to day operational management of the service reporting to the Chief Nursing Officer (CNO).

2.3 The Infection Prevention and Control Team

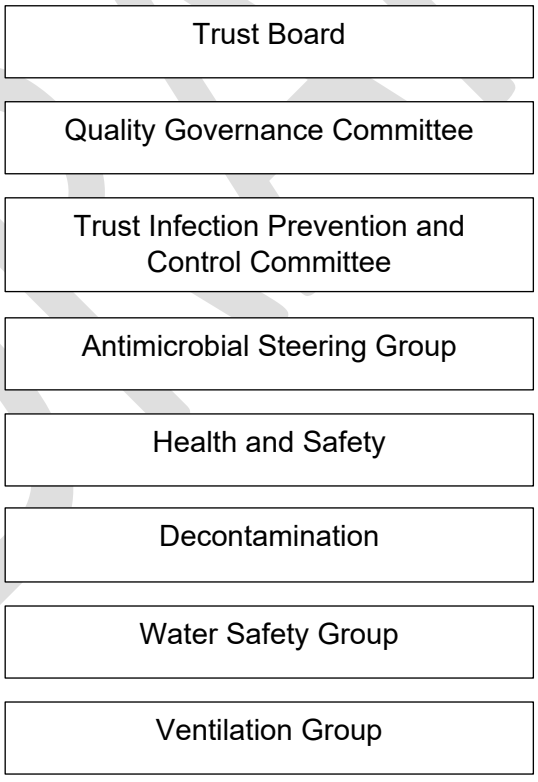
The DIPC has overall responsibility for the IPC Team. The IPC Team works collaboratively alongside clinical leaders at the Trust.

The IPC Team is led day to day by the DIPC for IPC and is supported by Infection Prevention and Control Nurse Specialists, Infection Prevention and Control Nurses, Fir mask testers, Mattress decontamination team, IPC Team Admin support.

The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development.

The IPC team devises and implements a robust Annual Programme of Work to reduce HCAIs. This is achieved by working in collaboration with all WAHT services and staff. The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

2.4 Committee Structures and Reporting Processes



Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Managing Director has overall accountability for the control of

infection at WAHT, and any IPC matters across the trust.

WAHT's performance against National and local thresholds are included in the Integrated quality Performance Report (IQPR) and TIPCC Reports which are presented at WAHT Quality Governance Committee

Quality Governance Committee

Quarterly IPC reports, the IPC Board Assurance Framework and the IPC Annual report are presented to the Quality Governance Committee (QGC) meetings. The QGC is chaired by a Non - Executive Director (NED), it is a delegated committee of the Trust Board which meets monthly. The purpose of the QGC is to provide oversight and scrutiny of infection prevention and control standards and practices and seeking assurance that IPC Standards are being met. The QGC will provide assurance to the Trust Board around WAHT's arrangements for protecting and improving the quality and safety of patient-centered healthcare, thus improving the experience for all people that encounter the services at WAHT.

Trust Infection Prevention and Control Committee (TIPCC)

The membership is multi-disciplinary and includes representation from the divisions, operations and quality directorates, estates department, antimicrobial pharmacists, and Consultant Microbiologist. Additional members are representatives from UK HSA, ICB and Private Finance Initiative (PFI) partners and patient representatives. The meeting is chaired by the EDIPC and meet quarterly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation and they are reviewed and approved by the QGC. The IPC BAF is also presented, discussed, and adopted at TIPCC before being presented to the QGC and the Trust Public Board. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

The purpose of this meeting is to oversee compliance against the Health and Social Care Act (2008, updated 2022) and to provide assurance that risks are appropriately managed and that appropriate arrangements are in place to provide safe, clinical environments for patients, visitors, and staff.

The IPC Governance Meeting is chaired by the EDIPC and is responsible for:

- Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.
- Reviewing, developing, and adopting relevant policies, procedures, care pathways and guidelines and standard operating procedures.
- Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.
- Ensuring, through the EDIPC, the associated Committees and the Trust Board are informed of any significant infection prevention and control concerns.
- To receive, review and endorse the publication of the Infection Prevention and Control Annual Report.

- To ensure that the wider aspects of maintaining IPC are reported and reviewed within the IPC group these include Health and Safety, Estates and Facilities, Water Safety, Antimicrobial stewardship, and occupational health.
- Effective management of IPC related outbreaks and concerns

Water Safety Group

The membership is multi-disciplinary and has representatives from PFI Partners and Authorising Engineers. The Group continues to monitor water risk assessments especially around Legionella, pseudomonas, flushing regimens, annual disinfection, Automated Endoscope Reprocessor (AER) and capital developments.

Decontamination Group

This group is chaired by the DIPC. The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The group monitors, challenges, reviews, and where appropriate acts in response to presented assurances to ensure that the trust is demonstrating compliance against regulatory standards. The aim of the group is to identify any risk factors in relation to decontamination, to identify any trust strategies for the safe decontamination of medical devices in accordance with national and local guidelines with particular reference to HTM 01-01 and 01-06, Decontamination policies, Health, and Social Care Act 2008 (updated 2022), MHRA guidelines, NICE IPG 196 Guidance – replaced with IPG 666 2020 and Care Quality Commission (CQC). The group receives reports from Endoscopy services, Outpatients and Specialist Surgery, Sterile Services (HSDU), theatres and Imaging with the group meeting quarterly. A Terms of Reference and Governance structure was developed and is reviewed by the Decontamination Group annually. The Group reports to the TIPCC Meeting.

Ventilation Group Meeting

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor ventilation risk assessments especially around air handling units, air extraction and capital developments.

2.5 Roles contributing to IPC service

DIPC and Consultant Microbiologist

The DIPC, and Consultant Microbiologist meet weekly to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

Infection Prevention and Control Link workers

The aim of our IPC link worker is to enhance the IPC knowledge of healthcare professionals working within WAHT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. Our IPC link workers are responsible for arranging IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

Quarterly link worker meetings are offered with the expectation that IPC Link workers attend regularly.

Divisional Leads, Matrons, Ward Manager, Sisters, Charge Nurses, and Team Leaders

Divisional leads, Ward Matrons, Sisters, Charge Nurses, and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Monthly cleanliness audits are undertaken with staff. These audits are reported in the Divisional Leads and Estates reports to the TIPCC meeting. The Sisters, Charge Nurses, Matrons and Team Leaders are responsible for ensuring the link workers are supported in performing their role and have appropriate time and resources to do this effectively. Self-audit scores and on-going work undertaken by the link workers is also included in Managers reports submitted to the TIPCC meeting.

Learning and Development Team

Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Arrangements are in place for staff training to be effectively recorded and maintained in staff records. Alerts inform managers of their staff's non-compliance with mandatory training. Training compliance is reported to TIPCC.

Roles and Responsibilities of all Staff

All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow the standard IPC precautions at all times and are familiar with IPC policies, procedures, and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and act as appropriate. All IPC policies and procedures are available on the staff intranet site, The Source.

SECTION THREE - Compliance with the Health & Social Care Act (2008); Code of Practice on The Prevention and Control of Infections and Related Guidance (2015)

Statement of compliance - Compliance with the Health & Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance (2015) (updated 2022):

The 'Hygiene Code'

Declaration of Compliance

Following self-assessment against the criteria in the Hygiene Code, the Trust is able to declare our compliance with the Hygiene Code for the year 2024-25.

Further, based upon our self-assessment in 2024-25 we are able to declare our partial compliance with the IPC Board Assurance Framework.

Criterion 1: Systems to manage and monitor the prevention and control of infection.

Leadership Arrangements

The *Health & Social Care Act (2008) Code of practice on the prevention and control of infections and related guidance (2015)* (Updated 2022) (also known as the Hygiene Code) sets out the arrangements all Trusts should have in place to prevent and manage infections.

An IPC specific Board Assurance Framework was introduced, most recently updated in February 2025. Regular self-assessment of compliance has been completed, with scrutiny via the Trust Infection Prevention Committee (TIPCC), then progressing along the governance structure to the QGC on behalf of the Trust Board. This has enabled the Trust to report a high level of assurance that we comply with the IPC BAF, as well as the Hygiene Code.

NHS England have kept the Trust on Enhanced surveillance due to the breach in the HCAI alert organisms. It should be noted this is a regional and national position with many Trusts exceeding the set Trajectories. This should not detract from the work that has been carried out to address the high infections rates.

The Trust Board remains committed to the prevention of infection as a priority, ensuring quarterly scrutiny by the Quality Governance Committee on behalf of the Board. The CNO is the executive lead for IPC and the DIPC supports the strategic delivery of the IPC program.

WAHT has a multi-disciplinary Infection Prevention Team led by the DIPC. The team has dedicated resources available to support its work and received support for implementation of several measures during the year to support the response to HCAI cases and outbreaks.

The Trust's Clinical Microbiologists support the team in all aspects of infection prevention including outbreak management, surveillance for and management of healthcare associated infections and policy development. This support is led by the Infection Control Doctor, a role currently shared between two Consultant Microbiologists. In addition, the Trust's clinical microbiology laboratory facilitates screening for and detection of key infections (known as alert organisms) both from clinical and environmental samples, as well as supporting the COVID-19 swabbing programme for our patients and staff.

Consultant Microbiologists and the Infection Prevention Team continue to support improved use of antibiotics as part of our antimicrobial stewardship work. The Antimicrobial Stewardship (AMS) Pharmacist has now been appointed and there are AMS leads within divisions.

Divisional Leaders remain committed to providing strong and visible leadership in relation to the prevention of infection. The responsibility of all staff to ensure they adhere to expected standards of infection prevention practice is set out in Trust job descriptions and has been reinforced on a regular basis throughout the year via a range of communications. Awareness of individual and managerial responsibilities has increased significantly.

Governance and Assurance

The DIPC reports to the CNO (EDIPC), the Managing Director and onwards to the Board on all matters relating to infection prevention and control.

The TIPCC business meeting, chaired by the CNO, is held once every 3 months, and TIPCC Scrutiny and Learning meetings take place in each of the intervening months and are chaired by the DIPC. TIPCC has formally established terms of reference and a cycle of business, in line with requirements in the Hygiene Code. It reports to the Quality Governance Committee, and onwards to the Trust Management Executive, which scrutinises performance and actions being taken on behalf of the Board.

The TIPCC Scrutiny and Learning Meetings provide an opportunity for detailed scrutiny of patients with HCAI's resulting in shared learning across the Trust and enables focus on the key issues needed to achieve improvement.

Divisions and key services such as Estates and Facilities report to TIPCC on the actions they are taking to reduce infections and improve standards. The reporting framework ensures Divisions review and understands variations in practice and hotspots requiring focused action.

Criterion 1: Systems to manage and monitor the prevention and control of infection.
• Leadership and governance arrangements are in place in line with Health and Social Care Act 2008 ~ (updated 2022) requirements. • There are robust Governance processes in place and the risk management system is used to support decision making and ensure the correct mitigations are in place. • A multi-disciplinary Infection Prevention & Control Team is in place, including nursing, administration along with data support and microbiology. • Patient representatives attend Trust infection prevention and control group. • CDI HCAI trajectory was breached despite extensive work programme to address the key themes and trends. • Executive Director for IPC sits on the Trust board. • A range of actions were taken during the year to identify and implement key improvements needed so that we can achieve the infection reductions needed.

- Our *Fundamentals of Infection Prevention and Control* are a core part of our programme.
- Continued working with system partners to review and reduce HCAIs including CDI.
- Continued working with partners to ensure smooth transfer of care between organisations and systems.
- Information on our Fundamental of IPC are displayed across the Trust. This includes wards displaying their achievement of the standards required.
- Our internet page contains key information for our patients and visitors, and the Trust use social media to share key messages to the public regarding infections including Norovirus, Influenza etc.
- Masks are available at Trust sites to ensure patients and visitors have the option to wear a face mask.
- Daily outbreak reports continue and are shared with our systems partners.
- The Trust EPR system has an IPC risk assessment in place to ensure correct placement of patients.
- TIPCC meeting TOR and membership reviewed annually.
- DIPC has provided quarterly reports to Quality Governance Committee including thresholds, risks, and progress against objectives.
- The Annual IPC Report is produced and presented to the public board.
- The Annual IPC Report is made available for public viewing via the Trust website.
- *Clostridiodes difficile* Improvement plan was developed and reviewed and monitored at the IPCG meeting.
- IPC BAF was developed, updated as required and presented to the TIPCC, QGC and the Public Board
- Risks associated with infection have been entered on the Trust risk register and are reviewed monthly.
- The IPC team continued to identify IPC risks and areas of weakness in policy and practice though audit and surveillance.
- CQC Provider Compliance Assessments completed.
- Information shared with external agencies and partners when requested.
- IPC Team has worked alongside clinical staff in the hospitals as a mechanism to deliver teaching and education to staff.
- All infection outbreaks reviewed, and service improvement plans developed so that relevant learning was appropriately communicated and acted upon.
- PIRs were completed for all patients who developed CDI.
- Alerts are added to patients' EPR to highlight risk of infection.
- New electronic patient record alerts have been developed to reflect emerging infections supported by informatics.
- IPC audit tools adapted in 2011/12 from the Department of Health (DH) /Infection Prevention Society Quality Improvement Tools and DH Saving Lives care bundles have been revised and updated to incorporate new guidance. These are reviewed and updated annually.
- High Impact Intervention audits are completed by the wards.
- IPC training is delivered via a mixture of face to face, bespoke and via a Heath Education E-learning package.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

- Our deep cleaning teams remain an embedded part of our cleaning programme; they remain responsive to the request for deep cleans.
- The use of HPV and UVc systems continue,

- The Trust has continued to monitor our cleaning standards using the national MICAD system and ensured results are available for all staff on the trust electronic quality reporting system.
- All areas have a functional risk assessment in line with the National Standards of Healthcare Cleanliness 2021
- A robust system of environmental audits is in place.
- All areas have a star rating displayed and reviewed annually as a minimum.
- Star ratings are reviewed if there are two consecutive audit failures as well as two consecutive improvements and adjusted accordingly.
- There is still improvement required on how audits are responded to.
- Cleanliness Scrutiny meeting in place to review all scores of 3* or less.
- We have scrutiny processes in place where concerns about cleanliness are identified.
- IPC audits also review levels of cleanliness and escalate concerns.
- Cleanliness scores reported to TIPCC.
- Annual PLACE assessments undertaken.
- Regular IPC site reviews with external partners

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

- Antimicrobial stewardship (AMS) made good progress with antimicrobial ward rounds.
- The Trusts new antimicrobial pharmacist commenced in post in April 2024.
- All Divisions have Divisional Board approved action plans to improve AMS and have improved their assurance levels during 2024-2025.
- Improvements are required to increase medical engagement in AMS.
- Trust Antimicrobial Treatment Guidelines are published on The Source.
- Participate in World Antimicrobial Resistance Awareness Week in November
- Trust has AMS meetings.
- Trust attends system AMS group meetings
- Work has taken place to implement the new electronic patient Record (EPR) for medications which will be implemented in 2025.
- Sepsis training is available for staff.
- NEWS and PEWS are used widely throughout the Trust.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

- Information on our *Fundamental of IPC* are displayed across the Trust. This includes wards displaying their achievement of the standards required.
- Our internet contains key information for our patients and visitors, and we have used social media to share key messages to the public.
- Masks are available to ensure patients and visitors have the option to wear a face mask.
- Daily outbreak reports continue and are shared with our systems partners.
- The EPR system contains an IPC risk assessment in place to ensure correct placement of patients.
- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.
- Communication boards are located across the Trust providing patients and visitors of key communication.
- The IPC Team have a page on the Trust intranet page which provides information

to staff.

- The external Trust website also has key messages relating to infection prevention and control.
- The Trust Intranet, The source, promotes infection prevention issues and guides users to information on specific alert organisms such as MRSA and *Clostridioides difficile* as well as key organisms that may be of particular concern seasonally.
- IPC produced an annual report covering the organisation's approach to prevention and control of infections for publication on the Trust's website.
- Hand hygiene included in patient/visitor/volunteer/staff/agency staff information leaflets.
- Strategically placed hand hygiene products available with information on their use.
- Continued encouragement for patient and public involvement in hand hygiene and cleanliness campaigns and services' Quality Review process, satisfaction surveys and PLACE inspections.
- Polices related to specific organisms and care pathways remind staff of the need to give affected patients and relatives leaflets about the infection.
- The IPC team continue to respond to ad hoc requests for information related to IPC under the Freedom of Information Act.
- IPC requirements are included in the health economy transfer/discharge form.
- IPC team share infection rates and outbreak information with appropriate services based upon local, regional, and national surveillance.
- Surgical Site surveillance data is submitted externally.
- Alert organism surveillance by the IPC team.
- IPC policies and procedures are available on the IPC page on the Source.
- MRSA screening compliance shared.
- IPC team promoted Clean Your Hands Day, Infection Prevention and Control Week and Antimicrobial Awareness Week.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

- Assessment tools for infection risks are in use for patients on admission and throughout the in-patient stay. This includes diarrhoea and vomiting as well respiratory risk assessment tool.
- EPR has been adapted to ensure the correct information is recorded to enable the correct level of reporting from the system. Work continues to improve education and compliance.
- Our Infection Prevention & Control Team provide a service to advise and support clinical staff on all infection-related queries.
- COVID testing moved to symptomatic testing only, there is a daily symptom checker in place that is in line with the National guidance for COVID symptom, this also covers the possibility of influenza.
- Outbreaks and infection-related incidents have been effectively dealt with in 2024-25. These are listed in Appendix 1.
- Responsibilities of groups and staff included in IPC policies.
- Support provided by IPC team included visits and telephone contact.
- Continued to develop link staff and support their role.
- Continued to audit compliance with IPC polices and care pathways.
- IPC team has access to IC NET Laboratory IT system.
- IPC team reported outbreaks and incidents of infection to the ICB, UK HSA and NHSE Outbreak of infection meeting are held with external partners and agencies to ensure transparency and that any lessons learnt are disseminated throughout the organisation.

- IPC received notification of outbreaks of infection within the local health economy.
- IPC specific organism policies available on the Source.
- Patients are screened for MRSA on admission.
- Antibiotic policy available to all clinicians.
- PIRs will be undertaken on all MRSA Bacteraemia.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.

- Highly visible senior nursing leadership has been maintained through leadership visits by divisional teams, the DIPC and the Chief Nursing Officers and deputy CNO.
- Statutory and mandatory training and Trust inductions continue to include infection prevention and control as core requirements.
- At the end of 2024-25, mandatory level 1 training (non-clinical staff) achieved 96% compliance meeting the Trust requirement. Level 2 training (clinical staff) was at 90% compliance. All divisions are above 90% for level 1 training.
- A significant amount of ward-based training, electronic resources and posters have been put into place to support staff knowledge and awareness as the pandemic continued to devolve and guidance changed during the year.
- We have acted on the learning from our review process for cases of *Clostridioides difficile* infection and HCAI infections. As a result of our reviews, we have a good understanding of the causes of these infections, and quality improvement measures are in place focussed on reducing these infections.
- Alerts are added to Sunrise to highlight risk of infection.
- Compliance with MRSA screening policy audited monthly, and findings shared.
- As appropriate, joint investigations and reviews held between local partners and the acute trust on cases of MRSA Bacteraemia and CDI.To assist staff with managing outbreaks.
- Bespoke IPC Training is delivered if need identified.
- IPC team supported the development of Trust clinical policies/procedures and Standard Operating Procedures (SOPs).
- Infection Prevention and Control Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in The Trust via a Q711 form.
- The IPC Team has attended conferences and study days throughout the year.

Criterion 7: Provide or secure adequate isolation facilities.

- The Trust has over 130 single rooms available to support isolation requirements. It should be noted that not all have en-suite facilities.
- Trust policy includes use of cohort facilities to nurse patients with the same infections when numbers exceed the number of single rooms.
- This cohort model has been used extensively, and this model has continued to be utilised for patients with the same infection, being flexed up and down depending upon the number of patients infected.
- Throughout the year we have amended our processes in response to the changing national guidance for the management of infections.
- Measles and MPOX have been a focus, and pathways have been developed to ensure that all patients and contacts are managed effectively.
- Isolation Risk matrix developed to aid patient placement.
- Risk assessments performed by ward staff with support from the IPC team when insufficient isolation facilities were available to meet demand.

- Cohort approach taken as necessary within the trust during outbreaks of diarrhoea and vomiting.
- All episodes where staff are unable to isolate patients are reported to Risk Management via Datix.
- COVID-19 swabbing has continued throughout the year in line with National Guidance.

Criterion 8: Secure adequate access to laboratory support.

- We have an onsite microbiology laboratory which is accredited by UKAS, confirming it operates an effective and quality-controlled service.
- The laboratory links with regional and national laboratory networks as required to provide a full range of microbiology testing.
- The laboratory provided sufficient capacity for on-site testing for our patients. Specialised samples such as measles PCR were sent to the regional lab.
- There remain staff capacity issues in the department which at times increases the pressure on the clinical teams.
- Weekly meetings are held with the IPC team to review HCAI cases.
- The DIPC and Consultant microbiologists meet weekly.
- Out of hours, the on-call duty microbiologists will provide Infection Prevention and Control advice for the Trust.
- Continuation of rapid testing for *Clostridiodes difficile* and use of typing to search for clusters and linked cases.
- Continuation of local test for Norovirus to speed up diagnosis and outbreak management of patients with infection.
- Continuation of local test for influenza to speed up diagnosis and outbreak management of patients with infection.
- Local testing for COVID-19 for symptomatic patients
- Point of Care testing available in Emergency Department for COVID-19 and Influenza
- Adequate resources available in laboratory for MRSA screening in line with national guidance.
- Mandatory surveillance also included MSSA, E. coli, pseudomonas Bacteraemia infections.
- Consultant Microbiologist is the IPC Doctor.
- Medical microbiology support provided 24 hours a day 365 days a year.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Use of national High Impact Intervention audit tools to monitor compliance, this will be reviewed next year to align to the EPR system. GAP and WREN results are available for all staff to view on our electronic quality reporting system, helping support improvement.

- Our policy review programme has been progressed, with the few outstanding policies in the process of being reviewed.
- Throughout the year we have implemented a wide range of policies and procedures to manage infection and promote prevention, in line with national guidance. We have put the National Infection Control Manual on to the intranet that is available to all.
- All policies refer to the National IPC manual.
- Participation in hand hygiene audit has improved since last year and now runs at no less than 87%. However, we continue to achieve hand hygiene practice compliance of 98%.

- Published evidence reviewed whenever policies were developed or reviewed on publication of new national guidance to ensure they reflect up to date, evidence based, best practice national guidance.
- New policies developed as need identified.
- In collaboration with Pharmacy commenced work to implement the relevant recommendations of the Tackling Antimicrobial Resistance 2024-2029, the UK's five-year national action plan.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

- Our Occupational Health Service along with Human Resources Team (Health, Wellbeing and Flexible working) supports the health and wellbeing of our staff, as well as the staff of our PFI partners.
- A health monitoring and vaccination programme is in place.
- We did not meet our staff influenza vaccination target.

SECTION 4 – Infection Performance

Respiratory Viral Infections

There remains a significant shift in focus and Living with COVID was promoted by UK HSA and NHS England. This was based on the lower impact of the current variants on mortality and admission to hospital. However, COVID has still impacted on the Trust's position as we continued to see patients admitted with COVID and acquire COVID whilst an inpatient. There are many variables to the acquisition.

The screening requirement is for symptomatic patients only. At times, these symptoms can be interpreted as other issues and a screen not taken as the symptom checker describes very broad signs of infection. The full respiratory panel was introduced as the Influenza season was declared. This enables multiple respiratory viruses to be detected.

This year Respiratory Syncytial Virus (RSV) in adults and children was more prevalent than previous season. This again was challenging as there was a requirement to recommend isolation for these patients. RSV is usually a very low-level infection with only minor symptoms, however this year the impact was greater on patients who were sicker and more symptomatic.

Influenza cases were significantly higher than last year with the trust managing multiple cases and outbreaks. Due to the number of influenza cases requiring isolation, a risk assessment was completed to reduce the isolation time for influenza patient contacts (patients who were contacts of influenza positive patients) to prioritise the side room use for those with active infections. The isolation of flu contacts is custom and practice and not based on any Acute NHSE/UK HSA guidance. The reduction in flu contact times has not resulted in acquisition of influenza.

This section of the report focuses on a summary of the actions we have taken to protect staff and patients from infection, as well as reporting information on hospital-acquired infection and outbreaks.

COVID-19 is reported to have an incubation period (the time between catching the infection and showing symptoms) between 1-11 days. This means someone can be admitted to hospital with no symptoms and test negative for COVID-19, despite having already caught the infection. National guidance sets out the following definitions for categorising COVID-19 infections which are detected during admission to hospital:

Community acquired	Onset day 0-2
Hospital onset – indeterminate acquisition	Onset Day 3-7
Hospital onset – probable hospital acquired.	Onset day 8-14
Hospital onset – definite hospital acquired.	Onset day 15 onwards

*The day of admission is Day Zero.
This has remained the same guidance and is unlikely to change in the foreseeable future.

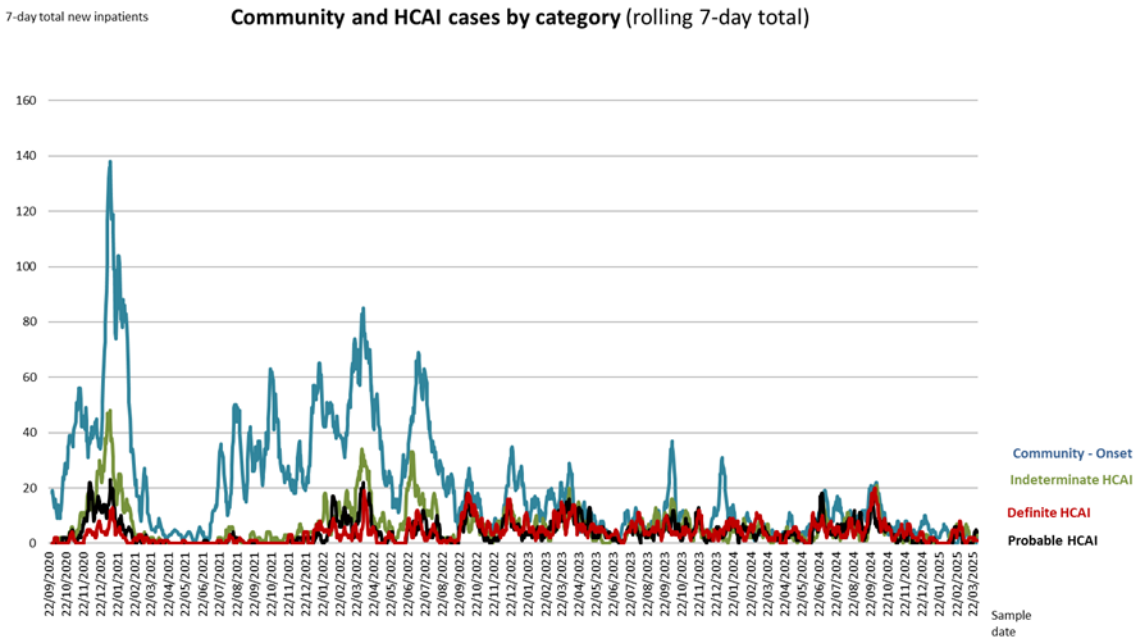
During the year 2024/25 we cared for 987 patients with COVID-19 infection.
This is a decrease of 19% when compared to the number of patients treated in 2023/24.

Of these 393 were determined to be probably or definitely acquired in hospital. This is 43% of all COVID patients treated in 2024/25.

This is a slight increase on the 41% of hospital acquired COVID infections in 2023/24. This should be caveated with the screening standard as only symptomatic patients are screened on admission.

Some symptoms may be low level, and the patient may not be considered symptomatic, so not swabbed.

Category	Category description	Total
1. Community-Onset	Positive specimen date <=2 days after admission to Trust	398
2. Hospital-Onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after admission to Trust	196
3. Hospital-Onset Probable Healthcare-Associated	Positive specimen date 8-14 days after admission to Trust	186
4. Hospital-Onset Definite Healthcare-Associated	Positive specimen date 15 or more days after admission to Trust	207
Total		**987**



Outbreaks of COVID-19 Infection

Despite our efforts, in line with many other trusts, we were unable to fully contain this highly transmissible virus and reported fifty-eight ward outbreaks during 2024/25. Each outbreak was reported and managed in line with national requirements.

Review and Learning
There are quarterly COVID outbreak meetings and there is a review of all outbreaks for the quarter. The Divisional Governance teams present cases and the learning that has happened at Divisional level to enable wider dissemination of learning.

Measures Taken to Protect Patients from Hospital-Acquired RESPIRATORY virus.

Throughout the year there have been steps put in place to ensure that the appropriate risk assessment and safe patient placement occurs. The Trusts EPR system has enabled staff to have access to a respiratory risk assessment tool. Where patients with a confirmed or suspected respiratory virus are placed is regularly reviewed, by both the ward and IPC team to ensure patients are separated as far as possible from those who do not have a respiratory virus.

- Hand hygiene messages are reinforced regularly to encourage staff and patients to clean their hands more often than normal.
- Alcohol hand gel is readily available in all areas.
- There is a risk assessment in place to determine when there is a requirement for universal mask wearing. This is based on number of cases, staff sickness and community prevalence.
- Access to masks for patients/visitors is available.
- The Trust continues to clean with disinfectant products that are effective against respiratory viruses.
- Special air scrubbers were installed in key areas to help to reduce the risk of airborne transmission of COVID-19.
- We swab patients in line with guidance to identify anyone who presents with respiratory and wider symptoms.
- The Infection Prevention and Control Nurses visit our wards regularly to support staff and check standards.
- The Trust takes take rapid action if an outbreak is identified to stop further spread of infection. This includes deep cleaning the ward and swabbing patients in the affected area.

Carbapenemase-Producing Enterobacterales (CPE)

CPE has been an endemic problem at the Worcester site for approx.4 years where CPE was identified following an outbreak in the Laurels wards and zonal kitchen.

There is a continued surveillance program that requires patients to have an admission and then then weekly screens. This checks for any ongoing acquisition of the organism that results in colonisation that may lead to an infection.

During 2024/25 there were 2 outbreaks of CPE. Aconbury 4 outbreak a total of 2 patients were found to be colonised, clinical, estates and facilities interventions halted the outbreak promptly. Avon 4 outbreak a total of thirty-six colonisations cases was identified through routine screening. An extensive investigation was completed by the trust; assistance from UK HSA, NHSE and ICB was sort as despite multiple interventions (estates works, HPV cleans and strict IPC precautions) and extensive MDT effort (Clinical Team, IPC, Microbiology, Facilities and Estates) we were unable to identify the source of the CPE. The zonal kitchen was not implicated in this outbreak. The source of the outbreak was suspected to be from hand wash basins and oral care. There have been no new cases since September 2024.

Measles

There has been a resurgence of measles in the region, particularly in Birmingham where there has been a high number of cases.

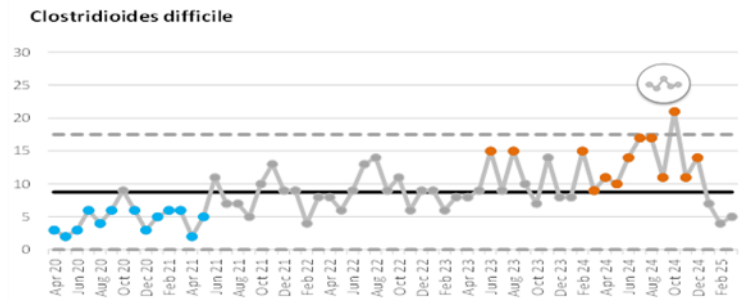
In preparation for potential cases, clinical pathways were devised. A screening tool is used to enable early identification of cases and therefore earlier isolation. Staff were encouraged to seek Occupational Health advice regarding vaccination status.

Measles Immunoglobulin pathways developed and shared with ICB.

The Trust has seen very few cases, and the appropriate care and treatment was received by the patients. Contact tracing was completed for patients and staff and actions taken as per the National guidance. There were no transmission events in the Trust to report.

In 2024-25 we achieved the 3 out of the 5 (MRSA, E. Coli, and Pseudomonas) national infection reduction targets. We were close to achieving our Klebsiella objective being over by 1 case. We did not achieve our internal target for MSSA bacteraemia reduction. Nationally there has been an increase of HCAI. We are unsure of the reasoning behind the increase, and this is currently being reviewed by UK HSA and NHS England. The Trust achieved zero MRSA bacteraemia which was a reduction from 7 reported in 2023/2024.

HCAI National Targets 2024/25	Outcome Against Target
Clostridioides difficile infection= 142 Vs 129	❌
MSSA = 46 Vs 40 (internally set)	❌
MRSA= 0 infections	✅
E coli BSI = 105 vs 112	✅
Klebsiella species= 36 vs 35	❌
Pseudomonas aeruginosa BSI = 12 vs 15	✅

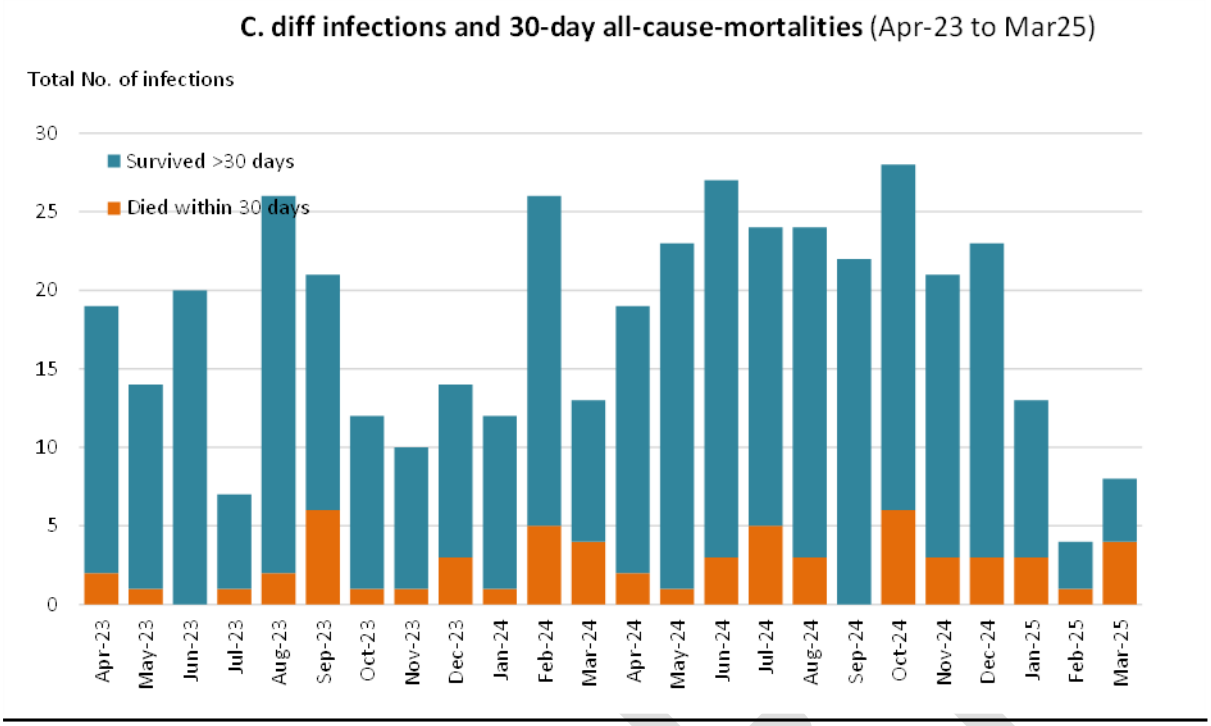
***Clostridioides difficile* Infection (CDI)**	**How Are We Doing?**
	We did not meet our improvement target this year. We reported 142 vs 129 full-year target, although most recent months show a reducing number.
To Reduce These Infections, We Have….	

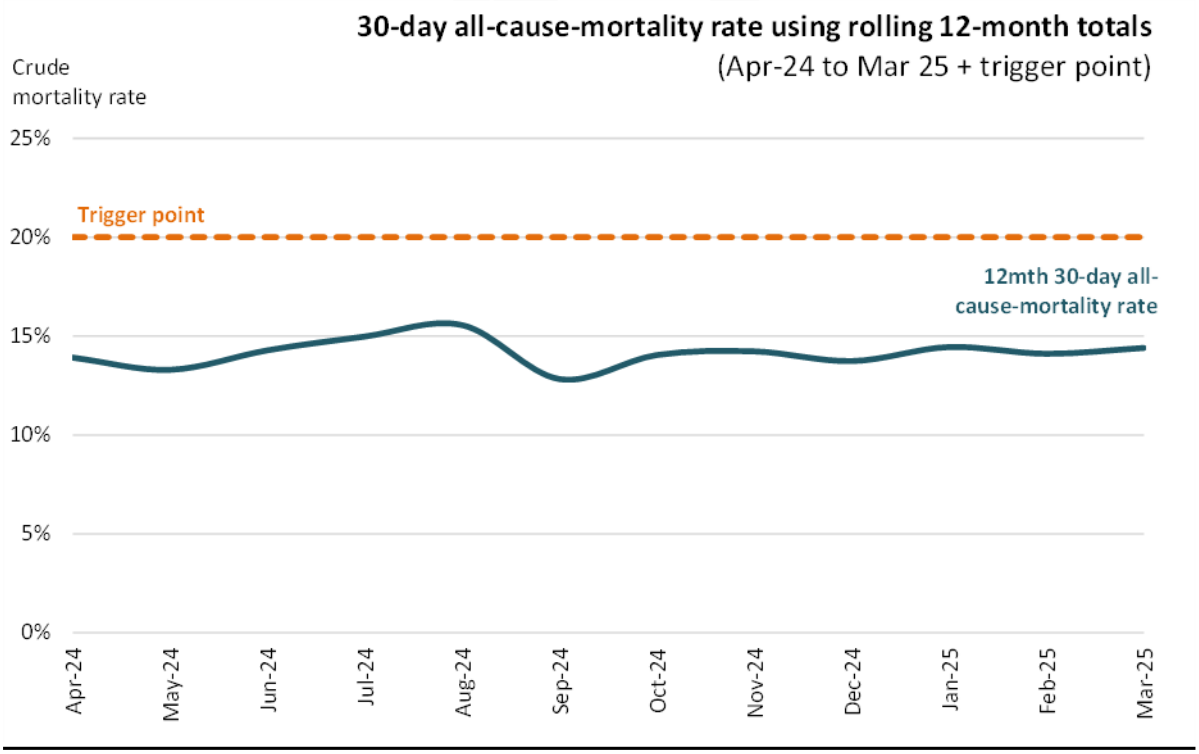
- Aligned case reviews with the PSIRF model which has allowed us to focus on the themes and trends obtained through the MDT case reviews.
- As a result, C. diff related documents are now embedded into the EPR system, cleaning standards and Star ratings are reviewed more frequently, and isolation facilities are easily identified with the implementation of a new daily side room report.
- Antimicrobial prescribing and stewardship (AMS) is well-recognised as a significant factor in the development of CDI. Throughout the year we have had a major focus on AMS, including monthly audits to monitor our compliance with the national *Start Smart Then Focus* principles. We have achieved significant improvements in AMS this year. 2024-25 saw the e re-implementation of an MDT approach to C.diff reviews with the Trusts newly appointed AMS pharmacist.
- Improved communication and awareness of C.diff between the Trust, positive patients, and GP colleagues by providing C.diff information following discharge in an attempt to prevent relapse and associated complications.
- "Gloves Off" campaign focused on staff use of PPE.
- Equipment trials are in progress to replace bed pan washer disinfectors on the WRH site with macerator systems, to reduce the risks of cross contamination caused by multi patient use items. There are 3 bed pan macerators (3 different suppliers) installed at the WRH site, all received favourably by the clinical teams and so far, no reported issues with drainage-blockages or leaks.
- Patient advice leaflet "Preventing Infections."
- Held drop-in sessions for Hand Hygiene and commode cleaning training and competence.
- Red, amber, Green (RAG) poster was updated and awareness promotion undertaken.
- Bed cleaning video is now part of mandatory training.

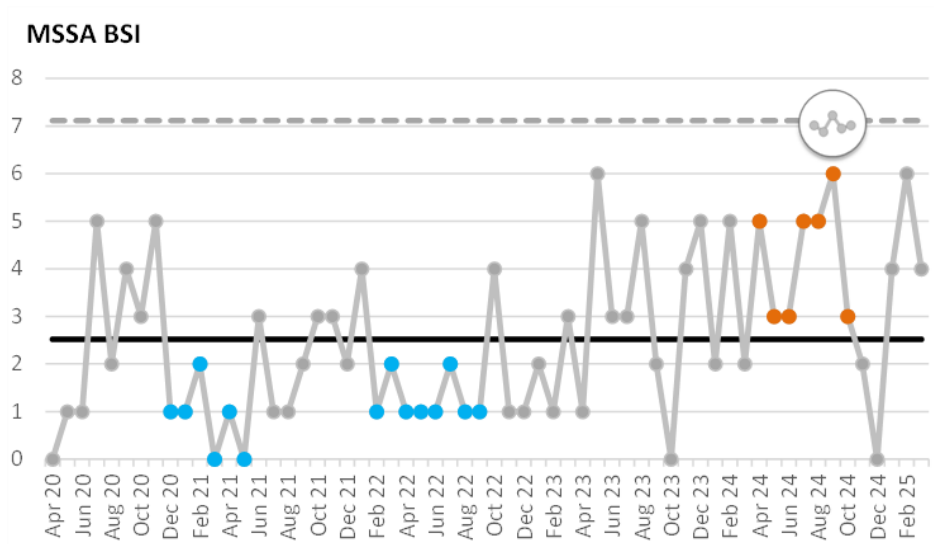
***Clostridioides difficile* 30-day all-cause mortality**

It is recommended in national guidance that 30-day all-cause mortality be monitored in CDI patients. The following graphs therefore show this: the number of patients who have died of any cause in the 30-days after having a positive test for CDI. This data includes patients from all settings.

The mortality rate based on rolling 12-month totals has remained close to 14% throughout the year and remains below the 20% trigger point.

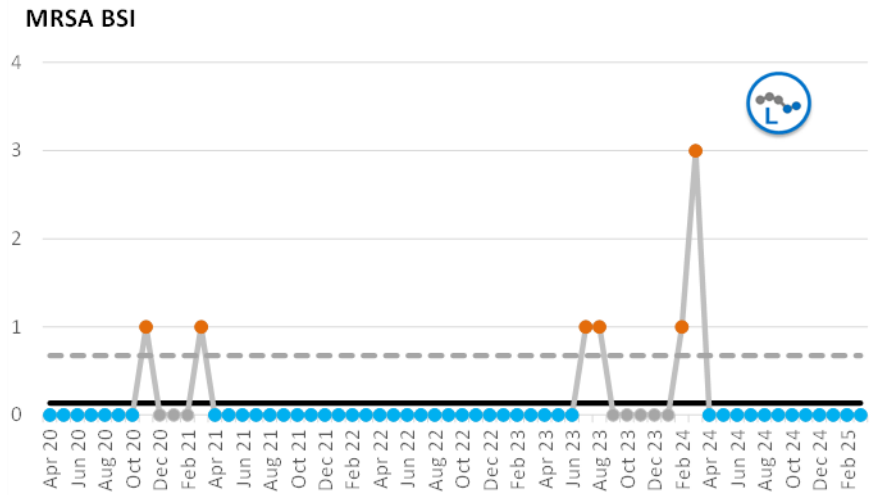




Meticillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia	How Are We Doing?
	Though no national target was set in 2024-25, we continued our focus on reducing MSSA bacteraemia and set an internal reduction target of no more than 17 cases, which was amended in Q3 to be 40. We did not meet our improvement target this year. 46-year end cases against our local target of 40.

To Reduce These Infections, We Have….

- Initiated the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
- Audit of use of packs by procurement, with link made of use and reduction in BSI risk/non-use and BSI risk.
- Attended Divisional Governance meetings to present/promote PVD projects.
- "Scrub the hub" poster which was rolled out across the Trust.
- In collaboration with the Professional Development Team and BBraun, launched the role of a PVD Champion at WRH site on 24th January 2024, Alexandra hospital launch planned for Q1 2025/26
- ANTT training materials on source page: videos and posters
- ANTT training must be completed before staff can complete cannulation training.
- Launched a teaching video on the use of the PVD forms on EPR.
- Promoted the "Gloves Off" campaign focused on staff use of PPE, through spot checks to clinical areas.
- Hand hygiene products change over to new supplier.
- RAG cleaning poster promoted.
- Quality improvement project to improve bed cleaning across the trust, updated bedspace check list and produced and launched a bed cleaning video for mandatory training, which is now available on ESR.

MRSA	How Are We Doing?
	Zero Tolerance Zero cases reported. The trust reported below threshold infections.

To Reduce These Infections, We Have….

- Link practitioner day -Focus on MRSA
- Ran the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
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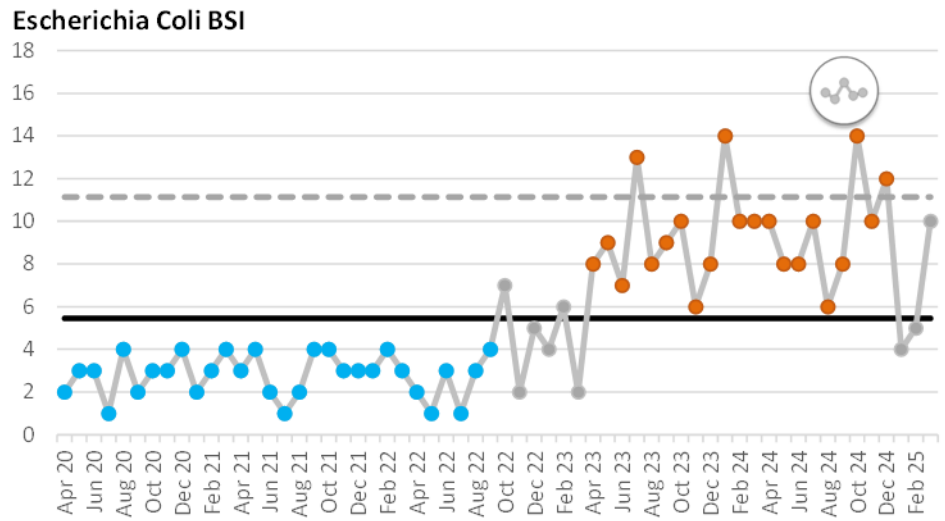
Ecoli	How Are We Doing?
	105/112 The trust reported below threshold infections

To Reduce These Infections, We Have….

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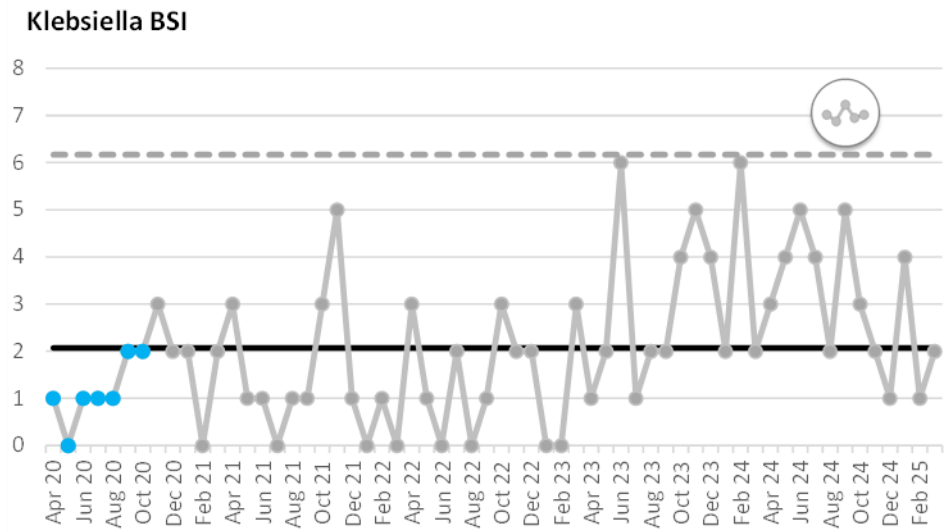
Klebsiella species BSI	**How Are We Doing?**
	We reported 13 vs 12 full year target. We did not meet our improvement target this year.

To Reduce These Infections, We Have….

<u>Focus on water management at link practitioner session.</u>

- Initiated the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
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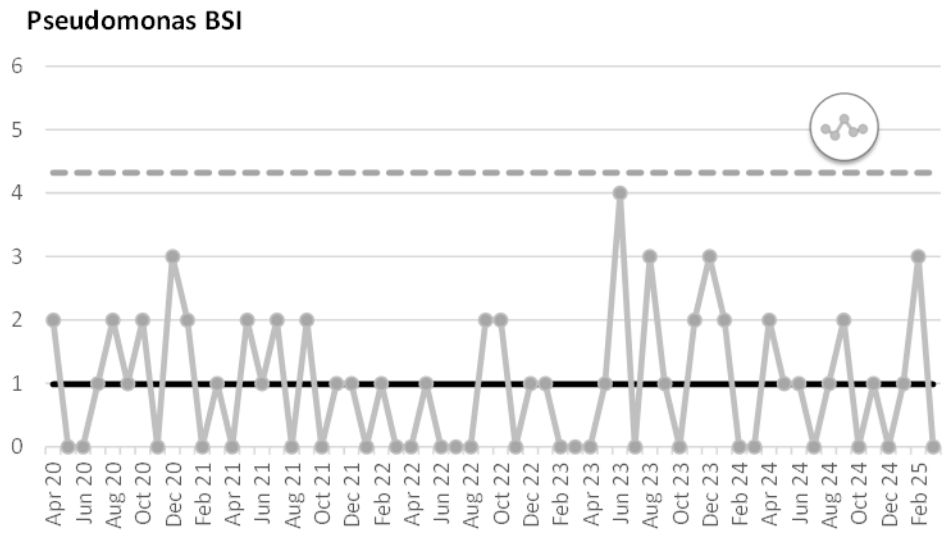
Pseudomonas aeruginosa BSI	**How Are We Doing?**
	. We reported 12 vs 15 full-year target. **The trust reported below threshold infections.**

To Reduce These Infections, We Have….

- Focus on water management at link practitioner session.
- Ran the Peripheral Venous Device (PVD) task and finish group.
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Surgical Site Infection Surveillance Survey

SSIs can range from a relatively a relatively trivial wound discharge with no other complications to a life- threatening condition" National Institute for Health and Clinical excellence (NICE) (2008).
Infections of the surgical site account for approximately 16% of all hospital acquired infections (HCAI), are estimated to double the length of post-operative stay in hospital and significantly increase the cost of care.

In April 2004 surveillance of Surgical Site Infections (SSIs) in Orthopaedic surgery became mandatory in all English NHS Trusts, specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice, as necessary. WAHT conduct surveillance in all four quarters for three of the four categories.

- Hip replacement.
- Knee replacement
- Repair of neck of femur
- Reduction of long bone fracture

	April-June 2024	July/Sept 2024	Oct-Dec 2024	Total
Hip Replacement	**130**	**123**	**130**	**383**
No. inpatient/readmission	1	0	1	2
% Infected	0.8%	0.0%	0.8%	0.52%
No. post-discharge confirmed	0	1	0	2
% Infected	0.0%	0.8%	0.05	0.52%
No. patient reported	0	0	0	0
% Infected	0.0%	0.0%	0.0%	0.0%
All SSI	1	1	1	4
% Infected	0.8%	0.8%	0.8%	1.04%
Knee Replacement	**141**	**156**	**137**	**434**
No. inpatient/readmission	0	1	0	1
% Infected	0.0%	0.6%	0.0%	0.23%
No. post-discharge confirmed	0	1	0	2
% Infected	0.0%	0.6%	0.0%	0.46%
No. patient reported	0	0	0	0
% Infected	0.0%	0.0%	0.0%	0.0%
All SSI	0	2	0	3
% Infected	0.0%	1.3%	0.0%	0.69%
Neck of Femur	**185**	**169**	**205**	**559**
No. inpatient/readmission	0	1	2	3
% Infected	0.0%	0.6%	1.0%	0.54%
No. post-discharge confirmed	0	0	0	1
% Infected	0.0%	0.0%	0.0%	0.18%
No. patient reported	0	0	0	0
% Infected	0.0%	0.0%	0.0%	0.0%
All SSI	0	1	2	4
% Infected	0.0%	0.6%	1.0%	0.71%

**Quarter four data is awaiting validation & release from SSISS

The Trust has initiated a review of the process of the SSISS and has identified a number of improvements to further strengthen the assurance in how we review the learning from SSI to ensure better outcomes for our patients as part of this review we are looking at:

Reports to the Surgical Site Infections Surveillance Service.

- The monitoring of reporting from the Surgical Site Infections Surveillance Service regarding Trust performance.
- The end-to-end process for Surgical Site Infections including security and learning from incidents of infection post-surgery. This will include engagement of:
  - Pre-Operative assessments to raise awareness regarding related infections.

    - Intraoperatively Theatre Journey to support both patient and environment preparedness.
    - Outpatients follow up appointment to monitor for signs of infection.
    - General Practitioners in proactively sharing post operative complications.
- Reviewing patient information in support of SSISS process and ensure changes to documentation goes through the governance process.
- How input and output of the Bone and Joint Infection MDT is shared for action and learning.

Implementation is currently in progress with inclusion and input from all stakeholders within the Trust.

Criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Written by Emma King Interim director for Estates and Facilities

Cleanliness

Our focus on cleanliness has continued throughout 2024-2025 continuing to work in accordance with the National Standards for Healthcare Cleanliness 2021, including the new reporting methodology and from March 2025 we have aligned ourselves with the update National Standards of Cleanliness 2025

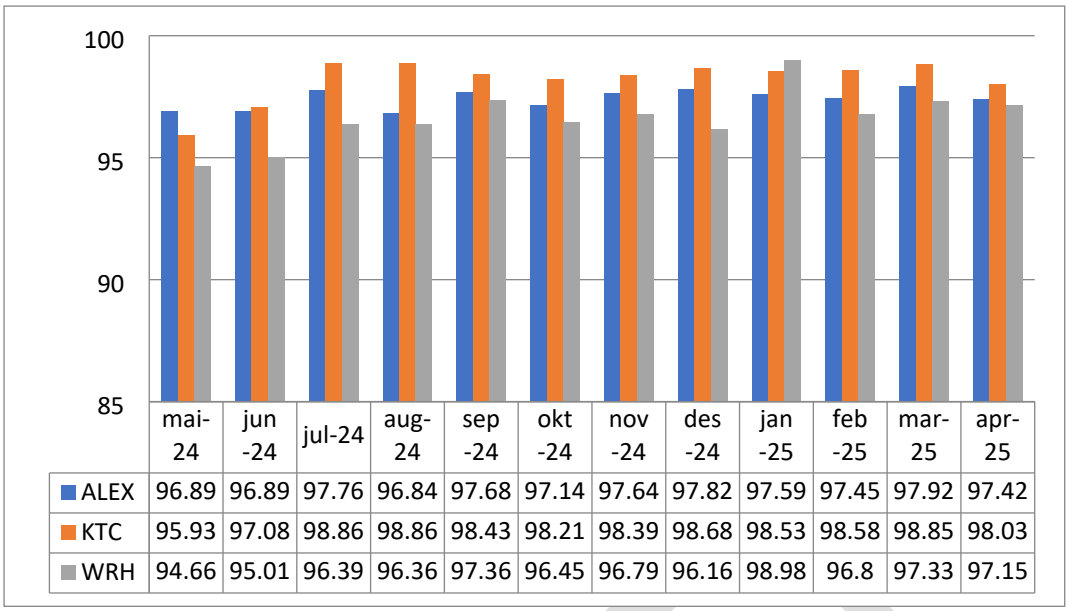
The audit scores for each functional area are represented in two ways: a percentage score and a star rating score. The percentage score is for internal verification and scrutiny that a safe standard has been achieved, whereas the star rating score is for external verification of this.

Cleanliness by Site

During April 2025, the average star ratings were as follows:

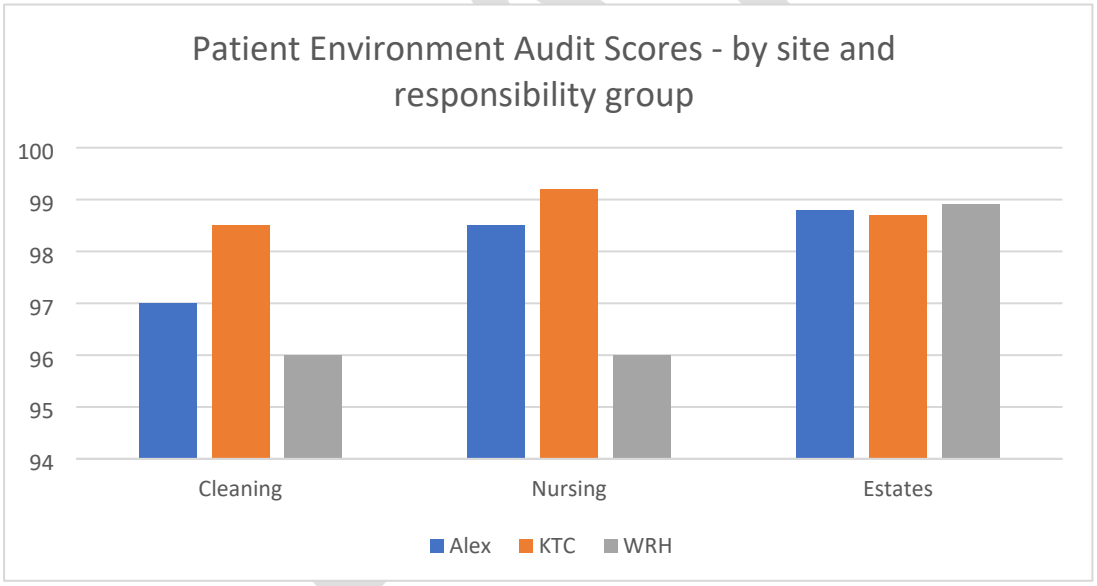
- Trust – 4.6
- Alex – 4.8
- KTC – 4.8
- WRH – 4.7

The trend over the last 12 months has seen cleanliness audit scores overall continuing to increase across the organisation We have continued to build on the improved working relationships and collaborative approach between the Estates and Facilities Teams with clinical teams. Regular scrutiny and review sessions are held to maintain focus on the importance of cleanliness to ensure safe environments.



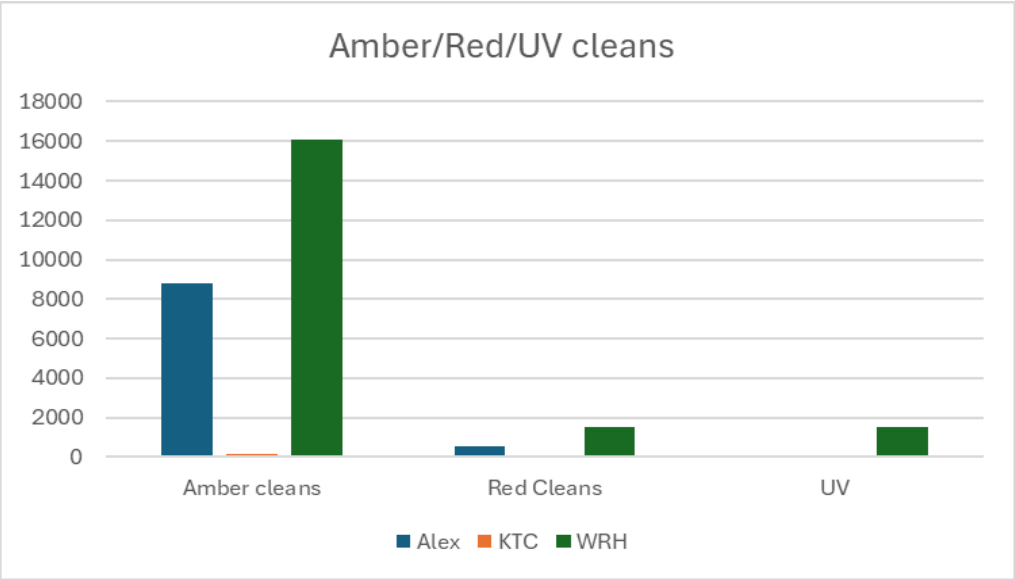
	mai-24	jun-24	jul-24	aug-24	sep-24	okt-24	nov-24	des-24	jan-25	feb-25	mar-25	apr-25
ALEX	96.89	96.89	97.76	96.84	97.68	97.14	97.64	97.82	97.59	97.45	97.92	97.42
KTC	95.93	97.08	98.86	98.86	98.43	98.21	98.39	98.68	98.53	98.58	98.85	98.03
WRH	94.66	95.01	96.39	96.36	97.36	96.45	96.79	96.16	98.98	96.8	97.33	97.15

Regular meetings are held with all stakeholder groups to review issues from areas that only attain a 3-star rating. These are led by IPCT, however the number required are reducing due to the continuing improvements based on the scoring methodology.



We have contributed to feedback in relation to the new scoring methodology via various network groups, that potentially the scoring methodology does not provide the necessary accountability for issues raised and is not always reflective of the standards.

Despite capacity levels we have continued with enhanced levels of cleaning including proactive routine Hydrogen Peroxide Vapour (HPV) and Ultraviolet-c (UV-c) decontamination of high-risk areas (at WRH and Alex) This includes dirty utility areas and communal bathrooms. Going forward we will be scrutinising the numbers being requested.



	Amber cleans	Red Cleans	UV
Alex	8820	559	107
KTC	182	93	Not used
WRH	16076	1506	1506

The Trust Monitoring Team continue to report directly into the Deputy Director of Estates and Facilities (Soft FM) which has enabled the team to remain independent of both cleaning services ensuring monitoring reports are objective and as accurate as possible utilising modern audit software aligned to the National Standards of Cleanliness

Previously we have reported concerns in relation to the performance of our PFI partners, however we have seen a significant sustained improvement, however we will continue to manage closely.

Safe Ventilation Systems

The Critical Ventilation Safety Group continues to meet regularly and is principally concerned with ensuring that Trust ventilation systems are inspected, tested, maintained, and operated safely across all 3 sites. The group also has a remit of ensuring that clinical staff are aware of any risks these systems may pose to clinical activity. There has been a review and update for the terms of reference for this Group.

In line with national guidance, an external Authorising Engineer (AE) Ventilation is in place to audit the management of the Trust's ventilation systems and appoint Authorised Persons (APs). APs are in place at all WAHT hospitals to manage the ventilation systems.

All critical ventilation systems are verified in accordance with HTM03-01, and systems are broadly compliant. Where there is a lack of compliance there are additional controls in place which are actively reviewed and managed via the Estates Team or our PFI partners.

Our specialist units such as theatres, endoscopy and your intensive care units have additional ventilation in line with guidance. However, one of our continuing challenges during the pandemic is that much of our hospital estate was built to have natural ventilation only. This means we cannot guarantee that the amount of fresh air entering those areas will fully

dilute or remove all COVID-19/influenza virus which may be present. Therefore, the trust has heavily invested in HEPA air filters called Rediairs. The installation of Rediairs air filters was completed across the Worcester Royal and Alexandra hospital in-patient settings during November-December 2024 Ward based training was given and standard operating procedure for maintenance was produced.

Water Safety

Our Water Safety Group is now chaired by the DIPC. The committee continues to meet on a quarterly basis, overseeing a system which is providing good assurance on water quality and governance. Our electronic system for recording water outlet flushing has been in place for over five years, with a system of escalation to management teams for any areas which do not complete their flushing and reporting.

The Water Safety Plan (WSP) was reviewed, updated, and commissioned in 2023/24 from our Specialist Water Management has been implemented which satisfied the latest guidance requirements in addition to HTM 04-01.

A programme of sampling is in place to detect any Legionella and *Pseudomonas aeruginosa* in the water system. Sampling results have been generally good across all sites, however there were several counts of *Pseudomonas aeruginosa* isolated via 6 monthly routine sampling. The adverse samples were dealt with promptly in accordance with the water safety plan to ensure patient and staff safety. The issue identified was poor condition of taps and cleaning deficits. There have been no linked infections to this incident.

Safe water management was a focus for our link practitioner's sessions held in April 2024 and 2 senior IPC nurses completed water management ILM training. The IPC Nurse manager and DIPC also hold ILM qualifications.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Written by Sadiya Hussain – Clinical Antimicrobial Pharmacist.

The Trust Antimicrobial Stewardship Group have continued to provide leadership and oversight for antimicrobial stewardship (AMS) activities, further building on positive progress made in 2023-24.

Key progress made during 2024-25 includes:

- Commenced antimicrobial ward rounds across both sites:
  AMS Snapshot data from ward rounds: Conclusions:
  No patients came to harm/became bacteraemic due to advice.
  Re-reinforced benefit of AMS ward rounds.
  Advice appreciated by clinical ward teams.
  No Datixes have been raised and no verbal/email complaints received.
- Commenced AMS education sessions across both sites.
- Appointment of antimicrobial Pharmacist in post April 2024.
- The overall level of assurance was assessed at level 5. The levels of assurance for the Divisions range from level 6 (OPAT Services) to level 4 (Surgery and SCSD). The Divisions have had representatives available to present their written AMS reports or if not, a verbal update has been provided including an update on their action plans.
- There has been a fluctuation in the overall numbers of Start Smart Then Focus audits completed by ward staff by junior doctors in January- March.

- The Quarterly Point Prevalence Survey results (where all charts are audited against antimicrobial prescribing standards on one day by the pharmacists) was undertaken during Q4. Results show that improvement is required for antibiotics to be prescribed in line with guidance and 72-hour reviews.
- All divisions have confirmed that AMS is embedded in their Quality and Governance agendas and have action plans signed off by their Divisional Boards.

CQUIN and NHS Standard Contract

CQUIN IVOS (Intravenous to oral switch) antibiotics

For 2024/2025, the Trust participated and submitted data for the following CQUIN: Timely switch of Antibiotics from IV to Oral. Although this was not incentivised, we were able to perform considerably better than the national criteria. The aim of this audit was to assess what % of patients are on IV antibiotics who could have been switched to oral treatment.

Target is achieving 15% or fewer still receiving IV antibiotics past the point at which they meet switching criteria. Minimum < 25% and maximum 15% (lower % indicates better performance) Inclusion criteria: Adults (>16 years of age) and paediatric (<16 years of age) inpatients with active prescriptions for IV antibiotics at the point of the audit.

Prompt switching of intravenous to oral antibiotic

Description	Achieving 15% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	
Numerator	Of the denominator, those who, at the point of audit, have already met the criteria for switching from IV to oral administration of antibiotics according to adult (16+ years of age) or paediatric (under 16 years of age) criteria as appropriate.	
Denominator	Total number of adult and paediatric inpatients with active prescriptions for IV antibiotics at the point of audit (sample size 100 patients per quarter, aim to cover all included wards/specialities).	
Exclusions	Patients in HDU and ICU Patients treated with intravenous antifungals or antivirals	
Data reporting and performance	For local agreement between provider and commissioner – the UKHSA portal will continue to take submissions where providers and commissioners wish to use this route. Details can be found in the AMR Programme FutureNHS Workspace (link below).	
Scope	Acute	Period: All quarters
Suggested thresholds	Minimum: 25% Maximum: 15% **Please note that for this indicator,** **a LOWER % = better performance**	Whole period %
Lead contact	england.amrprescribingworkstream@nhs.net	

Results:

Q1: 12.03%

Q2: 7.62%

Q3: 16.19%

Q4: 10.24%

The audit undertaken by the pharmacists in all quarters met the national target. This data is yet to be published on the national database.

This non-mandatory CQUIN will not be continuing nationally but will be continued as an internal Trust audit for the 2025/26.

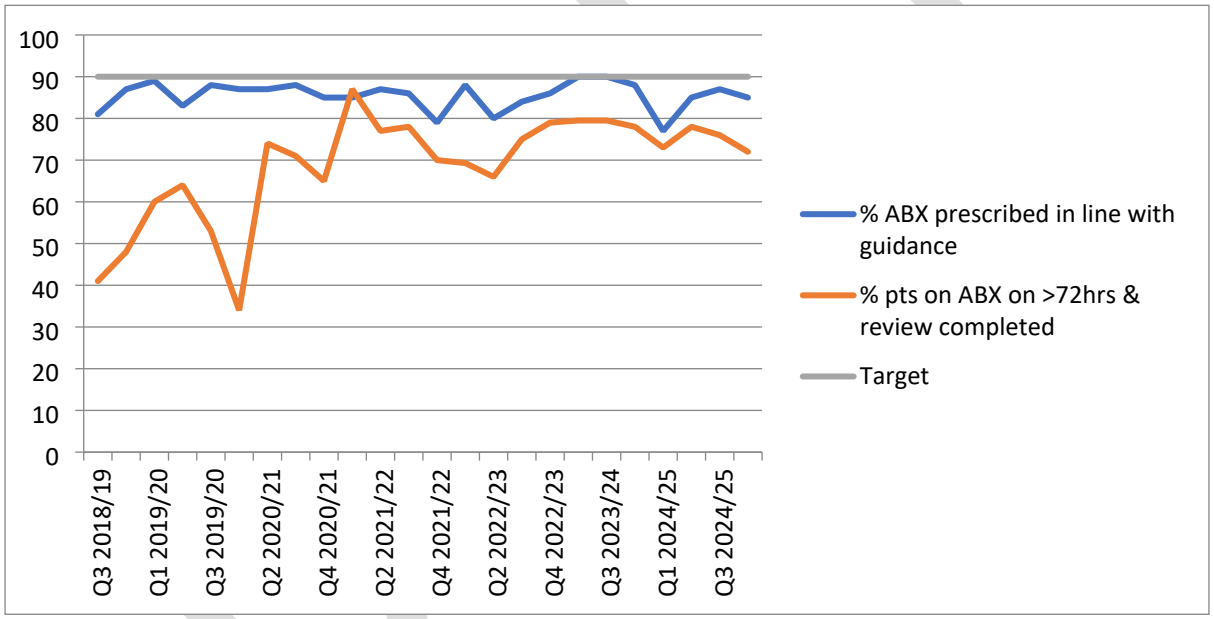
A poster created showing the benefits of IV to oral antibiotic switches and the impact this has on the nursing workforce and the green agenda was shared in the Nurse Midwifery and AHP board meeting.

Audit Results

Antimicrobial Point Prevalence Survey (PPS)

This audit was completed during Q4. Overall, the compliance of antimicrobials in line with guidance has not achieved the target – 85.02%. Wards in particular that require improvement as they achieved less than 80% are Specialty Medicine at ALEX W2 and W5, Surgical wards at ALEX and majority of the surgical wards at WRH, ALEX Urgent Care AMU and WRH MSSU.

The 72-hour reviews have not improved (from 75.71% to 71.65%) and have still not achieve the target. At the time of writing this report, this data has not yet been presented to ASG for discussion and development of any actions.



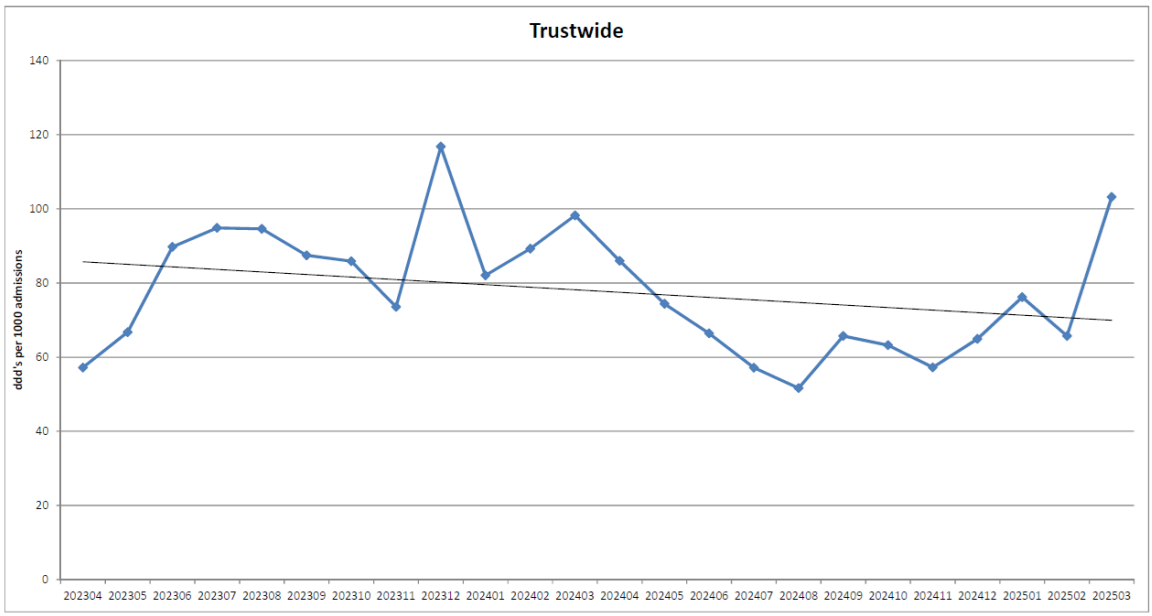
Carbapenem prescribing.

Carbapenem usage

Further to all the work undertaken by our antimicrobial stewardship leads and revision of prescribing policies, a downward trend in usage of carbapenems has been seen up until August 2024. There has been a slight increase since but this may have been due to new junior doctors commencing and due to high acuity of patients. The ward level data has been and continues to be scrutinised by ASG to identify clinical areas to target. It is noted that the Consultant Microbiologist AMS lead and AMS lead pharmacist have commenced ward rounds and provide a ward based presence.

Trustwide

ddd's per 1000 admissions
Date range in months: 202304 to 202503



Since the increased usage, the ward level data has been and continues to be scrutinised by ASG to identify clinical areas to target. The lead AMS pharmacist commenced in April 2024, and this is an additional resource to support changes in practice. It should also be noted that due to significant pharmacist vacancies, many of the medication charts are not being reviewed after admission until discharge. There will therefore be fewer antimicrobial interventions. It is also hoped that ePMA will also facilitate the appropriate prescribing of carbapenems.

An audit carried out by one of the trainee Pharmacists in 2023-24 found that:

- Meropenem was prescribed in accordance with the trusts antimicrobial guidelines and were prescribed correctly regarding the dose and frequency.
- If treatment had been at least 72 hours there was lower compliance with putting review/stop dates of the antibiotic.
- General surgery and acute medicine had the most amount of Meropenem prescribed.
- There was room for improvement when it comes to Meropenem prescribing as prescribing was not done 100% correctly all the time.
- Compared to a previous audit there was an improvement when it came to prescriptions being in line with the antimicrobial guidelines or deviating with a valid reason

A re-audit into carbapenem prescribing is going to undertake by one of the Pharmacists over a three-month period in the financial year 2025-2026 to overcome the following limitations:

- Above audit conducted over a 2-week period so potentially was not fully representative of Meropenem prescribing in the trust
- Given the small sample size received from the Alexandra hospital (4 prescriptions) the overall findings may not be a true representation of the trust as a whole.

NHS Standard Contract – data from FutureNHS relevant for Q2 2024/54:

DDD update

Across the NHS, an initiative was set to reduce consumption of Watch & Reserve antibiotics by ~10%, by 2024/25 whilst using 2017 data as a baseline.

The target in Q2 has not yet been achieved +16%.

	Trust information				Baselines			Rolling 4 quarter performance - FOR INFO ONLY				
2	NHS England Region	ICB Region	Trust Code	Trust Name	Total DDDs 2017	Total admissions 2017	Total DDDs per 1000 admissions 2017	Total DDDs Q3 2023-24 to Q2 2024-25	Total admissions Q3 2023-24 to Q2 2024-25	Total DDDs per 1000 admissions Q3 2023-24 to Q2 2024-25	% difference in DDDs per 1000 admissions from 2017 baseline	Notes
91	Midlands	NHS COVENTRY AND	RWP	Worcestershire Acute Hospitals NHS Trust	507230	149964	3382	626224	159920	3916	16	

It is expected that Q3 results will be available in June 25.

There are four Trusts (previously three) achieving the target in the West Midlands and the AMS lead Pharmacist has contacted colleagues to ask what they have done to achieve this.

Other ASG activities (some on-going):

- Extensive antimicrobial treatment guideline review has been undertaken focusing on rationalising broad-spectrum recommendations and improving proportion of Access list antibiotics and reducing proportion of Watch and Reserve list antibiotics. Divisions to focus on guideline promotion and education to improve compliance.
- Microguide (antimicrobial guide) successfully transitioned to EOLAS and currently reviewing new guidelines and drug monographs to be added.
- Paediatric antimicrobial guide approved and will be added to EOLAS.
- Engaging with the EMPA team to ensure the system can support antimicrobial stewardship including documentation of allergies, length of course and compliance with guidance.
- AMS representation at ICS/ICB groups to develop strategic priorities and identify actions. Five key prescribing priorities include: optimise therapy, reduce demand, reduce exposure, shorten courses, and narrow spectrum. We have completed a gap analysis against the ICS action plan which will be reviewed along with other providers in the system.
- Collaborating with Wye Valley regarding guidelines and adding antimicrobials on to the Hereford and Worcestershire formulary.
- The ASG terms of reference have been reviewed and identified that the group would benefit from ward-based nurses especially as they may be able to support and promote IV to oral switches, and challenge length of antibiotics courses. ASG members now include ward-based nurses and non-medical prescribers who are encouraged to attend the bi-monthly meetings.
- *The Antimicrobial Stewardship Policy was reviewed in June and updated.*

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

Our continued approach during 2024-25 has been to ensure open and clear communication with our patients, their carers, family and the wider public. Information is available on the internet Trust website and signposts patients/carers to National guidance. The IPC team have produced a patient information leaflet outlining IPC practices and how to stay safe in hospital by carrying out such things as good hand hygiene and wearing the correct PPE as directed by the ward teams.

Social media has been used to promote key messages about preventing infection, especially during the pandemic. Our public website contains a range of information to help inform the public, including on MRSA, *Clostridioides difficile*, influenza and Norovirus.

Information on COVID-19 and other organisms is available on a dedicated section of the intranet which can be accessed by all staff. Key messages are distributed by the communication team using a variety of media that is available across the Trust.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

We have several assessment tools available to reduce the risk of transmitting infection, and our admission process includes assessment of patients for signs of infection. This has been strengthened further and moved to a Respiratory symptom checker.

Our Infection Prevention Team works closely on a daily basis with wards, our site management teams and our cleaning teams to ensure patients with infection are rapidly identified, isolated correctly, and additional cleaning is in place as required.

During 2024-25 we identified and effectively dealt with a number of infection outbreaks and incidents relating to a range of infections.

With the introduction of the EPR system there has been a diarrhoea risk assessment tool introduced.

The policy for Outbreaks and Isolation of patients has been updated and an updated RAG poster issued to help decision making re cleans.

Criterion 6: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Strong and visible leadership by all senior clinical leaders continued throughout the year 2024/25, including leadership by the CNO and the DIPC.

Throughout 2024-25 we continued to require all staff to complete the electronic mandatory training rather than face-to-face sessions. We have introduced a face-to-face session for induction for HCAs. This includes donning and doffing, hand hygiene competencies and clear instruction on where to find policies.

Our compliance target in 2024-25 was 90%. At the end of 2024-25 the achievement was 90% for clinical staff, and 96% for non-clinical staff.

Ward-based training and electronic resources have remained in place to support staff during the year.

The IPC team have successfully delivered link practitioner training covering a variety of subjects.

Hand hygiene competencies are delivered at Ward level and there is a requirement for annual update.

Fit Testing
FFP3 mask fit-testing is stipulated by the Health and Safety Executive and any mask that is fit to the face must be fit tested.

This continued over 2024/25 with the withdrawal of government support in April 2023. The provision of the service was supported by NHS Professional staff however, the Trust successfully recruited two permanent staff to oversee fit mask testing. The fusion system was updated to enable direct booking and recording of fit tests.

Fit tests are provided for all Trust staff as well as our PFI partners.

Criterion 7: Provide or secure adequate isolation facilities.

In general, isolation for infection prevention reasons means caring for someone in a single room, preferably with ensuite toilet and washing facilities. Of our bed-base we had 175 single rooms across the Trust, which is 18% of our hospital beds. Of these 134 are ensuite, which is 13% of our beds. These beds are routinely used for isolation. When the number of patients with possible infection rises, patients with the same infection/suspected infection are nursed together in cohorts.

Cohort isolation continued to be used throughout 2024- 25 for influenza, COVID-19 and norovirus cases.

The Trust introduced a more standard model of isolation, with patients being isolated in single rooms and bays within the ward most appropriate for their clinical care based upon their reason for admission (our 'presenting condition model'). The national guidelines were adapted to ensure that the Trust was maintaining patient safety. Within the Frailty areas we continue to isolate patients who are classified as COVID contacts. This is supported by a risk assessment agreed at TIPCC.

We have infection assessment tools for patients on admission. If someone develops common symptoms of infection such as diarrhoea or respiratory symptoms during admission, these tools are used by staff to identify the need for isolation.

ED at Worcester has access to single cubicles, however, there remains significant attendees in the department that add to the overcrowding there. Increased cleaning has been implemented in both EDs, but this remains a challenging environment.

Due to the pressures on side rooms and often the demand outweighing the supply, IPC works with capacity and site to review side room provision and the 'live' side room" tool developed with Informatics' helps to support the clinical decision-making process.

Criterion 8: Secure adequate access to laboratory support.

We have our own trust-wide on-site microbiology laboratory, based at Worcestershire Royal Hospital. This provides a full range of microbiology services, linking with the national reference laboratory network for specialised testing which cannot be performed locally. The laboratory is UKAS accredited, confirming it operates an effective and quality-controlled system.

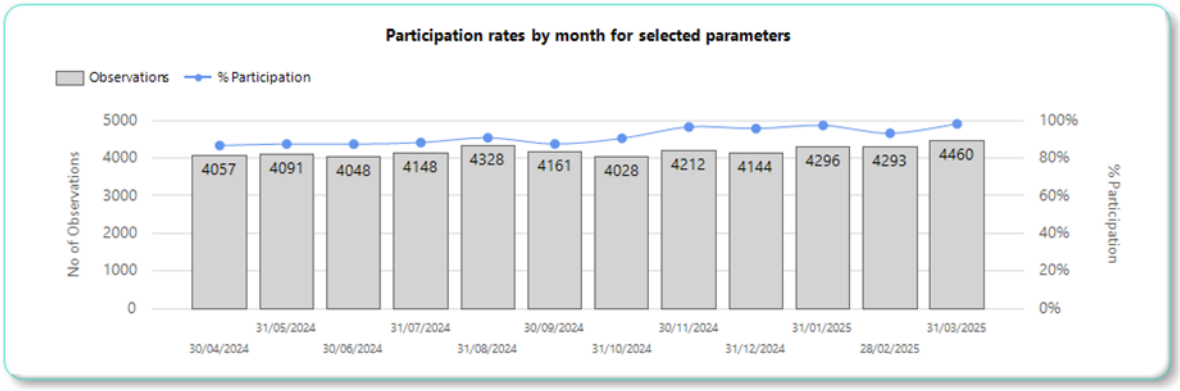
Throughout 2024/25 the laboratory has maintained sufficient increased capacity to provide all the required testing for COVID-19 for the health system across Worcestershire, via a range of rapid and standard tests. In 2025/26 the laboratory will continue with work to further extend the range and number of rapid testing platforms available for other infections. This includes molecular based testing for enteric pathogens including a wider range of viruses to assist in the control of infection.

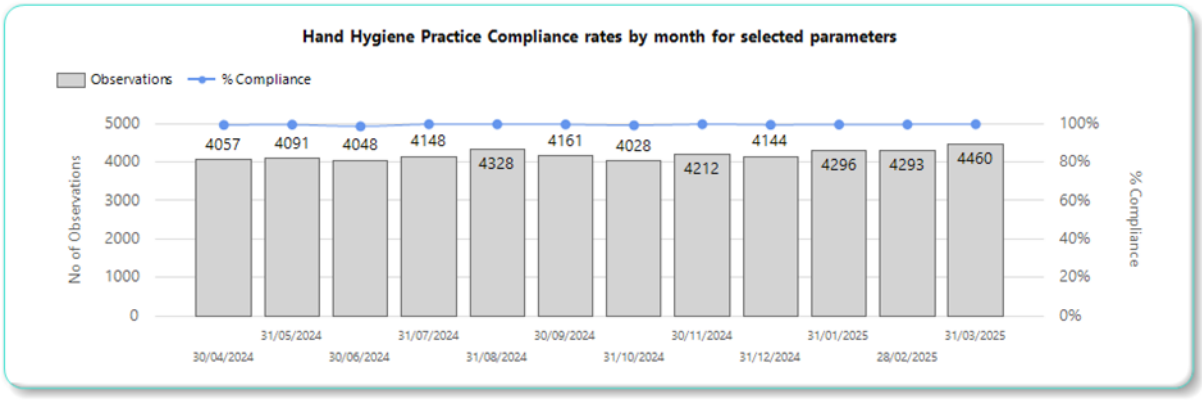
The department has been challenged at times due to the lack of staff but there have been no incidents reported relating to performance due to staffing levels.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

We monitor adherence to a number of our *Fundamentals of Infection Prevention and Control* with a programme of monthly auditing via our electronic system with reporting in real-time. The national High Impact Intervention audit tools issued by NHS Improvement have been used as the basis for the monitoring tools. The compliance information is included routinely within divisional reports to TIPCC, supporting detailed review of good practice.

Hand hygiene is audited monthly, and all clinical areas are expected to participate. There has been a high level of compliance, achieving over 99%. However, there has been a variable compliance with completion.





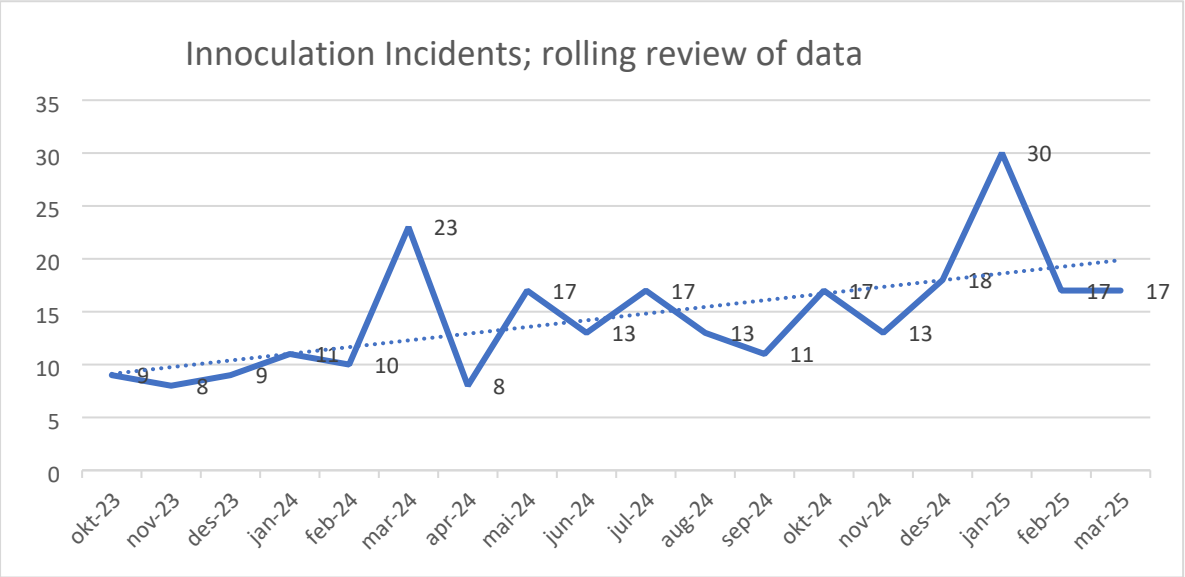
During the past year, the audit program and response to alert organisms have shifted and a cleanliness and standard infection control interventions are measured. Work is in progress to move the IPC audits to GAP to ensure that all clinical areas can audit at any time and contribute to the ward accreditation process.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
Written by Julie Noble, Head of Health & Safety and Fire Safety

The Health and Safety Team are responsible for ensuring there are systems and processes in place to enable legal compliance against secondary legislation, which if complied with effectively, protects staff from exposure to infectious diseases. An example is compliance against The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. To comply with this regulation the Trust has an Inoculation Policy and a Safer sharps group (that includes Occupational Health leads) that meets bi-monthly to analysis inoculation injuries with the aim to identify areas of concern/improvement and implement corrective and preventative measures.

Inoculation injuries were the highest cause of injuries reported under the H&S category during 2024/25 via Datix. There had previously been some disparity between records held by Occupational Health and via Datix therefore during the year reporting was promoted. Positively, the number of inoculation incidents reported is low compared to the number of interventions with sharps and equipment conducted by staff on a daily basis; however, staff must avoid injuries where possible – but reliably report all inoculation incidents if one occurs.

The number reported this year was 144, which is a significant increase compared to 86 (23/24) and 69 (22/23) with an increasing trend as demonstrated below:



- The type of device used, resulting in the most injuries was a hollow-bore needle.
- The main cause of injuries was inattentiveness. This being staff were not being focused on preventing harm to themselves.
- The second cause was not following the correct process for disposal of sharps.
- The top three activities being conducted when the injuries occurred was: Taking blood, disposal, and surgical procedures.
- The highest affected group was nursing/HCA staff.
- Reporting divisions were: Corporate - 2, SCDC – 48, Spec Medicine – 15, Surgery – 28, Woman`s and Children`s – 23, Urgent Care – 27.
- ED and Theatres at WRH were the highest reporting areas (12 incidents each); Collectively the number of incidents by theatres across all sites is a concern (total 21).
- During the year there were 7 inoculation incidents reported to the HSE to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, this was a significant increase compared to zero the previous year. These were reported due to staff being exposed to a Blood borne disease (e.g. HIV, Hep C) (Listed as a Dangerous Occurrence under RIDDOR).
- Staff affected by the RIDDOR injuries were Doctor x 2, PA 1, Nurse x 3, 1 Radiographer.
- The Injuries were sustained when staff were: Taking Bloods (4) Inserting a CV line (1), Splash (1), Giving IV medication (1).
- The first reported incident led to the HSE assessing the investigation and then subsequently visiting WRH / ED to assess the Department / Trusts processes for the management of sharps. Unfortunately, they did not consider this was robust and two Improvement Notices were issued October 2024. The Trust was then required to implement improvements and provide evidence to the HSE. Example improvements were:
    - The Inoculation Policy was amended and highlighted to all staff, via screen savers, divisional governance leads, briefings.
    - Training on venepuncture / cannulation for new starters was changed requiring Trust training to be conducted / signed off before staff are permitted to practice.

- A new Safer Sharps Awareness training package was launched for all staff.
- The workplace risk assessment template was amended to ensure staff are risk assessing the use of safer and non-safer sharps and implementing mitigation for their risks.
- The Procurement team introduced new safer sharps devices (e.g. safer hypodermic needles) and continue to evaluate products as part of an on-going improvement plan.
- The safer sharps group was refreshed with the DIPC chairing meetings and membership widened to include representatives from professional development, procurement, and wider divisional clinical representation. The purpose of the group was revised to ensure outputs from data analysis can be addressed (e.g. more training, change of devices etc).
- A new Investigation questionnaire was rolled out for use post inoculation injury to aid assessment of compliance against the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 / Inoculation Policy, and to ensure lessons learnt were addressed.
- New Investigation training package was rolled out to ED senior staff; and ED staff attended H&S training for managers to ensure they were competent with risk assessing.
- A new Scrutiny and Learning group was formed (February 2025) to critically assess selected inoculation incidents and to share with a wide representation of clinical staff the findings to aid wider sharing / learning and prevention.
- This is on-going work. NB at year end the final sign off of evidence to the HSE was still under review.

- Biological Incidents (11):
  - The number reported is a significant increase compared to last year where only 3 incidents were reported.
  - All were splashes. 6 incidents were reported by differing theatres across the Trust reporting fluid/bodily fluid splashed in the eye whilst conducting their task. These locations should risk assess their tasks and wear eye protection where a reasonably foreseeable risk is noted.
  - The remaining 4 incidents occurred when a surgical task was conducted, or blood splash occurred. All staff must follow the inoculation policy for these types of incidents if fluids have got into the eyes.

The health and safety team work with clinical teams to prevent all types of injuries; especially any that may lead in an exposure risk. Clinical teams therefore need to comply robustly with Trust H&S and Infection Contril policies.

Occupational Health Services

All healthcare workers can access Occupational Health services. Our Occupational Health Service has a programme of staff health assessment to ensure healthcare workers are both protected from infectious disease by vaccination and are screened as required on employment to ensure they do not pose an infection risk to patients. The OH service supports the health and wellbeing of our healthcare workers across the Trust, as well as supporting our PFI contractors' staff. All healthcare workers are health screened on employment, vaccination status is checked at this stage and any outstanding vaccinations are offered on commencement of employment and all healthcare workers are *offered* BBV testing at pre placement. Decisions on offering immunisation is made in line with OH Policy and local risk assessment as described in 'Immunisation against infectious disease' (the 'Green Book') and

other guidance from UKHSA. Records are kept on Cority, as part of confidential staff occupational health records, including where vaccination has been offered and refused.

If healthcare workers are to work in areas where they will be undertaking Exposure Prone Procedures (such as maternity, theatres, A&E) then validated EPP bloods are taken (prior to medical clearance being given) for Hepatitis B Surface Antigen, Hepatitis C Antibody and HIV Antibody/Antigen.

Vaccines are offered based on risk assessment and are free of charge to all healthcare workers. Vaccine clinics are held at Worcester, Kidderminster, and Redditch Hospitals for accessibility.

If any healthcare workers are coming from Countries identifeid as having a high prevelance for Tuberculosis (TB) by the GOV.UK website for incidence of TB TB profile then they will have an IGRA blood test which identifies if they have latent TB. Positive cases are referred to the Acute Trusts TB Specialist Team for appropriate advice and/or treatment. A positive IGRA test does not prevent healthcare workers from starting work providing they are symptom free.

Our staff winter vaccination programme was promoted for 24/25 and involved co-administration of flu and Covid boosters, delivered in partnership with the Health and Care Trust. The programme was delivered by Crest pharmacy across the region.

Improving uptake continues to be a challenge but this was comparable nationally across other Trusts. The flu vaccination was subsequently offered until March 2025.

Vaccine	Population	Doses	Percentage
Flu	**5,828**	**1,999**	**34.3%**
Employee Staff Group		Uptake	
Nursing and Midwifery		33%	
Additional Clinical Services		29%	
Medical and Dental		35%	
Allied Health		42%	
Estates and Ancillary		34%	
Admin and Clerical		40%	
Healthcare Scientists		44%	
Add Prof Scientific and Technical		46%	
Students		25%	

Vaccine	Population	Doses	Percentage
COVID	**5,828**	**1,386**	**23.8%**
Employee Staff Group		Uptake	
Nursing and Midwifery		20%	
Additional Clinical Services		19%	
Medical and Dental		29%	

Allied Health	29%
Estates and Ancillary	23%
Admin and Clerical	28%
Healthcare Scientists	37%
Add Prof and Technical	38%
Students	0%

The Occupational Health Service also provides timely risk assessments and appropriate referral after accidental occupational exposure to blood and body fluids. Information provided on Datix is cross checked daily against information held by Occupational Health to ensure that incidents are not missed. Occupational Health also have a direct line for reporting of incidents during the Departments working hours, Monday to Friday 8.30-16.30, outside of these hours staff report incidents via ED. Awareness continues to be raised to all healthcare workers around best practice regarding prevention and advice following inoculation injuries and the Trust has recently launched an updated inoculation injury policy.

Occupational Health also provide advice and support in the event of infectious disease outbreaks and once notified of staff contacts will check the employee vaccination status and will follow up with the healthcare worker as required.

SECTION FIVE - Our Plan for 2025-26

In the coming year we will continue to strive for clean safe care for our patients. We will continue to focus on protecting patients and staff from all infections, reacting and risk assessing the Trusts requirements against the national guidance to ensure we follow recommended good practice.

Our overall aim remains to achieve excellent infection prevention standards and very low rates of infection. Although we have not met all of the Trajectories, we have worked to increase the engagement with teams and increase their understanding of IPC and improve standards.

We will continue our focus on hand hygiene, cleanliness, antimicrobial prescribing, and the care of invasive devices.

With the introduction of Patient Safety Incident Response Framework (PSIRF) the IPC team have worked with the clinical and governance teams to align the reviews to the new way of working. There is a strong focus on actions and learning from infection incidents. There is work underway to have the DATIX form as the assessment tool for the incident to enable an auditable process and to track completion of actions. There will be shared learning disseminated across the Trust.

Top three priorities will be:

1. Optimisation of Cdiff management – focus on AMS, cleaning, and patient assessment.

2. Promotion of the fundamentals of infection prevention and control, to include cleaning both environmentally and equipment. This will cover all responsible groups.
3. Education and training to ensure that we have a skilled workforce that have good knowledge of IPC to deliver safe clean care. In line with the Infection Prevention and control education framework.

To deliver these improvements and continue responding to the Quality Priorities we are implementing a comprehensive annual infection prevention improvement plan for 2025/26. This continues our focus on our '*Fundamentals of Infection Prevention and Control*' along with the other core actions we must take to achieve our aim.

References

1. The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). (Updated 2022) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

2. Start Smart Then Focus: antimicrobial stewardship toolkit for English hospitals (2015). https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus

3. Infection prevention and control education framework 2023. https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

4. UK 5-year action plan for antimicrobial resistance 2024 to 2029 https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029

Appendix 1: Outbreaks and Incidents

During 2024-25 we identified the following infection outbreaks and incidents which were not related to COVID-19:

Organism	Summary-ward outbreaks	Learning and Key Actions
CDiff	**2 X outbreaks** **ARU – 2 cases** **Beech B – x 2cases**	Robust cleaning is in place as per policy. Improvement required in D&V risk assessment and stool chart completion.
CPE	**2 x outbreaks** **Aconbury 4** **2 Cases** **Avon 4** **36 Cases**	Estates works, Rolling HPV clean and surveillance screening implemented in both areas, drain treatment and screening remains in place
Influenza	**15**	Ward closure and cleaning in larger outbreaks and rolling HPV completed. Less outbreaks for this year compared to 2023/24,
Norovirus	**7**	Ward closure, isolation of patients and deep cleans completed.
MRSA	**2 outbreaks** **NNU x 4 cases** **Aconbury 3** **3 cases**	Robust cleaning is in place as per policy. Increased MRSA screening undertaken. MRSA screening introduced o Transitional care

Appendix 2: WAHT Infection Prevention and Control Improvement Plan 2025-26

WAHT Statement of Intent

The Trust is committed to achieving excellent infection prevention practices, and we aim to be one of the best organizations in the UK for our rates of infection.

The prevention of infection remains as a key priority for Worcestershire Acute Hospitals NHS Trust in 2025-26. This will be achieved through continuing and determined focus on improving clinical practices, antimicrobial stewardship, and the environment of care, and by continually improving the knowledge of our staff so that they can achieve excellent standards of infection prevention practice.

This improvement plan supports delivery of the WAHT Quality Improvement Strategy and 4ward Improvement System. It sets out the objectives and actions that will be taken across WAHT to achieve our ambition to be one of the best organizations in the UK for our rates of infection, and to ensure compliance with Care Quality Commission Standards and 'the Hygiene Code' (2022), and our Infection Prevention & Control Board Assurance Framework.

Key Issues and Elements for Focus

Focus: Infections

- *Clostridioides difficile* infection
- *Staphylococcus aureus* bacteraemia, including MRSA.
- E coli and other gram-negative bacteraemia
- Respiratory Viruses
- Multi-Drug-Resistant Organisms, including Vancomycin Resistant Enterococci and *Carbapenemase Producing Enterobacteriaceae*
- Urinary Tract infections, including those related to urinary catheters.
- *Pseudomonas aeruginosa* in augmented care
- Preparedness for Ebola, MERS, Plague and other novel or emerging infections
- Norovirus

Priority Elements of Improvement Programme

- *Fundamentals of IPC – embed standards.*
- Hand hygiene and bare below the elbows
- Environmental Cleanliness
- Management of the environment to minimise aerosol and droplet transmission, including improvements in ventilation
- Prescribing of antimicrobial agents and proton pump inhibitors
- Decontamination of medical devices
- Aseptic non-touch technique (ANTT)
- Policy development, staff training and competence to support implementation.
- Audit and monitoring of policies, facilities, and key practices
- Sharps safety & waste management
- MRSA, CPE and other MDRO screening and MRSA decolonisation, respiratory swabbing
- Update and Implementation of care bundles; specific focus on invasive devices, wounds
- Isolation facilities, including negative pressure facilities and practices.
- Refurbishment of facilities; fabric of the estate
- Emergency preparedness for annual threats, and novel/emerging infections (HCID)
- Public involvement and information provision for patients, visitors, and the public
- Collaborative working across secondary, primary and community care.
- Research & development opportunities to improve local practices and knowledge.

Drivers: Guidance, Standards, Reports

- Priorities and Operational Planning Guidance (NHSE)
- National Infection Prevention & Control Manual
- Patient feedback
- Learning from incidents and outbreaks
- CQC Standards, and the Hygiene Code (2022)
  - National infection Prevention and Control Board Assurance Framework
- National guidance including on MRSA & CPE prevention, TB, Influenza
- National guidance on infection prevention practices: epic3
- NICE Quality Standard 113 (2016), Quality Standard 49 (2013) and Quality Standard 61 (2014)
- UK Five-Year Antimicrobial Resistance Action Plan
- National Standards for Cleaning (2025)
- Safer Sharps legislation, H&SaW Act
- 4ward Improvement System
- Care Excellence Awards

	Objective	Reporting
1.	***Clostridioides difficile* infection** • The number of new cases of Trust-attributable *Clostridioides difficile* infection will meet the national target of no more than the contractual set trajectories.	Via TIPCC and monthly performance reporting
2.	***Staphylococcus aureus* bacteraemia** • There will be no Trust-attributable cases of MRSA bacteraemia. (zero tolerance) • The number of new cases of Trust-attributable MSSA bacteraemia will meet the national target once this is announced: locally agreed target no more than cases per annum	Via TIPCC and monthly performance reporting
3.	**E coli bacteraemia** • The number of E coli bacteraemia will reduce to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
4.	**Klebsiella species bacteraemia** • The number of *Klebsiella spp* bacteraemia will reduce to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
5.	***Pseudomonas aeruginosa* bacteraemia** • The number of *Pseudomonas aeruginosa* bacteraemia will reduce to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
6.	**Respiratory Viruses** • Patients, staff, and visitors will be protected from nosocomial respiratory infection. • The number of HCAI infections will be minimised, aiming to benchmark at or better than the Midlands rate.	Via TIPCC
7.	**Carbapenemase-Producing *Enterobacteriaceae* (CPE) and other multi-drug-resistant organisms.** • There will be no detected Trust transmission of CPE or other MDRO during the year. • Screening programmes will be in place in key departments with at least 95% compliance with the screening programme	Via TIPCC
8.	**Antimicrobial prescribing** • More than 90% of antibiotic prescriptions are in line with prescribing guidance or specialist advice. • More than 90% of antibiotic prescriptions are reviewed within 72 hours of initiation. • Reduce consumption of 'Watch' and 'Reserve' category antibiotics by 4.5% compared to 2018 baseline. • Minimum 90% participation and 90% compliance *with Start Smart Then Focus* monthly audits	Via ASG and Medicines Safety Committee; also reporting to TIPCC. Report to ICB AMS group
9.	**Norovirus & Influenza Preparedness** • The Trust will be appropriately prepared for infection emergencies, including large outbreaks in hospitals, and new or emerging infections with significant public health implications. • Preparedness for high-consequence infections will be reviewed.	Via TIPCC, with link into Emergency Planning & Resilience Response Meeting
10.	**Fundamentals of IPC** • Fundamentals to be promoted and embed. • This includes hand hygiene performed consistently by staff in accordance with the World Health Organisation '5 moments for hand hygiene' at least 98% of the time	Via TIPCC and Divisional governance meetings

	Objective	Reporting
11.	**Cleanliness & Care Environments** • All areas across WAHT will consistently meet or be above the national minimum standards for cleanliness, as set out in the *Fundamentals of IPC.* • Environments will support effective infection prevention, by complying and being maintained in compliance with relevant Health Building Notes, and Health Technical Memoranda. • Water safety and the safety of critical ventilation systems will be maintained. • Improvements will be made in ventilation in clinical areas to reduce risk of spread of airborne infections.	Via TIPCC, PEOG and Divisional governance meetings
12.	**Decontamination of Medical Devices** • Medical devices will not pose a risk of infection to patients; they will be single-use or decontaminated effectively in compliance with HTM 01-01 and 01-06.	Via TIPCC and Divisional governance meetings
13.	**Staff Training and Competence** • All staff will possess the knowledge, skills and competence needed to practice safely and minimize risk of infection, and this will be reflected in key standards audits; in particular, all relevant staff will be trained and competent in ANTT, and statutory and mandatory training: 95% minimum. • All staff will complete donning/doffing training, and relevant staff will be FFP3 mask fit tested.	Via TIPCC and Divisional Governance Groups
14.	**Patient & Public Involvement** • Patients, visitors, and the public will be informed about and involved in infection prevention. Information on the internet will be developed and improved. • Involvement in the development of information • Engagement with cleanliness reviews	Annual review by TIPCC
15.	**Research & Development** • New and novel programmes of work will be identified and progressed in support of the ambition of the Trust, to achieve very low rates of infection, and excellent standards of infection prevention practice.	Annual review by TIPCC

Governance & Management

This corporate plan underpins, integrates, and influences improvement plans in the Divisions and the corporate Infection Prevention Team. Lead responsibility and accountability for local plans rests with Divisional Management Teams. A detailed delivery plan has been developed to achieve the aims and objectives set out in this summary plan.

Progress with this programme will be monitored via the Trust Infection Prevention and Control Committee (TIPCC), chaired by the Chief Nursing Officer/DIPC, and supported by the DIPC. Updates will be provided to the Trust Management Executive Meeting, the Quality Governance Committee, and to the Board as part of regular reporting in place.

Progress with local plans and escalated issues will be monitored and managed via Divisional Governance Meetings, and updates will also be provided to the Infection Prevention and Control HCAI Scrutiny meeting.

Approval: TIPCC **Date:**

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**08/07/2025**
Title of Report:	Safeguarding Adults, Children & Young People Annual Report 2024/2025
Lead Executive Director:	**Chief Nursing Officer**
Author:	Deborah Narburgh, Head of Safeguarding
Reporting Route:	Integrated Safeguarding Committee – Approved 27.05.2025 Minutes of Integrated Safeguarding Committee –agenda item 09: *09 Annual Report Safeguarding 2024 - 2025* *Approved by those present.*
Appendices included with this report:	1. Integrated Safeguarding Annual Report 2. Safeguarding Committee Escalation Report
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Safeguarding Annual Report 2024/2025 details the work undertaken in order for the Trust to meet its regulatory, legal and statutory obligations in relation to the safeguarding of adults, children and young people and requirements of the PREVENT Duty as a 'specified authority'.

The annual report also details activity undertaken by the Trust in the delivery of partnership priorities working with both the Worcestershire Safeguarding Children Partnership (WSCP) and Worcestershire Safeguarding Adults Board (WSAB) and associated sub-groups.

Recommended Actions required by Board or Committee

The Quality Governance Committee is invited to receive the Safeguarding Annual Report 2024 / 2025 for **Assurance.**

Executive Director Opinion[1]

The CNO offers assurance to Trust Board that the Trust is meeting its regulatory, legal and statutory obligations in relation to the safeguarding of adults, children and young people and requirements of the PREVENT Duty as a 'specified authority'.

[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.

Safeguarding Adults, Children & Young People Annual Report
April 2024 – March 2025

1.0 Introduction/Background

Safeguarding activity has continued to increase in volume and complexity during 2024/25:

- Of particular note is the increase to the Multi-Agency Risk Assessment Conference work (MARAC) for victims /survivors of domestic abuse.
- Adult MASH activity has also continued to increase with activity during 2024/25 increased by over 100% when compared to the previous year.
- The national and global situation remains under constant review in respect of emerging terror threats and the response to the Prevent, Pursue, Protect & Prepare agenda.
- 2 unannounced inspections by the Care Quality Commission were undertaken during 2024/25 where safeguarding was scored as 3 (evidence of a good standard)

2.0 Issues and options

2.1 Leadership Arrangements

Listen, Learn, Lead:

The Chief Nursing Officer (CNO) is the Executive Lead for safeguarding adults, children, young people and PREVENT. The Deputy Chief Nurse leads the safeguarding portfolio on behalf of the CNO.

2.2 Assurance

The Trust Integrated Safeguarding Committee is chaired by the CNO or Deputy and meets bi monthly. The Integrated Safeguarding Committee reports to the Quality Governance Committee (QGC) gaining assurance on behalf of the Trust Board that its legal and statutory duties in respect of safeguarding adults, children & young people are met.

The Integrated Safeguarding Committee work in accordance with an agreed work plan. Attendance at the Committee by a representative of Herefordshire & Worcestershire Integrated Care Board (ICB) provides a level of oversight and scrutiny as part of the safeguarding assurance process.

Terms of reference are updated annually.

2.3 Safeguarding Risk Register

The Integrated Safeguarding Committee review all risks on a bi-monthly basis and mitigation is in place. Safeguarding is currently linked to the following open risks:

2.3.1 Current high risks:

ID4119 Policy Revision

ID3430 Safeguarding Alerts – transfer of narrative from Oasis to Patient First System

ID4277 Risk of abduction / absconding –also monitored via Women & Children

Current high risks (12- 14) are:

ID2873 – Safeguarding training compliance

2.3.2 Moderate risks:

ID1748 CAMHS service out of hours –monitoring Committee Women & Children

ID5076 Paediatric attendances Alexandra Hospital – monitoring Committee Emergency Medicine

2.3.3 Low risks

ID5361 – Integrated Safeguarding Team capacity

ID5668 – EPR and partner access to Trust systems in order to undertake safeguarding activity where the H&WHCT represent 'health' e.g. Paediatric Liaison

ID4621 Adoption records –also monitored via Data Quality /Health Records Group

2.3.4 New risks added 2024/25

ID5856 - Safeguarding alerts do not transfer to stand alone systems

ID5857 - Training compliance matrix for Safeguarding Adults Level 3 is not as per the Intercollegiate Document published 2024.

2.3.5 Closed risks 2024/25

ID4701 - Out of hours request for health attendance at strategy discussions

3.0 Care Quality Commission(CQC) Regulatory Activity - Mandatory Training

What needs to happen: CQC 'Must / Should do': Mandatory training compliance of 90% across all levels of safeguarding training, MCA & DoLS

Care Quality Commission inspections have repeatedly cited mandatory training compliance as an area of ongoing concern. Despite the training compliance position, the regulator has acknowledged within inspection reports that staff are able to recognise and protect patients from abuse, working well with other agencies to do so.

3.1 Outturn Position as at 31st March 2025:

3.1.1 Safeguarding Adults

	Q4 2023/24	Q4 2024/25	Compliance required 90%
SGA L1	94%	95%	Compliant
SGA L2	90%	92%	Compliant
SGA L3	89% (159/179 completed)	77% (152/198 completed)	Partial compliance

Do what we say we will do:

As at year end, Safeguarding Adult training Trustwide L1 & L2 is fully compliant with the 90% requirement. L3 has seen an increase in headcount of 19 staff requiring this level of training when compared to last year. As L3 training is low numbers when compared to the other levels, this will have an impact on the overall Trustwide level of compliance.

Action taken: L3 sessions are available to book via ESR or evidence via the refresher route.

Associated Risk:

Adult Safeguarding: Roles and Competencies for Health Care Staff (2nd Ed) –Published July 2024

The implications of the updated intercollegiate document for adults is currently being worked through and a gap analysis undertaken. The impact is most likely to increase the numbers of staff within the organisation who will require their job role to be mapped to L3 SGA training. Risk register ID5857.

3.1.2 Safeguarding Children

	Q4 2023/24	Q4 2024/25	Compliance required 90%
SGC L1	93%	95%	Compliant
SGC L2	89%	93%	Compliant
SGC L3	89%	83%	Partial compliance

Do what we say we will do:

As at year end, Safeguarding Children training Trustwide L1 & L2 is fully compliant with the 90% requirement. L3 compliance has dropped by 6% over the last 12 months.

3.1.3 MCA & DoLS

	Q4 2023/24	Q4 2024/25	Compliance required 90%
MCA & DoLS L1	90%	93%	Compliant
MCA & DoLS L2/3	86%	82%	Partial compliance

Trust compliance with MCA & DoLS higher level remains below the 90% Trustwide requirement.
Do what we say we will do:
The team continue to offer a range of training opportunities for staff to access, including bespoke sessions.

3.1.4 Medical & Dental Staff Training Compliance: Safeguarding Adults and Children:

Staff Group	Competency	Sum of % completed 31st Mar 2022	Sum of % completed 31st Mar 2023	Sum of % completed 31st Mar 2024	Sum of % completed 31st Mar 2025	Trend	Compliance required 90%
Medical & Dental	SGA L2	78.93%	70.37%	76%	82%	↑	Partial compliance
	SGC L2	76.41%	65.55%	74%	77%	↑	Partial compliance
	SGC L3	80.71%	83.23%	79%	80%	↑	Partial compliance
	MCA & DoLS L2			50% (234/467 completed)	48% (238/495 completed)	↓	Partial compliance
	MCA & DoLS L3			86% (313/363 completed)	79% (312/394 completed)	↓	Partial compliance
	Combined L2/3 – Higher level			66%	64%	↓	Partial compliance

2024/25 has seen an improvement in medical and dental safeguarding training compliance across all levels. However, MCA & DoLS training compliance has continued to decline.

3.1.5 System Pressures and impact on mandatory training

The Trust and system partners have continued to face significant challenges as a result of the demands placed upon frontline services, patient flow and capacity during 2024/25. Three critical incidents were declared during December 2024, with a system wide critical incident declared thereafter.

3.2 Care Quality Commission(CQC) Inspection outcomes – Safeguarding

During 2024/2025, there were 2 unannounced inspections undertaken by the CQC in relation to services provided to children & young people. In respect of safeguarding, the overall score for both inspections was 3 (evidence shows a good standard).

3.2.1 Children and Young People, KTC Inspection 20th September 2024, Report published 26th February 2025:

- *We did not collect enough information from patients about their experience of safeguarding to express their views in this report. However, children, young people, parents, and carers spoke positively about the service and were assured it was a children's only theatre day and felt secure.*
- ***Staff knew how to identify children and young people at risk of, or suffering harm and worked with other agencies to protect them**. Staff were able to ask for advice from senior leaders and the safeguarding team if they had a concern with a child's welfare.*
- ***Staff understood how to report abuse and were aware of the escalation processes to make a safeguarding referral. Staff and the managers had a good understanding of involving other agencies, for example, police, the local authority and the trust safeguarding leads.***
- *Most staff had completed training on how to recognise and report abuse for adults and children. In addition, the trust had staff within the safeguarding team to level 4 and level 5 children safeguarding to provide advice about any safeguarding concerns.*
- *Safeguarding advice and support was available from the safeguarding team Monday to Friday 8.30-4.30. Outside these times there was a named doctor in trust for children's safeguarding.*

- *Staff updated electronic patient records weekly by the safeguarding team to identify and alert staff about present and previous safeguarding concerns.*
- *Supervision was provided regularly by the trust and was accessible to all paediatric staff.*
- *Managers attended a bimonthly safeguarding meeting to monitor systems and processes.*
- *Managers produced reports to present to the Chief Nurse about safeguarding quality and performance.*

3.2.2 Children and Young People, ALEX Inspection 1st October 2024, Report published 11th April 2025

- *We did not collect enough information from patients about their experience of safeguarding to express their views in this report. However, children, young people, parents, and carers spoke positively about the service and were assured it was a children's only outpatient clinic.*
- ***Staff knew how to identify children and young people at risk of, or suffering harm and worked with other agencies to protect them. Staff were able to ask for advice from senior leaders and the safeguarding team if they had a concern with a child's welfare.***
- ***Staff understood how to report abuse and how to make a safeguarding referral. Staff and the managers had a good understanding of involving other agencies, for example, police, the local authority and the trust safeguarding leads.***
- *Most staff had completed training on how to recognise and report abuse for adults and children. All nurses were expected to complete safeguarding children level 3 as part of their mandatory training programme.* ***Although not all staff had completed the annual training modules required, staff demonstrated the required knowledge and understanding to safeguard children and young people.*** *Leaders monitored the number of staff that had completed training modules and escalated this information upwards as part of the governance process. In addition, leaders liaised with staff to ensure they were able to complete the training at the most suitable opportunity.*
- *Safeguarding advice and support was available from the safeguarding team Monday to Friday 8.30-4.30. Outside these times there was a named doctor in the trust for children's safeguarding.*
- *Staff updated electronic patient records weekly by the safeguarding team to identify and alert staff about present and previous safeguarding concerns.*
- *Managers attended a bimonthly safeguarding meeting to monitor systems and processes.*
- *Managers produced reports to present to the Chief Nurse about safeguarding quality and performance*

4.0 PREVENT/WRAP

The Trust is fully compliant with its statutory obligations and training compliance for PREVENT in accordance with the PREVENT Duty requirements.

4.1 Training compliance

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty. NHS Trusts are a health specified authority within the Act. NHS England has incorporated *Prevent* into its safeguarding arrangements, so that *Prevent* awareness and other relevant training is delivered to all staff who provide services to NHS patients. This is supported by a Prevent Training and Competencies Framework (NHSE October 2017). Trusts were required to achieve an 85% compliance rate for PREVENT basic awareness and WRAP as of March 2018.

Basic Prevent Awareness Training (BPAT)	Compliance 85%
Q4 2024/25	
94% (1808/1919 staff completed)	Compliant

Prevent L3 and above	Compliance 85%
Q4 2024/25	
95% (5295/5562 staff completed)	Compliant

Do what we say we will do:

The Trust has consistently sustained the national requirement of 85% for PREVENT training across all levels in accordance with the PREVENT Duty.

4.2 PREVENT referrals

The Chief Nurse is the Executive lead for PREVENT. The Operational Lead is the Head of Safeguarding. Compliance with the PREVENT duty is reported quarterly to NHS digital, and the PREVENT Lead for the Integrated Care Board.

The Trust has made 4 referrals to PREVENT during 2024/25. Cases referred have included:

- Young person – extremist ideologies being expressed. Attendance following a knife attack on another young person. Parental concerns re online activity
- Adult –mental health concerns – verbalising wish to blow up a public place (hospital)
- Rhetoric involving white supremacy. Mental health factors. Identified as part of wellbeing /sickness absence processes
- Islamophobic rhetoric. Mental health concerns.

4.2.1 Current themes

Ideologies of concern remain extreme right wing terrorism(XRWT), right wing extremism (RWE) and Islamist extremism. The online space remains the primary area of activity, used to share extremist material, narratives, and to facilitate communication between like-minded individuals. More recently, the use of music has also been seen as a medium for the sharing of extremist narratives / beliefs.

4.2.2 PREVENT data upload to NHSE PSCAT

The Trust has met all of its statutory reporting deadlines for PREVENT during 2024/25.

4.3 PREVENT Partnership working

4.3.1 Current National Threat Level - Joint Terrorism Analysis Centre(JTAC)

The current threat level remains **SUBSTANTIAL** – this means an attack is likely. Given the current national and global situation, this remains under constant review by JTAC.

4.3.2 Counter Terrorism Local Profile (CTLP)

The Head of Safeguarding represents the PREVENT Executive Lead on behalf of the Trust. Actions coming from the Counter Terrorism Local Profile (CTLP) inform the Worcestershire Strategic PREVENT Strategy and associated work streams. Outcomes are shared via the Integrated Safeguarding Committee. The Trust received the CTLP briefing in February 2025.

Do what we say we will do:

Key messages from the CTLP were shared with staff via the annual Prevent newsletter during March 2025:

- Examples of specific cases /individuals and methods employed – including Worcestershire examples
- Focus on stickering /graffiti
- Use of misinformation in fuelling tensions / activity
- Mass shooting, bladed articles, use of vehicles, chemical /biological weapons

4.3.3 Proscribed Groups

Agencies were tasked to review their Policies & Procedures in respect of proscribed groups (extremist groups or organisations banned under UK law).

Do what we say we will do:

A standard clause has been drafted with HR colleagues for use in Trust Policy, recruitment packs, job descriptions etc.

4.3.4 Protection of Premises Bill (Martyn's Law)

The Protection of Premises Bill builds upon the Protect and Prepare strands of the Government's wider counter terrorism strategy, CONTEST. The aim of the Bill is to ensure public premises and events are better prepared and ready to respond for terrorist attacks; requiring them to take reasonably practicable steps, which vary accordingly, to mitigate the impact of a terrorist attack and reduce physical harm. In addition to this, certain larger premises and events must also take steps to reduce the vulnerability of their premises to terrorist attacks. The threat picture remains complex, evolving and enduring, with terrorists choosing to attack a broad range of locations.

Do what we say we will do:

The Head of Safeguarding has been working with Emergency Planning to review the implications of what is known thus far. Worcestershire has set up a 'Protect' working Group to consider fully the legislation and implications for partners. The Trust is fully represented on this group.

Next steps:

An internal working group has been developed to consider the implications of this Law. The CTLP Protect & Prepare briefing pack will inform initial considerations.

4.3.5 PREVENT Strategy Group

Prevent Assurance and contribution to the Worcestershire Strategic Action Plan

During September the Trust submitted its Prevent Assurance Statement in relation to the 8 key priorities and also its contribution to the wider Worcestershire Strategic action plan. The Trust was able to offer a high level of assurance to the partnership in this regard.

4.4 Annual PREVENT Newsletter 2024

Published during April 2024 and circulated via Weekly Brief.

4.5 Supplementary activity

Newsletters and briefings continue to be circulated to professionals to keep them appraised of PREVENT activity e.g. signs & symbols

5.0 Female Genital Mutilation (FGM)

The Trust has robust systems and processes in place to recognise and report cases of FGM in accordance with the FGM Mandatory Reporting Duty (2015).

The Named Midwife, and Named Doctor are leads for FGM within the Trust providing oversight and statutory reporting of identified cases of FGM. The Named Midwife has responsibility for upload of the FGM indicator to the NHS Spine to alert staff that there is a family history of FGM.

5.1 FGM National Dataset reporting

There have been 15 reported cases of FGM during 2024/25.
Country of origin: Nigeria, Gambia, Iraq, Israel.

5.2 FGM-IS Standard Operating Procedure (SOP)

Female Genital Mutilation Information Sharing (FGM-IS) is a national IT system for NHS staff that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM).

Do what we say we will do:

SOP updated July 2024, to reflect most up to date guidance, including Working Together to Safeguard Children, revised December 2023.

5.3 FGM Awareness Day 6th Feb 2025

Trustwide communications circulated to raise staff awareness of FGM. Although FGM is predominantly identified in obstetric services, other areas need to remain alert e.g. surgery, urology.

5.4 NHS England - RCPCH Requests for Female Genital Mutilation medical examination in under 18-year-olds in the emergency department – published February 2025

New RCPCH guidance states that Paediatricians undertaking assessments of children who may have experienced FGM need to be trained and competent. As per the Government Working together to safeguard children 2023: statutory guidance, a strategy meeting should be held between the statutory partners (Health, Social Care and Police), to determine the child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm. The role of the (appropriately skilled and experienced), health practitioner is to advise about the appropriateness or otherwise of medical assessments. The appropriate time and location of any medical assessment should be agreed at the strategy meeting.

Do what we say we will do:

The Guidance has been circulated to relevant practitioners /depts by the Named Doctor Children's Safeguarding.

6.0 Homelessness 'Duty to Refer' - Homelessness Reduction Act 2017

The Trust has in place systems and processes to meet the requirements of the Homelessness Reduction Act 2017.

6.1 Homelessness Pathway Project

The Worcestershire Homeless Pathway Project provides specialist support to inpatients within acute and community hospitals across the county as well as offering training to staff and students. The role currently sits within Worcester City Council and is funded via ICB NHS funding.

6.2 Referral Data

144 (**for Q1-Q3**) referrals were made to the service during 2024/25: of these:

Alex Hospital	38
Worcester Royal Hospital	83
Kidderminster Treatment Centre	1

- 93 referrals were male
- 51 referrals were females
- 7 cases involved domestic abuse /violence
- 10 cases deemed to lack mental capacity to make a homeless approach

6.3 Safeguarding Concerns

31 of the total referrals for Q1-Q3 had safeguarding concerns.

Quarter 1 2024	7
Quarter 2 2024	10
Quarter 3 2024	14
Quarter 4 2025	Data unavailable as at time of report

7.0 Modern Slavery / Human Trafficking

The Trust has in place systems and processes to meet the requirements of the Modern Slavery Act 2017 working with our partners to protect those at risk.

The Integrated Safeguarding Team continue to provide advice and support to staff when concerns are identified on a case by case basis. Case example:

- Concerns that a woman had been trafficked into the UK by Albanian Mafia for the purposes of prostitution. The woman was referred to the National Referral Mechanism (NRM).

7.1 Home Office – Modern Slavery Statement
The Trust annual Modern Slavery statement was uploaded to the Home Office during June 2024.

7.2 Human Trafficking Foundation
Modern Slavery Newsletters and key messages are shared via the Integrated Safeguarding Committee.

8.0 Suicide Prevention

The Trust is actively working with partner agencies in relation to suicide prevention and the support and signposting agenda.

8.1 Worcestershire Suicide Audit Group
Commenced during 2022/23 the group was set up to look at a real time surveillance system(RTSS). The aim of the RTSS is to seek to reduce deaths by suicide in Worcestershire. The process will help to provide bereavement support to residents of Worcestershire affected by suspected suicides in a timely fashion. Data and information gathered during this process is used to identify patterns and trends so that suicide prevention strategies can be adopted and inform public health interventions and strategies. The Head of Safeguarding represents the Trust on this group. Areas considered during 2024/25 include:

- Death by suicide 'hotspots' /areas of risk
- Learning – inquest, other statutory reviews
- Data – local, national
- Support & signposting services

8.2 World Suicide Prevention Day -10th September 2024
The annual world suicide prevention day provides the opportunity for people, across the globe, to raise awareness of suicide and suicide prevention. The theme for this year was 'changing the narrative on suicide and a call to action for all of us to start the conversation'.
Do what we say we will do:
Resources were promoted Trustwide to share key messages to our staff.

8.3 Glow of Hope
A creative gathering for anyone affected by suicide or passionate about suicide prevention, facilitated by local artist Oliver Bliss. The event was run by Behind the Smile, a local mental health and bereavement charity along with support from Worcestershire's Bereaved by Suicide Service and PAPYRUS Prevention of Young Suicide.
Do what we say we will do:
Trustwide communications circulated to promote the event.

8.4 SpeakOUT Peer Support Group
Communications were circulated in respect of SpeakOUT who provide a support group for those who identify as LGBTQ+ and have lost a loved one to death by suicide. The information was also shared with the Trust LGBTQ+ Network Chair for wider circulation.

8.5 'Coping at Christmas'
Communications circulated Trustwide promoting mental health and suicide prevention sources of support.

9.0 Mental Health Act

Medical staff need to ensure s5(2) paperwork is completed in accordance with requirements of the MHA to ensure the detention is lawful.

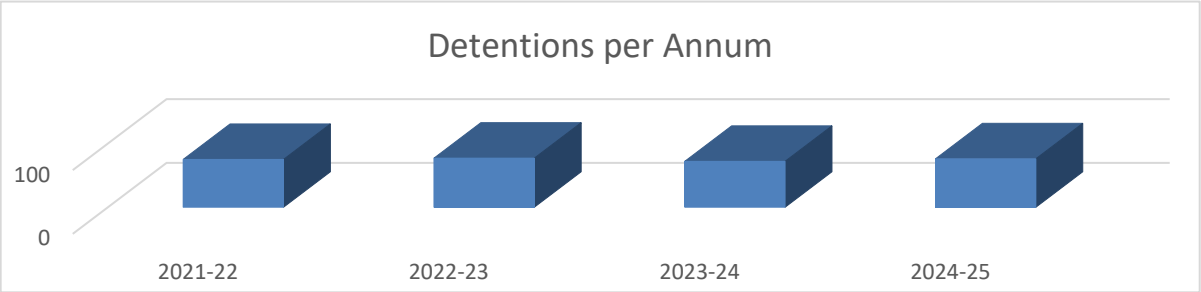
The Mental Health Act 1983 (amended in 2007) is the law which sets out when a person can be admitted, detained and treated in hospital for a mental disorder. The Act is supported by a 2015 Code of Practice. All applications for admission are made out to the 'Hospital Managers', meaning the organisation in charge of the hospital. In practice, most decisions are delegated to clinicians. Providers require specific registration with the Care Quality Commission to deliver care. There has been no relevant Case Law and no alterations to legislation during 2024/25.

9.1 Types of Detention

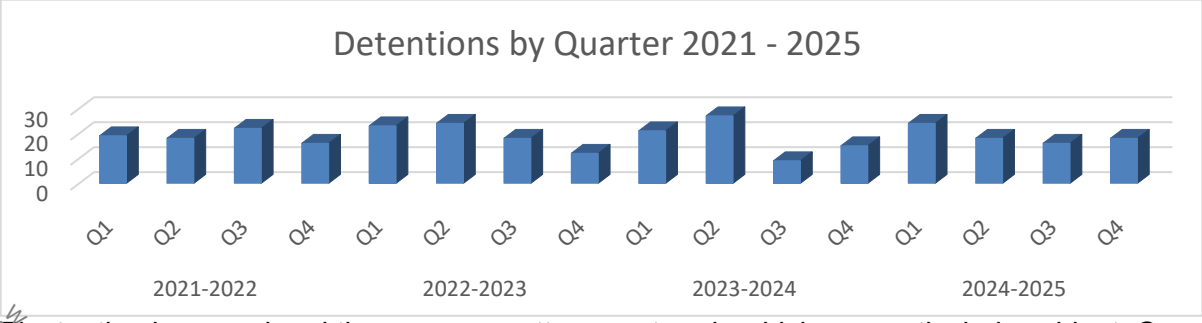
Section 2	detention in hospital for up to 28 days for assessment and/or treatment
Section 3	renewable treatment section which lasts for up to 6 months initially. Once renewed twice, the section duration becomes one year
Section 4	Admission for assessment in cases of emergency where only one doctor is available; lasts up to 72 hours. Can be converted to a section 2
Section 5(2)	Doctors' holding power, allows detention for up to 72 hours for the purposes of assessment. Patients must already have been admitted to hospital

9.2 Uses of Section

The Trust were Hospital Managers to 76 detentions during 2024 /25.
The detentions involved 52 individuals.
There was 1 detention open as at year end.

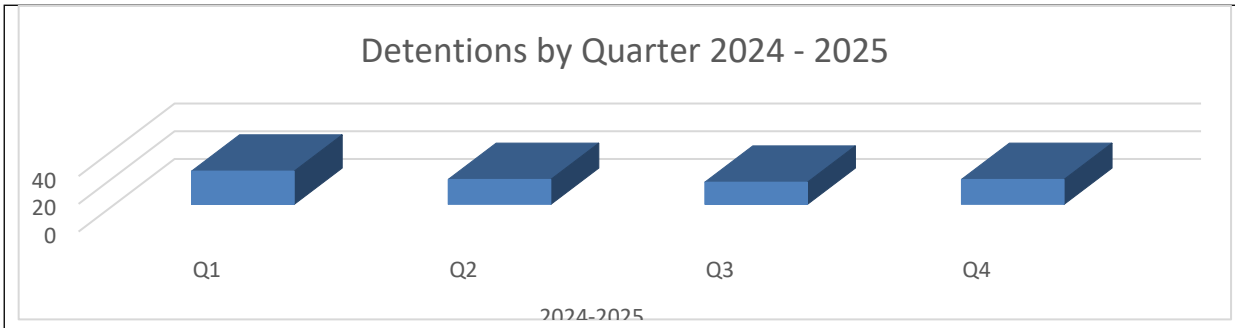


The graph below shows the number of sections held within the Trust, quarter by quarter from 2021 when the contract began, to 2025.



Fluctuation is normal and there are no patterns or trends which are particularly evident. Quarters 1 and 2 predominantly continue to see the highest levels of activity.

9.3 Section activity by quarter 2024/25



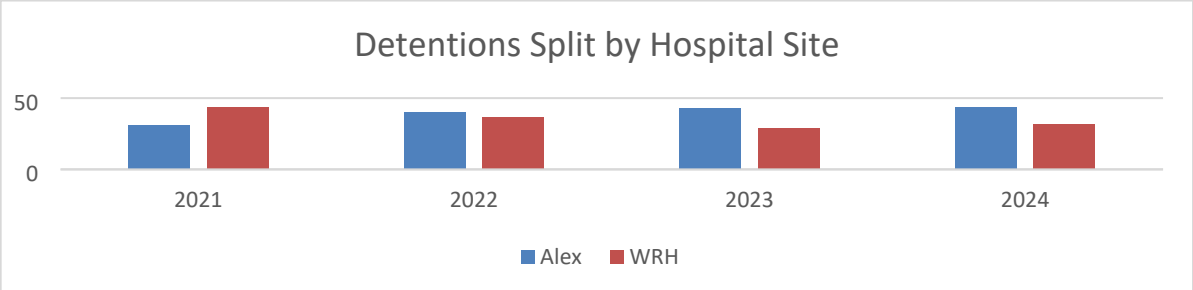
Quarter 1 in this year had the highest number of detentions recorded within the contract.

9.4 Breakdown of Section Activity
By type:

- Section 2 42
- Section 3 24
- Section 5(2) 9
- CTO 17E recall 1

9.5 Section Activity by Hospital

	2021	2022	2023	2024
Alex	31	40	43	44
WRH	44	37	29	32



Most activity appears to be at the Alexandra Hospital, which is located nearer to New Haven, an older adult mental health unit based in Bromsgrove.

9.6 Section Activity by Ward
The wards with the most detention activity are as follows:
Alex

- AMU - 18
- Ward 2 - 10

WRH

- AMU - 9
- Hazel - 4

These 4 wards accounted for 54% of activity.

9.7 Breakdown of Sections

There are a variety of ways in which sections can start:

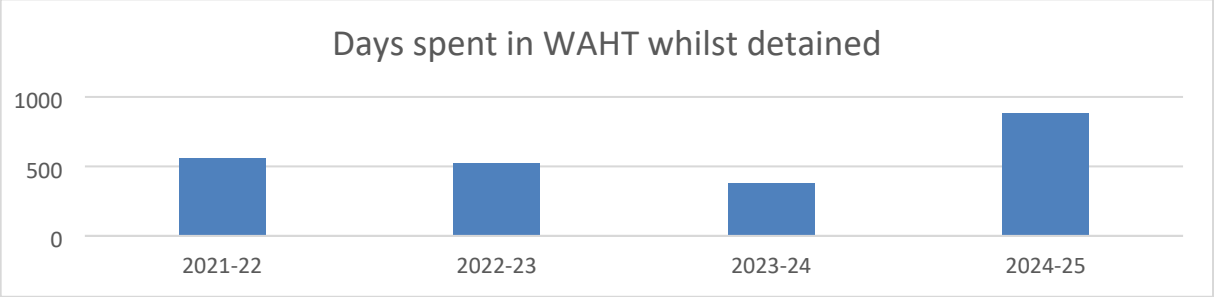
Direct Admission (where the admission under section takes place directly to the Hospital Managers of the Trust)
Regrade (where a section changes type whilst under the care of the Hospital Managers of the Trust)
Regrade from Informal (this is where a section is started after a person has been admitted voluntarily. Usually – but not always – a holding power)
Transfer (where the section was started whilst the patient was under the care of another provider and subsequently moved to WAHT)

The most common way for sections to start in WAHT within this year was a regrade from informal (n38):

- 11 sections were regraded while the patient was receiving care at WAHT; and
- 27 sections were transferred into the care of WAHT. All of the sections that transferred into WAHT, were from HWHCT.

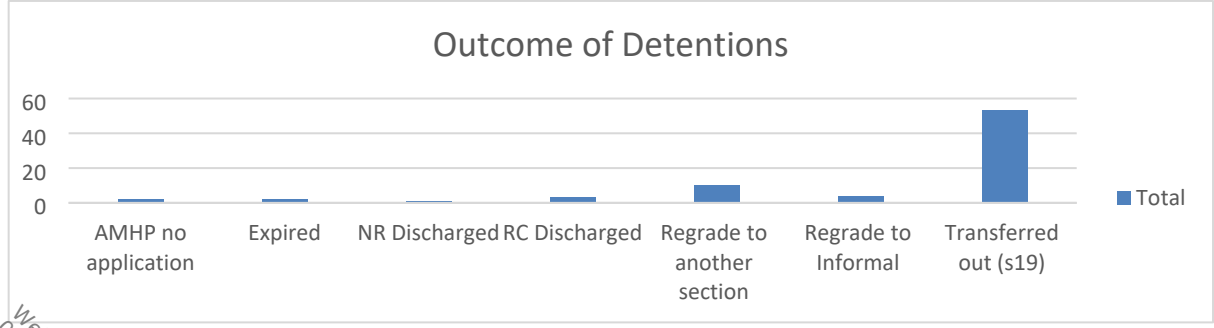
9.7.1 Time Spent on Section

In total, patients spent 879 days on section within the year, an increase on previous years.
7 of the 52 individuals spent 451 days on section, equating to 51% of total days.



As would be anticipated, the majority of patients who were sectioned were transferred out to mental health care providers once their physical health was stabilised.

9.7.2 Outcome of detentions 2024/25



9.8 Gender and Ethnic Breakdown of Detained Patients

9.8.1 Gender

- 33 were female

- 19 were male

9.8.2 Age

- 18 were over 65
- 31 were between 18 and 65
- 3 were under 18

9.8.3 Ethnicity

- White British 46
- White and Black Caribbean 1
- Any other White Background 2
- White and African 3

9.9 Rights & Hearings

Patients who are detained under the Act are encouraged to appeal to the First Tier Tribunal and to the Hospital Managers. Patients are entitled to legal aid for the former, but not the latter. The Associate Hospital Managers (AHMs) are delegated the right of discharge by the Hospital Managers. In addition to appeals, the AHMs hold a review when a patient's section is renewed or when a Nearest Relative is barred from exercising their power of discharge.
Whenever a patient is detained within WAHT, they will receive information relating to the section and their rights of appeal in accordance with the MHA 1983 and the Code of Practice 2015.

9.9.1 First Tier Tribunal (Mental Health) (FTT)

Patients have the ability to apply to the FTT once in every period of detention and are legally aided to obtain representation in doing so. At certain junctures, the Hospital Managers are obliged to make an application to the FTT if the patient themselves has not done so. There were no FTT applications during 2024/25.

9.9.2 Associate Hospital Managers (AHM)

The AHMs are specially trained lay people who sit on hearings panels and work to ensure that patients have hearings on appeal and at the renewal of a section. There were no AHM hearings within WAHT within 2024/25.

9.10 Sections Declared Invalid

10 sections were declared invalid within the year; all were documentation errors within the statutory forms used for Doctors' holding powers. In each case, MHA Liaison were advised and via them, the wards. The person and their Nearest Relative will have been notified in writing that an error had occurred.

Action taken:

During Q3 a Trustwide briefing was circulated giving *step by step instructions* for medical and nursing staff to ensure the legal documentation for s5(2) detentions are met.

9.11 Care Quality Commission Notifications

There were no notifications to the CQC required within the year.

9.12 Supplementary Activity

9.12.1 Lampard Mental Health Inquiry – Essex

The Lampard Inquiry, is the first public inquiry specifically looking into mental health deaths. It will aim to understand what happened to patients who died at children and adult inpatient units, under the care of the NHS in Essex, between the years 2000 and the end of 2023.

Do what we say we will do:
The inquiry and terms of reference were discussed at the Integrated Safeguarding Committee in September. Any findings relevant to Acute providers will be reviewed as the inquiry progresses.

9.12.2 Case of Valdo Calocane – Nottinghamshire Healthcare NHS Foundation Trust
On 25 January 2024, VC was sentenced at Nottingham Crown Court to be detained indefinitely at a high-security hospital following the murder of 3 individuals and attempted murder of 3 others.
VC was under the care of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) between May 2020 and September 2022. During this period, he was acutely unwell, presenting with symptoms of psychosis; and appearing to have little understanding or acceptance of his condition. Issues with him taking his medication were also recorded at an early stage.
The case resulted in:

- the CQC carried out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008.
- Homicide review (patient had a severe mental health diagnosis)
- NHS England (Midlands) Independent Investigation - Theemis – Published February 2025
- National Statutory Enquiry agreed – Judge led
- Nationally, NHSE have asked every Mental Health Trust to review these findings and set out action plans for how they treat and engage with people who have a serious mental illness, including how they work with other agencies such as Police. Trusts have also been instructed not to discharge people if they do not attend appointments.

Do what we say we will do:
Although the Trust is not a mental health service provider organisation, the Trust has undertaken a review of the recommendations and findings from the VC case which have been shared via associated Trust governance forums.
Further action planned:

- Following discussion held at the NMAB on 26th March, the Trust has linked with Nottinghamshire NHS Trust to seek further information on the 'Safe now' dashboard. This will be reviewed to see if it could add value to existing processes.

10.0 Safeguarding Supervision

The Trust has systems & processes in place to deliver safeguarding supervision in relation to Midwifery & Maternity, Children & Adults and requirements of the combined regional assurance tool.

Safeguarding supervision continues to be delivered across the Trust via a number of mediums.
Do what we say we will do:

- Richard Swann Safeguarding Supervision training promoted offering free places to Trust staff.
- Specialist teams receive regular supervision from the Named Professionals due to the complexities of their caseloads
- Supervision Newsletters have been circulated via the Weekly Brief in relation to Joint Targeted Area Inspection (Domestic Abuse)
- Trauma informed webinars have been promoted Trustwide

10.1 Safeguarding Supervision Policy
Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare (Working Together to Safeguard Children 2023). Working to ensure adults and children are protected from harm requires professional curiosity, professional judgment and professional challenge. It is recognised that working in the field of safeguarding entails making difficult and risky professional judgments. It is demanding work that can be stressful. Therefore, all frontline practitioners must be well supported by effective Safeguarding Supervision, advice and support.
Do what we say we will do:
The Trust Policy was fully reviewed and updated during 2024/25 to include adult safeguarding supervision providing a 'think family' and 'across the lifespan' approach.

10.2 Volunteers and Safeguarding Supervision – links to Regional Assurance Tool – Adults & Children

To build on the safeguarding supervision offer across the organisation, an agreed process is now in place for Trust volunteers which includes:

- The quarterly report from the Volunteer Manager will include safeguarding
- Cake 'n' chat events for volunteers – safeguarding will be an agenda item at each of these
- Safeguarding section within the regular volunteer newsletter – circulated August 2024 detailing the Trust offer of supervision methods for volunteers
- Updated section to include supervision in the volunteer handbook
- The Volunteer Policy will be updated to include safeguarding supervision

Do what we say we will do:

The increased level of assurance in regards to volunteers will enable the Trust to fully meet the requirements of the supervision offer detailed within the combined regional assurance tool completed bi-annually for S11 children and safeguarding adults: *6.4 Organisations can evidence that supervision (including clinical/specialist) is happening on a regular basis for all staff and volunteers.* This assurance is next due 2025/26.

11.0 Safeguarding Alerts

Action required: The Trust has several standalone systems that do not speak to PAS. This can create risk if staff do not check PAS alongside the stand alone system. Risk ID5856

11.1 Strategy Meetings – sharing health information: forthcoming OPD attendance

The Trust is notified by H&WHCT of any child for whom a strategy discussion has taken place. The Integrated Safeguarding team then check whether the child has any forthcoming outpatient appointments with the Trust and ensure the respective clinician is made aware. An alert is added to clinical systems to appraise practitioners that concerns have been raised that have met the threshold for a strategy discussion. Prior to this, practitioners would not have been aware that concerns around the child had met the threshold for a strategy discussion as some parents/carers do not disclose such information in order to avoid detection. A significant number of these cases result in child protection enquiries (s47) being undertaken.

- Strategy notifications 2024/25 received – 1248 (2023/24 n1181) ↑
- Children discussed – 2024/25 n2624 (2023/24 n2475) ↑
- 116 of these children had forthcoming OPD with the Trust

Outcomes:

	Q1	Q2	Q3	Q4
S47	434	438	543	496
S17	44	101	153	92
NFA	32	56	47	23
EH	1	2	2	1
Continue with Plan	22	33	50	34
No outcome	6	10	5	0

Categories:

Q1	Q2	Q3	Q4

Sexual Harm	121	171	175	108
Physical Harm	104	128	151	138
Emotional Harm	52	60	121	121
DA	119	94	176	111
Neglect	80	79	85	96
CE	42	60	58	59
Other	21	48	34	13

11.2 Paediatrician Attendance - Out of Hours Strategy Discussions
During June 2024, the Designated Doctor for H&W ICB confirmed that there was no commitment for health representation at strategy discussions out of hours. The only scenario where representation for an OOH strategy meeting would be for a patient admitted to the ward for health reasons. Otherwise, the expectation is that the strategy meeting would be called in-hours on the following morning where the IST from the Health and Care trust would represent 'health' and share information.
Do what we say we will do:
This information has been shared internally and the associated risk closed – risk ID4701.
The Trust has received 9 notifications (involving 17 children) of out of hours strategy discussions during 2024/25. The on call Paediatrician contributes as required, on a case by case basis.

11.3 NHS England - Standard Operating Procedure: Supporting a system approach for safeguarding alerts – change to process
If the concern is at a level where a national 'health' alert is being considered, there needs to be a multiagency strategy meeting. Police and social care should take the lead on any alert process. A health alert should not be routinely offered. The value and rationale why a 'health only alert' must be clearly evidenced. Any action outcome proposed at a multiagency strategy meeting must be discussed and if agreed as an appropriate course of action this will then need to be endorsed by the ICB.
Do what we say we will do:
Information shared re change to process for request of National Alerts with key professionals July 2024.

11.4 New Safeguarding Alerts during 2024/25
Healthcare records have approved the following alerts to enhance the safeguarding alerts held within Trust clinical systems:

- Care Leaver – to assist with the non-statutory reporting requirement for death of any care leaver
- Hospital Independent Domestic Violence Advisor (HIDVA) – to aid identification of cases being managed by the HIDVA which may not meet the high risk threshold for MARAC

11.5 Supplementary activity
11.5.1 Safeguarding Alert Newsletter
Circulated Trustwide during March 2025 to raise staff awareness of the alerts in use and how to check them to inform patient care / risk.

11.5.2 Desktop Communications 07.03.2025
To promote key messages in respect of safeguarding alerts.

11.6 Child Protection Plan (CPP) – Long List Audit (June 2024)

The Integrated Safeguarding Team receive a weekly list of starts and ceases for Child Protection Plans (CPP) from Worcestershire Children First (WCF); including unborns subject to CPP. Information received within the report is reliant upon when the Social Worker enters the details of the plan on the WCF system which then gets pulled through to the weekly report received by the Trust. The alerts held within clinical systems are then updated to reflect this.
Where the alert is in relation to an unborn, the alert is added to the mother and then should be transferred to the baby at delivery. The alert on mother is then ceased, and a previous CPP alert added. In order to ensure that we are not missing any CPP for children or unborns a review of the 'long list' at frequent periods is undertaken and alerts held within Trust clinical systems checked.

11.6.1 Data review:
Date of Long List received from Worcestershire Children First reviewed: 17th June 2024.

11.6.2 Type of data:
Alert list type: Child Protection Plans (including unborns).

11.6.3 Number of Alerts reviewed:
Total number of alerts reviewed: 619

11.6.4 Findings:

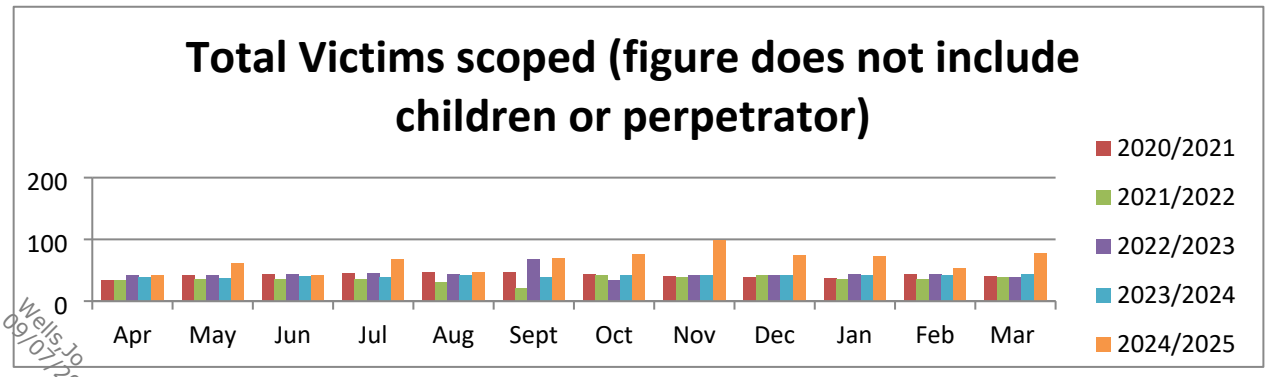
- Total number of alerts flagged correctly: 611 (99%)
- Total number of alerts present where the notification from Worcestershire Children First was made to the Trust a minimum of 2 weeks after the start date of the plan: 27 notifications.
- NHS Spine – child on list, but not showing as on a CPP on NHS Spine. Child not born here x 1 case
- On the long list, but has not appeared on the weekly list for flagging – 3 cases. Alerts have now been added to clinical systems to reflect plan and start dates.

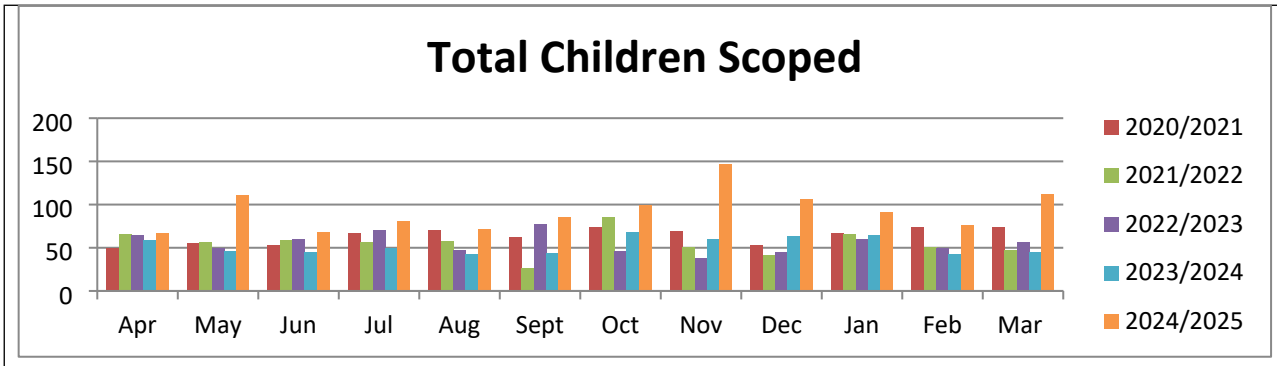
Do what we say we will do:
Safeguarding alerts form part of a regular audit schedule to ensure the accuracy of alerts held within clinical systems.

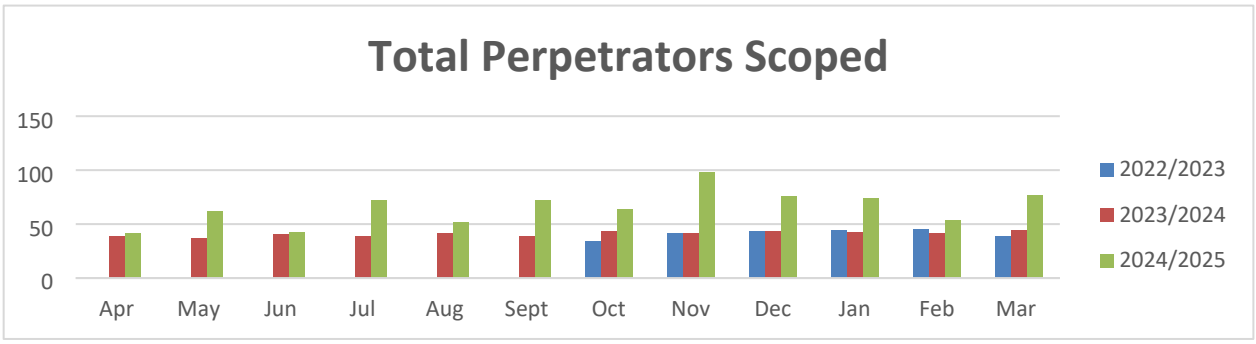
12.0 Domestic Abuse /Domestic Violence

The Trust has established systems and processes in place for the identification and reporting of domestic abuse, including support services for onward advice & support (this service covers both staff and patients).

12.1 Multi-Agency Risk Assessment Conference (MARAC)
The Trust has undertaken 2673 (2023/24 n1600) individual scoping's for *high risk* domestic abuse during 2024/25. **This is a 67% increase on last year's scoping activity for MARAC.** This intense scoping practice /adding of alerts to clinical systems, ensures that staff are alerted to high risk victims and children of domestic abuse should they fail to attend departments or appointments.

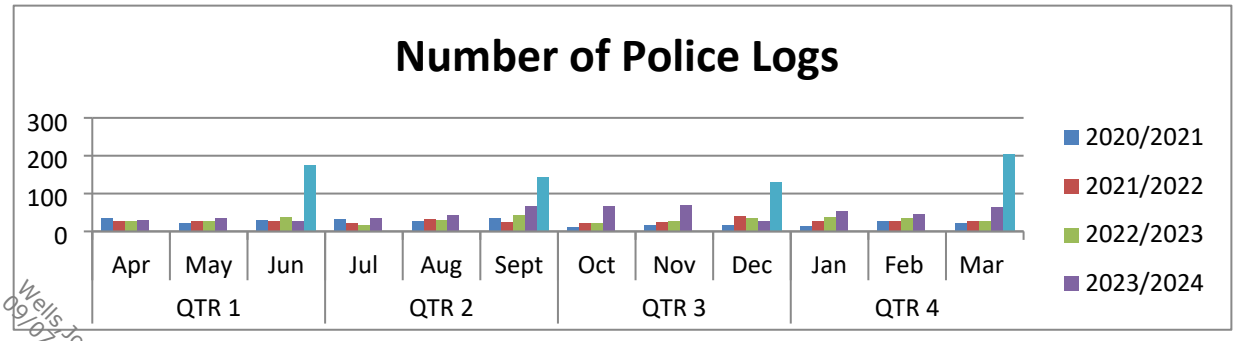




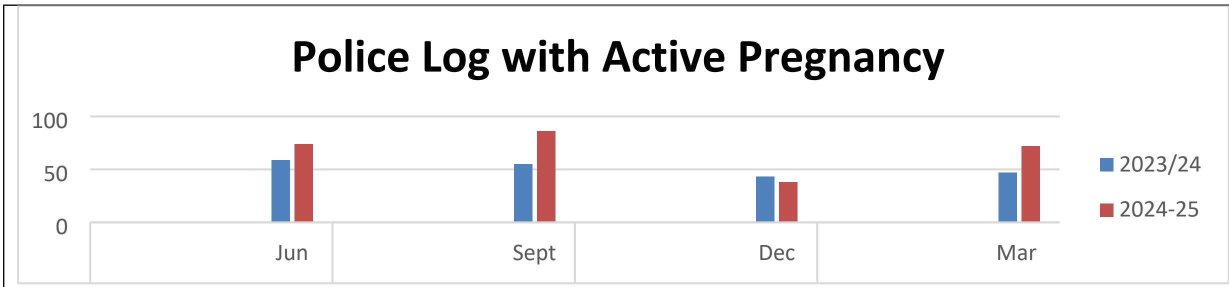


12.1.2 Increased number of MARAC meetings 2024/25.
Due to the significant backlog of MARAC cases, the number of MARAC has increased during 2024/25. Ordinarily, we would scope for 2 MARAC meetings per month (which would entail scoping for 23-25 **cases** per MARAC (victim, children, perpetrator). Over the last year, there have been 7 months where 3 MARAC have been held, 4 months where 2 MARAC have been held and during November, 4 MARAC were held. This has had a significant impact on agencies tasked with scoping cases and providing information.

12.2 Police Logs flagged:
Police Logs are received by WAHT Integrated Safeguarding Team. All victims and their children are "flagged" on Trust Information Systems. Police Logs are received when the victim or perpetrator is pregnant or have recently delivered. 653 Police Logs have been reviewed and flags added to clinical systems during 2024/25. Police log activity has continued to increase during 2024/25 (2023/24 n564).



Of the 653 logs received, 270 (41%) cases had an active pregnancy. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth.



12.3 Hospital Independent Domestic Violence Advisor (HIDVA)
The below details referrals during 2024/25. In total,120 (2023/24 n81) referrals were made to the HIDVA service across the Trust. This trend is consistent with increases to domestic abuse associated work streams during 2024/25. Worcester Royal Hospital site continues to submit the most referrals.

Referrals by site	Q1	Q2	Q3	Q4	Total
Redditch Alexandra Hospital	13	7	8	8	**36**
Worcester Royal Hospital	18	22	19	25	**84**

Engagement by Referrer	Q1	Q2	Q3	Q4	Total
Redditch Alexandra Hospital	8	5	6	6	**25**
Worcester Royal Hospital	11	16	12	7	**46**

12.4 Operation Flagship – Domestic Abuse Partnership Board – Euros (June 2024)
Statistics show a significant increase regarding the risk of Domestic Abuse during football tournaments, in response to this, West Mercia Police launched Operation Flagship. Data from the National Centre for Domestic Violence revealed that incidents involving domestic abuse increases by 26% when England play and 38% when England lose.
Do what we say we will do:
Trustwide communications were circulated via Weekly Brief to alert staff to the increased risk and offers of support available.

12.5 Service improvement - Training developments
As of the beginning of November, the HIDVA and Integrated Safeguarding Team have a 'slot' on Trust Induction specifically for domestic abuse; thereby targeting all staff at the point of commencement in post.
Domestic abuse training is currently delivered on:

- Midwifery Mandatory Training Days (MMT) and Midwifery Preceptorship.
- Preceptorship Training

12.6 Domestic Abuse – Policy & Procedures -Employees
This has been brought up on the back of the Domestic Abuse Act and also some learning from a recent joint domestic homicide review and child safeguarding practice review, whereby a mother and a child were involved in a house fire. The mother was a Social Worker by profession and had alleged that she'd received some threatening calls at work around the domestic abuse agenda that she'd

reported to the Police. Part of the learning from the review, which isn't published yet, has been around what do we do as employers when an employee says to us that they are receiving threats or domestic abuse concerns whilst at work?

Do what we say we will do:

Our Health and Safety Lead has confirmed the Trust does have a managing violence and aggression policy and contained within there is information around our duties as an employer around liaison with the Police and the actions that would ensue.

12.7 Joint targeted area inspection (JTAI) of the multi-agency response to children who are victims of domestic abuse – Practitioner Briefing – September 2024

The new theme was published during September 2024. The JTAI will focus on:

- *reflect the definition in the Domestic Abuse Act 2021*
- *focus on unborn children and children aged 0 to 7 years who are victims of domestic abuse*
- *When looking at the experiences of younger children, we will consider the support for other children and adult victims in the same household.*

Do what we say we will do:

Trust wide and targeted communications have been circulated on the newly published theme in order for staff to prepare in the event a JTAI is called within Worcestershire.

12.8 Supplementary activity

12.8.1 Children & Young People HIDVA Service

The HIDVA service has now been extended to offer a service to children & young people from the age of 5yrs. Trustwide communications circulated.

12.8.2 Victim Support – WeMatter Campaign

Resources promoted Trustwide to raise awareness. WeMatter is a totally digital service providing specialist support to children and young people aged 8–17 years old, who have been affected by domestic abuse. WeMatter delivers the CYP Domestic Abuse Recovery Toolkit, which offers a range of activities and discussions informed by Trauma Focused Cognitive Behaviour Therapy.

12.8.3 #Cut it out

Free training sessions promoted Trustwide funded by North Worcestershire Community Safety Partnership to raise awareness of domestic abuse.

12.8.4 White Ribbon Day – 25th November 2024

A joint Herefordshire & Worcestershire White Ribbon Conference, held on Friday 22nd November, saw over 300 delegates booked to attend on the day, a record for Herefordshire and Worcestershire.

12.8.5 WREN report Mother to Newborn: Risk of Domestic Abuse

A new WREN report has been developed for when the mother is at risk of domestic abuse and she is flagged on clinical systems. At birth, a risk of domestic abuse alert will be added by the Named Midwife to the newborn to ensure staff are alert to the risk of domestic abuse. It is well documented that domestic abuse increases during pregnancy and therefore poses a risk to both mother and any newborn.

12.8.6 SafeLives Newsletter Feb 2025

Shared Trustwide to keep staff appraised of current training opportunities and latest information.

12.8.7 Remote Tracking of Hearing Aids – Companion App

Information was shared with relevant Trust departments in respect of the risk of remote tracking (within range of the phone) which may pose a risk to Looked After Children or victims of domestic abuse.

13.0 Safeguarding Children – Exploitation

The Trust works with partner agencies in respect of the exploitation of children and young people

13.1 GetSafe – Child Exploitation

GetSafe is Worcestershire's multi-agency response to the protection of children at risk of exploitation and works in a focused and co-ordinated way to protect those most at risk.
During 2024/25, Trust staff submitted 12 GetSafe referrals.
The GetSafe risk assessment has been further reviewed and updated during 2024/25 supported by a programme of workshops for practitioners.

13.1.2 GetSafe Portal and Weekly Triage Meetings

The Trust has provided information for 1280 children/young people during 2024/25. Of these:

- 410 new referrals
- 870 reviews – this number has dropped considerably from the previous year (n1320), however if the child is rag rated green and in receipt of the appropriate intervention then the case is closed to GetSafe (unless any new information comes to light).

13.2 Multi-Agency Child Exploitation (MACE)

The Trust 'flags' on clinical systems any child for whom it receives a MACE report. This ensures practitioners are kept informed of the risks surrounding the child in the event they should attend any of our services. During 2024/25, 328 MACE scoping / flagging have been undertaken. This is also a reduction on the previous years' activity (n390).

13.3 WREN Report ED Attendances

In order to identify children/young people attending the Trust who may be at risk of exploitation a WREN report is run daily based upon key words from the attendance: gun, gang, knife etc. The report is reviewed daily by the Integrated Safeguarding Team to ensure all appropriate actions have been taken in order to protect and safeguard the individual or others.

Do what we say we will do:

- During 2024/25, 3193 children/young people attendances were reviewed via this process
- Of the 602 referrals recorded into the Family Front Door, 407 were made by Trust staff or the Integrated Safeguarding Team (68%).
- Conversion rates continue to be monitored by the QAPP sub-group of the WSCP

13.4 GetSafe Operational Group – 'On the Road' 5th Anniversary

The 24th-30th June marked the five-year anniversary of Worcestershire's Get Safe programme – a multi-agency partnership committed to tackling child exploitation and supporting victims and their families who experience this. The team (including the Trust Named Nurse Safeguarding Children) went on tour in the Sunshine Radio bus to six locations across the county to help local young people, parents/carers, professionals and the public to learn how to spot the signs of child criminal exploitation.

14.0 Statutory Partnership Working – Children

The Trust is meeting its statutory requirements as a partnership agency and contributing to the work of the Worcestershire Safeguarding Children Partnership and its associated sub groups

14.1 Working Together to Safeguard Children, 2023 – Safeguarding Children Policy Revision

Further to the revision of Working Together (WT), 2023, the ICB were allocated a sum of money to ensure all 'health' Policies and Procedures are WT 2023 compliant. As a result of this piece of work,

a 'health' Safeguarding Children Policy was developed containing core local, regional, national guidance. Local Trust information was subsequently inserted into the core Policy.

Do what we say we will do:

The Trust Safeguarding Children Policy has been approved and published March 2025.

14.2 Case Escalations

The Trust has made 14 escalations for complex cases during 2024/25. Themes:

- Parents failing to engage with services
- Parental substance misuse
- Mental health –tier 4 provision
- Children within a family not seen by professionals for many years
- Young child – self harming behaviours. Parents unable to manage child. Child subsequently removed from parents' care.

14.3 WSCP Newsletters

Circulated Trustwide to keep staff appraised of learning and work of the Worcestershire Safeguarding Children Partnership.

14.4 Audit activity - Quality of referrals to Family Front Door

45 Trust referrals were reviewed during 2024/25. Of these:

- 4 rated as outstanding
- 26 rated as good
- 15 rated as requires improvement – feedback given to respective practitioners

14.5 Multi-Agency Safeguarding Hub (MASH)

The Trust has shared information for 17 MASH requests for children during 2024/25.

Themes:

- Neglect
- Substance misuse
- Ineffective parenting
- Unhealthy relationships

14.6 Worcestershire Safeguarding Children Partnership

14.6.1 Child Death Overview Panel (CDOP)

The Named Doctor attends CDOP on behalf of the Trust.

Action taken:

- The Trust continues to support the Sudden Unexplained Death in Childhood (SUDIC) and CDOP process via information sharing and attendance at respective meetings.

14.6.2 Sudden Unexplained Death in Childhood (SUDIC)

The Named Professionals have scoped and submitted reports/attended on behalf of the Trust for 11 SUDIC cases during 2024/25.

Themes:

- Road traffic accident
- Extreme prematurity
- Cardiac arrest
- Found unresponsive
- Underlying health conditions

14.6.3 Specialist Child Death Review Nursing Service

The Specialist Child Death Review Nursing Service involved in the child death review process works together with other partners to meet two main objectives:

- to improve the experience of bereaved families, as well as professionals, after the death of a child
- to ensure that information from the child death review process is systematically captured to enable local learning and, through the National Child Mortality Database (NCMD), to identify learning at the national level, and inform changes in policy and practice.

From April 2025 there will be a new approach to the above service. The service following a funded business case for an increase to staff, will cover all of Herefordshire & Worcestershire in terms of all statutory reviews; and have a focus around prevention. The service currently covers up to 18yrs, however there is a proposal that this may be extended up to 24yrs.

14.7 Rapid Review / Child Safeguarding Practice Review (CSPR)
The Trust has undertaken scoping for 1 rapid review during 2024/25 (6-month old baby, cardiac arrest). The case did not meet the criteria for a CSPR. No single agency learning for the Trust identified.

14.7.1 Child Safeguarding Practice Review (CSPR) status:
Alfie Steele - Child Safeguarding Practice Review – Webinar
The review did not identify any single agency learning for WAHT.
A multi-agency action plan has been developed and is being progressed with oversight and input from the Quality Assurance Procedures & Practice sub-group (QAPP) of the Worcestershire Safeguarding Children Partnership.
Do what we say we will do:
A webinar was promoted Trustwide during August, to share the learning from the Alfie Steele Local Child Safeguarding Practice review. This has now been added to ESR.

14.7.2 SCR 6 – CSPR commissioned, defined areas for review. Audit activity complete (where the child or young person has a parent or carer who is a registered sex offender but with whom they still have contact). Review now complete. Report in final stages.

14.7.3 CSPR 59 (joint CSPR and DHR)
This case involved the death of a mother and significant injury to a young child as a result of a house fire. In progress.

14.7.4 CSPR 78 (joint CSPR and DHR)
This case involved a murder and attempted murder observed by children in the household. In progress. Progressing as a DHR only to include the children. Report in progress.

14.7.5 Local Child Safeguarding Practice Review (LCSPR): Leicester
This case involved domestic abuse and non-accidental injury. In progress.

14.7.6 CSPR 42 (CSPR)
This case is on hold due to Police processes. Case involved alleged rape of a young person.

14.8 Supplementary activity:
14.8.1 Keep Me Safe…. When I'm with Dogs'
In March 2022, a 2-year-old child was mauled by a Rottweiler owned by his dog-breeder grandmother after opening a gate into a field where the animals were kept and subsequently died as a result of his injuries. Following on from this, a significant amount of work was undertaken by the Integrated Safeguarding Team across the Trust to develop a Policy and pro formas for dog bite

attendances. It is known, that not all serious injury / fatal dog bite incidents are as a result of banned breeds.

Do what we say we will do:

The guidance has been published and promoted across key staff groups. A series of webinars have been promoted to support roll out.

14.8.2 Early Help - bite size training

Worcestershire Children's Services run a dedicated training programme for practitioners working with children, young people and their families in Worcestershire. Information circulated to key staff groups.

14.8.3 Gender Identity and requests for new NHS numbers

Currently when a person requests to change their gender on their NHS record, NHS guidance is that they are issued with a new NHS number. This has potential clinical and safeguarding implications for these children & young people. This was escalated to NHSE safeguarding via the ICB Designated Nurse as the partnership is seeing an increase to cases of gender incongruence and gender related distress, and there is currently no clear guidance in this regard. NHSE have advised that in such cases the 'call me' or equivalent, should be utilised in preference to changing the NHS number which may create a risk. Any future changes to this process will require a system wide approach.

14.8.4 Information Sharing - Advice for practitioners providing safeguarding services for children, young people, parents and carers (May 2024)

This HM Government advice outlines the importance of sharing information about children, young people and their families in order to safeguard children. The advice replaces the HM Government Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers published in July 2018.

Do what we say we will do:

The revised guidance will be incorporated into Policy revisions going forward. A copy has been uploaded to the Safeguarding Hub on the Trust intranet as a resource /reference for staff.

14.8.5 Multi-Agency Child Safeguarding Procedures – West Midlands

Was replaced during March 2025 by the TriX online platform. Communications circulated to advise of changes.

14.8.6 Onside Herefordshire and Worcestershire Children's and Young People's 0-25 years Early Intervention and Preventative Wellbeing and Mental Health Service

Communications circulated in respect of this innovative new service, working as part of the integrated care system to deliver early intervention and preventative support for children and young people across Herefordshire & Worcestershire.

14.8.7 Keeping Children Safe, Helping Families Thrive - Breaking down barriers to opportunity November 2024

The aim of the document is to reset the children's social care system by delivering a whole-system and child-centred approach to reform, resetting how national government works in collaboration with local government and local partners with a focus on 4 key principles:

1. children should remain with their families and be safely prevented from entering the care system
2. where children cannot remain at home and it is in their best interests, we should support children to live with kinship carers or in fostering families, rather than in residential care
3. vital that we fix the broken care market
4. need to invest in the key enablers which underpin the children's social care system

The key principles will be woven into partnership working going forward.

14.8.8 Ingestion of Sodium Nitrate – External Trust Risk Alert
Shared from Birmingham and Solihull Mental Health Trust in respect of patient deaths related to sodium nitrite which can be readily obtained from the internet. Ingested in quantity this substance is lethal. Linked to the making of suicide pills and links identified to pro-suicide sites advertising this method and informing people how to make 'suicide kits'. The alert has been shared with key departments in the Trust.

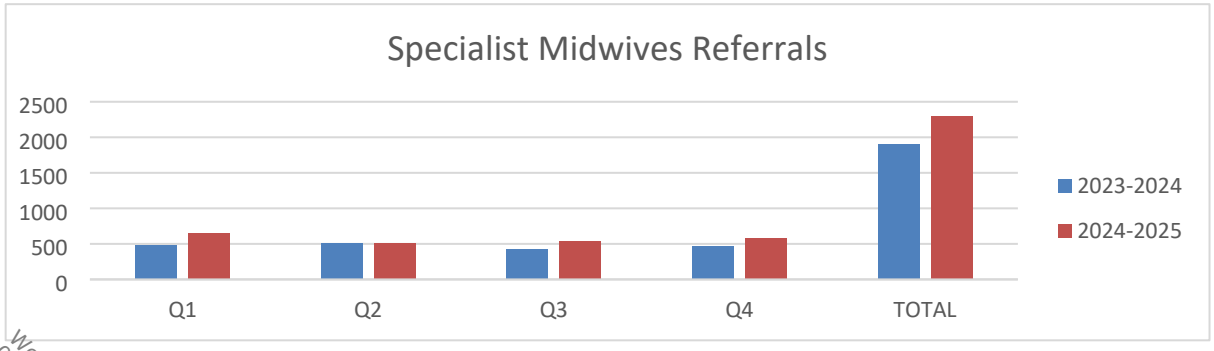
14.8.9 SEND inspection of Worcestershire Local Area Partnership (Inspection dates: 22nd – 26th April 2024)
This inspection was carried out at the request of the Secretary of State for Education under section 20(1)(a) of the Children Act 2004 further to an earlier inspection completed during November 2021.
Findings:
There are widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently. A monitoring inspection will be carried out within approximately 18 months. The next full re-inspection will be within approximately three years. As a result of this inspection, His Majesty's Chief Inspector requires the local area partnership to prepare and submit a priority action plan (area SEND) to address the identified areas for priority action.
Implications for WAHT:
None of the inspection findings directly link to WAHT. Areas for priority action to be led by NHS Herefordshire & Worcestershire ICB, Worcestershire Children First, Worcestershire County Council. The Trust internal LD Steering Group continue to progress associated workstreams to drive the quality improvement agenda for both adults and children. Safeguarding is represented and contributing to the work of the steering group.

15.0 Midwifery & Maternity

The Trust provides a robust service in relation to the safeguarding of vulnerable women and children overseen by a Named Midwife

15.1 Multi Agency Safeguarding Hub (MASH)
The Trust has shared information /attended MASH for 36 unborns during 2024/25. This number is slightly reduced on last year's activity (n38).

15.2 Specialist Midwifery Referrals:
There have been 2297 referrals to the Specialist Midwives during 2024/25. This has seen an increase on last year's activity (n1901).



The 'top 3' reasons for referral during 2024/25 were:
1. Children's Social Care – previous involvement
2. Substance misuse
3. Domestic abuse –past

15.3 Case load on Plans during 2024/25
Child Protection (CPP) – 298
Child in Need (CIN) – 206
Interim Care Orders Granted (ICO) - 21

15.4 Unborn Strategy Discussions
The Trust has contributed to 128 unborn strategy discussions during 2024/25 and all were attended either by the Named Midwife or Specialist Midwife.

15.5 Safeguarding Supervision
Specialist midwives deliver Safeguarding Supervision to all Community Midwives (CMW) and Continuity of Care Midwives (COCT) as per Trust Safeguarding Supervision Policy. These sessions take place as 1:1 or group sessions on a six monthly basis as they are case load holders. 190 midwives received supervision during 2024/25.
For maternity unit staff who are not case load holders, safeguarding supervision is in the format of Maternity Safeguarding Newsletters shared via Effective Handover. Safeguarding updates are also delivered within Maternity Mandatory Training.

15.6 Teenage Link Midwifery Service:
The 4 Teenage Link Midwives are based within the Community Midwifery Teams. They offer an enhanced package of care to this vulnerable group of young parents to be, as per the Teenage Guidelines. 131 teenage bookings (less than 20yrs at time of delivery) have met the criteria for this service during Q2-Q4. The 4 Teenage Link Midwives have established clinics within their community settings offering both antenatal and postnatal support.

15.7 Urine Toxicology Screening
During 2024/25, 369 UTS screening tests were undertaken. Of these, 104 tests were positive for illicit substances (28%).

15.8 British Pregnancy Advisory Service
British Pregnancy Advisory service (BPAS) notify the Integrated Safeguarding Team of women who have sought consultation or have had a consultation but not attended for further follow up. This is to ensure the woman is not concealing the pregnancy and has accessed antenatal care. They also advise of women who have decided to continue with the pregnancy but safeguarding concerns have been identified. 19 notifications were received during 2024/25. Lateral checks are then completed and if in receipt of antenatal care, the locality specialist midwife is notified.

15.9 West Midlands Ambulance Service – High Risk Cases Alerts
As of October 2024, improvements to communication and alerting WMAS to high risk safeguarding maternity cases was implemented. This process is supported by an agreed standard operating procedure.

15.10 NICU/TCU WREN report
The Named Midwife for Safeguarding receives a daily report highlighting babies within the units who have safeguarding alerts held within Trust information systems.
Do what we say we will do:
The Named Midwife reviews safeguarding documentation within Badger Net and discusses with NICU/TCU staff, offering support and guidance to the staff who need to attend safeguarding meetings. 66 babies have been identified from this report during 2024/25. As of Q4 2024/25, the Named Midwife for Safeguarding attends the Allied Professionals Neonatal Weekly meeting where concerns with current inpatient babies are reviewed and discussed.

15.11 Hospital Independent Domestic Abuse Advisor (HIDVA) referrals
From July 2024, Maternity HIDVA referrals are now made directly to West Mercia Women's Aid (WMWA) via the Maternity Information System, Badger Net. Named Midwife/WAHT Domestic Abuse Lead receives these referrals, and attends monthly meetings with the HIDVA's to discuss the referrals. This process ensures victims are engaging with the HIDVA service and Specialist Midwives are aware of the outcomes.

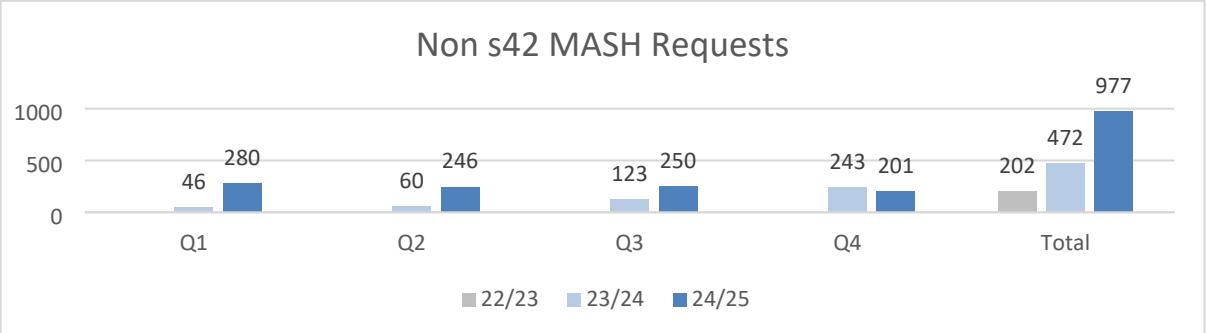
15.12 Child Protection Information Sharing System (CP-IS) – Flagging of Unborns subject to CPP
During 2024/25 further to lateral safeguarding checks, it became apparent that not all unborns subject to a CPP were being flagged by the Local Authority in CP-IS. This was escalated locally and Nationally and remedial action taken. The Named Midwife continues to monitor this and exception report into the Integrated Safeguarding Committee /escalate on a case by case basis.

16.0 Safeguarding Adults

The WSAB objectives are incorporated into all safeguarding work streams in order to provide assurance to the Board that WAHT is fulfilling its statutory requirement as a partner agency. WAHT either attend, or are represented on all of the WSAB associated sub groups contributing to the work of the Board. WSAB newsletters are circulated to promote the work of the Safeguarding Adult Board amongst staff groups

16.1 Multi-Agency Safeguarding Hub(MASH)
The Trust has shared information /attended as required 977 adult MASH requests during 2024/25.
Themes in relation to:

- self-neglect
- financial abuse
- emotional & psychological abuse
- Non engagement with services



It can be seen that the volume of work associated with adult MASH has continued to increase significantly this year.

16.2 Cases progressing to S42 Enquiry
8 cases have progressed to S42 enquiry during 2024/25.
Themes in relation to:

- Sexual assault –subsequently closed to the Police and Local Authority
- Neglect
- Care provision
- ? Missed pneumothorax

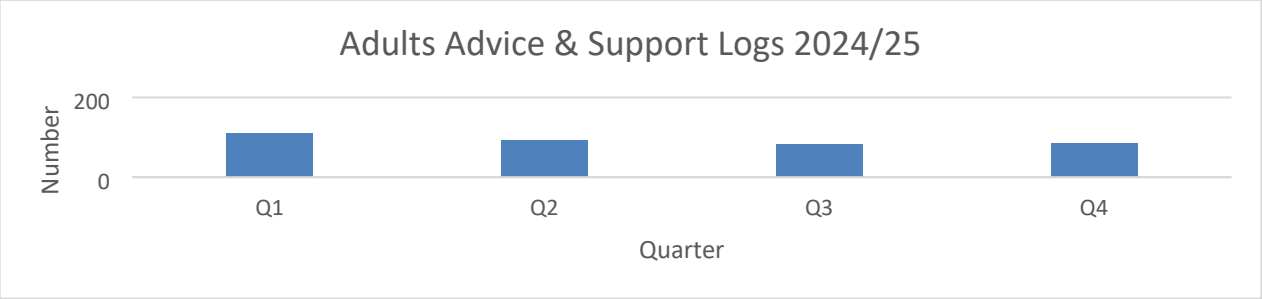
16.3 Safeguarding Early Response & Triage Team (SERTT)

A number of cases have been scoped to inform the triage process prior to a full s42 enquiry. Themes in relation to:

- Discharge planning
- Tissue Viability
- Physical presentation
- Alleged omissions of care

16.4 Advice and support logs - Adults

The Integrated Safeguarding team have provided advice & support for 371 cases involving adults during 2024/25:



16.5 Worcestershire Safeguarding Adult Board (WSAB)

16.5.1 Rapid Review (RR) and Safeguarding Adult Reviews(SAR)

As can be seen from the below, there has continued to be a significant amount of work in relation to the rapid review and safeguarding adult review process during 2024/25.

The Trust contributes to this work as a partner agency of the Worcestershire Safeguarding Adults Board and associated sub groups.

	Type Title of review	Status	Outcome	Single agency actions identified
RR SAR 66	RR SAR	**Published as Mrs Kaur 17.12.2024**		Nil identified
Extended SAR 68	Extended SAR	Report out for comment		
Extended SAR 70	Extended SAR	**Published as 'Jack' March 2025**		Nil identified
Discretionary SAR Case 76	Discretionary SAR	Rapid review	In progress	
SAR Case 72	SAR	**Published as 'James' March 2025**		Nil identified
SAR Case 85	RR SAR – defined terms of reference	**Published as 'Robert'**		Nil identifed
Case 89	RR scoping	Criteria not met	Rapid Review	Nil identifed
Case 86	RR scoping	Criteria not met	Rapid Review	Learning Brief formulated – 'Gillian'
Case 81	RR scoping	Rapid Review	Rapid Review	
Case 87	RR scoping	Criteria not met	Rapid Review	

16.5.2 SAR Learning

Learning from SAR and rapid review is a standing agenda item on the Integrated Safeguarding Committee agenda. All published SAR are shared to keep staff appraised of the learning from SAR to improve practice.

16.5.3 Worcestershire Safeguarding Adult Board(WSAB) – SAR and Learning

During March 2025, the Trust submitted assurance to the WSAB in respect of organisational actions taken in respect of multi-agency learning from a number of SAR. We were able to offer a high level of assurance in this regard.

16.5.4 Single Agency Action Plans /Assurance
SAR 'Peter'
Recommendation: Worcestershire Acute Hospitals NHS Trust should ensure that staff exercise appropriate professional curiosity when persons present with self-harm injuries and that consideration is given to raising a safeguarding concern.
Do what we say we will do:
A Trustwide briefing was circulated via the Trust Worcestershire 'Weekly Brief' to ensure all staff are appraised of the key learning from this SAR. In addition, the learning was also shared via the Urgent and Emergency Care Governance meeting held on the 6th March 2024 to ensure the key messages are shared with frontline /front door practitioners.

LeDeR increase to online & telephone appointments
Assurance was submitted to the Chair of the P&QA sub-group in August, further to a request to provide an outline of Worcestershire Acute Hospitals NHS digital inclusion plans, particularly any measures which are being taken to address the points detailed following a joint learning event held in November 2022 with the LeDER Programme:

- *How this can create confusion, often leading to them avoiding asking for help.*
- *Many stated that they often found themselves sat waiting for a return call which can make it difficult for them to ensure that an advocate is with them when the call comes in.*
- *They also find that they are constantly repeating their story and are often not sure who to.*

The Trust was able to offer a high level of assurance that patient experience lies at the heart of our digital strategy.

Prevention of Future Deaths (POFD) Report – 'Karen'
A Request was received from the Worcestershire Safeguarding Adult Board in respect of the Prevention of Future Deaths report presented recently by the ICB to Board. Worcestershire Acute Hospitals NHS Trust were asked to provide information on the processes in place within our Acute Hospitals in respect of the case of 'Karen Thomason' and the subsequent Regulation 28 Notice issued to North Cumbria Integrated Care Board.
Background
Karen was 52 years old and alcohol dependent when she died. Cause of death was given as Acute Ethanol Toxicity. Karen had been admitted to hospital on numerous occasions due to her alcohol use and was documented as living a risky lifestyle. Karen collapsed at home on 31st October 2023 and was discharged home later that day. Housing staff had previously requested that they were notified of discharges to ensure support was put in place. This did not happen, and Karen was found unresponsive the following day at home and death was confirmed by the ambulance staff.
Do what we say we will do:
Assurance was provided to the WSAB regarding handover, triage, alerts, alcohol liaison, documentation, mandatory training etc. The findings of the POFD case have been shared with the Emergency Dept Senior Responsible Officer (Sunrise) representative to ensure learning is considered /built into the new electronic patient record.

16.5.6 Multi Agency Action Plans /Assurance
SAR 'Joseph'
Local Shared Care Record – action from WSAB Performance & Quality Assurance Subgroup
Do what we say we will do:
As Sunrise (electronic patient record) is rolled out, clinical staff are supported by a training package and 'floor walkers' to assist in any queries / training etc. It has been requested that the functionality of the shared care record be reiterated as part of this support to clinical staff to promote awareness and usage.

'Dorothy' – recommendation 5
All agencies were tasked with ensuring that public facing information was available on their websites for when choosing care.
Do what we say we will do:

Links to the Local Authority webpage detailing services available uploaded to our public facing website during October 2024.

'Dorothy' –recommendation 3
Assurance was provided during October to the LDP&C sub-group of the WSAB in respect of:
training provided to employees on recording and documentation, particularly in relation to the use of labels such as 'challenging behaviour' in order to ensure that there are accurate descriptions of the behaviour, issues, or problem, rather than the use of ambiguous generalised statements and the resultant disguised compliance. The SAR recommends the need to cease the use of such labels from records as best practice, thus encouraging practitioners to provide factual and accurate information about the physical and emotional needs of the individual.

Rapid Review Learning: 'Gillian'
Gillian was a 52yr old lady with a moderate Learning Disability and physical disability. Gillian lived at home with her 82yr old father and required support for all of her activities of daily living, including hoist transfers. Gillian was able to communicate verbally, but she would often only do this with people she knew well. As a result of a fall, Gillian sustained a fractured neck of femur and required admission to hospital. Gillian subsequently died.
Trustwide Newsletter detailing learning in relation to:

- Gillian's *Voice* not being heard or reflected in decision making
- Carer assessments
- MCA and decision making for patients with an LD
- Safeguarding considerations
- Escalation & Professional curiosity

'Alison' – Recommendation 4
During July, the Trust were asked to provide assurance as to how it had promoted the MCA Podcast. Full assurance returned to the P&QA sub group.

BS45
During September, the Trust submitted assurance to the WSAB assurance regarding the following recommendations from the SAR BS45:
Rec. 2 Supervision for Staff:
Ensure that you have appropriate supervision in place that supports practice especially in safeguarding.
Rec 3 Professional curiosity:
a) Ensuring that the organisation provides a culture where curiosity to see beyond what is observed is encouraged?
Rec 5 Professional practice:
Assurance that there are checks and balances to ensure that practice that falls below that which would be expected can be identified and improved.

16.6 Combined SAR & Domestic Homicide Review (DHR)
Current status:

	Status	Status	Outcome	Single agency actions identified
Case 7	Combined SAR & DHR	Report submitted to CSP/Home Office for approval – still pending	Combined SAR & DHR	No single agency actions identified

16.7 Domestic Homicide Reviews
The Trust has undertaken scoping and contributed to 9 DHR during 2024/25:

- DHR12 – Dudley –in progress – limited involvement
- DHR14 – Herefordshire case – did not meet threshold for DHR
- DHR37 – in progress
- DHR38 – criteria met for DHR

- DHR39 - criteria met for DHR
- DHR40 – criteria met for DHR
- DHR41 – criteria met for DHR
- DHR42 – scoping submitted
- DHR43 - criteria met for DHR

16.7.1 Multi Agency Action Plans /Assurance
Published DHR WO4 2020 'Poppy'
This Domestic Homicide Review concerns the death of an 80-year-old woman, Poppy, who was killed by her 82-year-old husband Dad, in their family home in Warwickshire in February 2020. Following his arrest, Dad was detained in hospital to await trial at Crown Court but sadly died in hospital within a short time.
Do what we say we will do:
The publication on 28th November was supported by a communications strategy. There was no single agency learning for the Trust in respect of this case.

16.8 Complex Adult Risk Management (CARM) Framework
The CARM framework was introduced by WSAB in May 2022. A CARM Project Lead was employed in October 2022, one day a week as an agency worker to help embed the framework. From 22nd August 2023, a 12-month contract was created enabling the hours to be increased to 14 per week. This funding is due to cease at the end of March 2025.
The learning from the Thematic Safeguarding Adult Review Regarding People Who Sleep Rough, Sept 2020, identified a need to improve multi-agency working. The CARM framework was developed by WSAB following this as a framework, to facilitate effective working with adults who:

- are at risk of harm due to their complex needs;
- where the risks cannot effectively be managed via other processes or interventions, such as section 9 care and support assessment or section 42, safeguarding enquiry under the Care Act 2014;
- the adult's engagement with support is intermittent or it has been difficult to engage with the adult;
- individual agency procedures have not been able to resolve the problem(s);
- without some form of support, the risk is likely to increase.

Impact:
The CARM process, if not effectively managed once funding ceases, may leave some individuals at significant risk of harm. Agencies are working alongside the WSAB to agree processes to be followed. Discussions remain ongoing as at the time of this report in respect of future funding position.
Further Action:
CARM data will be reported going forward as part of the Quarterly /Annual Report for internal oversight. A CARM alert has been requested to ensure high risk patients that are being managed via this multi-agency framework are highlighted to clinical staff in the event they present to any of our services.

16.9 WSAB Strategy Day - Annual Objectives 2025/26
At the recent WSAB strategy day, the following objectives have been agreed as priorities for 2025/26:
Objective 1 - *Promote and embed the Self-neglect policy and CARM framework, demonstrating how they can ensure effective multi-agency work, through contextual safeguarding which supports the family (including carers) as a whole.*
Objective 2 - *To develop and implement a communication strategy which further embeds work undertaken on the application of the Mental Capacity Act, including awareness and assessment of executive function in practice.*
Objective 3 - *Continue to develop opportunities to link into wider relevant workstreams and forums across the county, which can impact on safeguarding practice and prevention. (e.g. Health Worcestershire, Carers Forum, Domestic Abuse Forum, Multi-faith networks)*

Do what we say we will do:
The objectives will inform workstreams for the coming year.

16.10 WSAB Self-Neglect Toolkit
During August, WSAB published new self-neglect guidance.
Do what we say we will do:
The new guidance was promoted Trustwide, shared with allied health professional colleagues and uploaded to the Safeguarding Hub on the Trust intranet as a resource for staff.

16.11 Safeguarding Adults week 18 -22nd November 2024
A number of resources were shared Trustwide with a focus upon professional curiosity.

16.12 WSAB Recognition Awards - Tissue Viability
Work together, celebrate together:
On 20th November, the Trust Tissue Viability team received an award from the Worcestershire Safeguarding Adults Board (WSAB) for the work the team undertake in their clinical practice in respect of the recognition of safeguarding and tissue viability concerns in the category of – Prevention: Best Practice award.

16.13 WSAB Newsletters
Circulated Trustwide quarterly to update staff on the work of the Board.

17.0 National Campaigns
The Trust promotes National Campaigns to raise staff awareness of safeguarding matters

Campaign materials in relation to the following have been promoted during 2024/25:

- Female Genital Mutilation - 6th Feb 2025
- Stop Loan Sharks week – 13-19th May 2024
- Suicide Prevention - 10th September 2024
- Safeguarding Adults week –18-22nd November 2024
- White Ribbon Campaign – November 2024
- Illegal Money Lending Newsletters

18.0 Further Audit / Quality Assurance
Action required: audit schedule completion in accordance with Audit Schedule

The audit plan is monitored as a standing agenda item by the Integrated Safeguarding Committee**.** All statutory safeguarding returns have been submitted within agreed timeframes.

18.1 ICON (babies cry; you can cope) – Reduce the risk of Head Trauma – undertaken May 2024
The following Dip Sample audit looked at a small sample of maternity records to identify whether midwives and maternity support workers are having the discussion and sharing the advice and guidance regarding ICON and reducing abusive head trauma with parents following the birth of their newborn baby.
For Midwives the requirement is:

1. In hospital at discharge by Midwife, this is often when father is also present or at home birth discharge, when men are present, the opportunity to engage with men at this point is crucial.
2. During the first 10 days when the Community Midwife goes out to see the mother at home with a light touch reminder.
3. At time of transfer of care from maternity services to Health Visitor.

Findings
Good practice:
From the small sample of postnatal cases reviewed, it is apparent that ICON is discussed consistently at discharge from hospital to the Community Midwife.
Areas for improvement:

- ICON was discussed in only 50% of the cases reviewed within the audit, by the Community Midwife at the point of discharge to Health Visitor.

Do what we say we will do:
The audit was repeated during March 2025 with the compliance rate at 100%. Assurance was provided to the ICB in this regard.

18.2 Teenage Pregnancy Audit – ID11670
During a collaborative 0-19yrs working in partnership meeting an issue was raised regarding the perceived rise in "teenage pregnancies" with reference to one demographic area. The Named Midwife and Public Health Midwife undertook an audit during April 2024 to review 2022/23 data.
Aims of the audit were:

- To provide a baseline audit for any amendments or additions necessary to WAHT guidelines
- Identify areas where service need has increased and possible reasons for increase
- Highlight any areas or pockets where there is a concentrated increase
- Identify team caseloads and areas of increased need

Findings:

- There are areas of increased cases, however, there is a general rise across the whole region
- Cases have increased for all 4 of our community teams
- If the trajectory for 2024 continues we will see another rise on last year
- Teenage link midwives are more important than ever to ensure our young parents have access to the services they require

18.3 Multi-agency audit – Closing the Learning Loop – Peer on Peer Abuse, Identification of Need & Risk
Assurance was provided to the QAPP sub group of the WSCP during April. High level of assurance provided.

18.4 Quality Assurance Practice & Procedures – WSCP Multi-agency audit – Closing the Learning Loop - Voice of the Child
Assurance was provided to the QAPP sub group of the WSCP during July. High level of assurance provided.

18.5 Domestic Abuse & Early Help
Assurance was provided to the QAPP sub group of the WSCP during August. High level of assurance provided.

18.6 Get Safe Operational Group Audit – Deep Dive
Undertaken July 2024, March 2025. Of these, 1 rated as good, 1 requires improvement.

18.7 NHS England Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) – Safeguarding & Social Media Policy
NHS England require all provider organisations to have a Policy in place that meets the requirements of the NHS England Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) section A1.3:
We have a policy regarding internet and social media use which addresses safeguarding.

Do what we say we will do:
The Policy has been developed, approved and assurance given to NHS England via the P-SCAT return.

18.8 WSAB MCA Audit – December 2024
MCA audit completed for WSAB: *young people under the age of 24 where a safeguarding concern was raised. Most have a learning disability or mental health concern.*
Do what we say we will do:
The audit findings were submitted to the P&QA Sub-group of the WSAB at the end of December. A high level of assurance was provided on our initial review of the returns that MCA and advocacy (where required) were being considered by practitioners.

18.9 Article 3 Human Rights Unannounced visit – ED Worcester - 13th November 2024
An out of hours' observational visit was undertaken to the Emergency Dept at Worcester Royal Hospital on 13.11 2024 by the Head of Safeguarding to look at compliance with Article 3 of the Human Rights Act. The visit included observation of the public waiting room and patients waiting in the corridor. A 'secret shopper' approach was taken to the visit and introductions to patients made on an individual basis to gain valuable feedback and insight into their experiences. Article 3 protects individuals from:

- torture (mental or physical) and
- inhuman or degrading treatment or punishment

Public bodies such as NHS hospitals, must respect and protect individuals' human rights. If they know this right is being breached by someone else, they must also intervene to stop it. The state must also investigate credible allegations of such treatment (including by third parties).
Overall, the findings from the visit were positive with many patients and their families appearing satisfied with the care received.
Some areas for improvement in relation to privacy and dignity were identified, and these are forming part of the quality improvement works now underway by the Division.

19.0 Managing Allegations
The Trust has an agreed Policy and Procedure in place for the management of allegations and safer recruitment practices.

The Trust has in place an agreed Policy and Procedure in order to manage allegations made in regards to people in a position of trust.

19.1 Increased number of Position of Trust referrals
The workload in relation to the Management of Allegations remains significant. The Chief Nursing Officer as Executive Lead retains oversight of the cases and actions being taken.
Themes in relation to:

- Physical abuse –staff on patient
- Professionals non engagement with Children's Social Care following an allegation and potential for transferrable risk
- Where cases have been subject to NMC involvement we are seeing a number of registrants being removed from the Professional Register
- Allegations of sexual assault subject to Police investigation
- Use of illicit substances
- Disguised compliance
- Medical staff concerns

19.2 Chaperone Policy - Adults
Reviewed and updated. Finally approved and uploaded to key documents.

Do what we say we will do:
Due to a number of concerns whereby the presence of a chaperone may have mitigated an allegation, a newsletter has been circulated Trustwide to raise staff awareness of both the Policy and the safeguards that the use of a chaperone in practice affords.
Action planned:
CNO Policy & Strategy Unit, Nursing Directorate, NHS England are currently consulting with Trusts on their chaperone policy /procedures. The Integrated Safeguarding Team has contributed to this consultation. Further meetings are scheduled for May 2025.

19.3 Safeguarding Newsletter – Allegations of Sexual Abuse /Sexual Assault and links to the Trust Chaperone Policy – October 2024
Key messages communicated Trustwide to align with the updated Chaperone Policy and the Trusts Sexual Safety Charter.

19.4 DBS Dispensation for Medical Staff whilst awaiting DBS outcome
Highlighted in view of a recent case via Position of Trust.
Trust stance in this regard to comply with safer recruitment practices to be worked through with the Chief Medical Officer and Chief People Officer.

19.5 DBS Webinars
A series of webinars were promoted Trustwide in relation to:
i) DBS Gathering Information Workshop
ii) DBS Enhanced Application Process
iii) DBS Update Service Masterclass

19.6 Volunteer Action Plan – Saville & Lampard – DBS Checks & attendance at Trust Induction – Annual Assurance
Safeguarding Audit ID 10352 (July 2019) demonstrated a poor level of compliance in relation to information held on the Trust Volunteer database relating to DBS checks and attendance at Trust Induction. An action plan was created and progress to provide assurance has been communicated through the Integrated Safeguarding Committee.
Do what we say we will do:
Annual assurance update was provided to the Integrated Safeguarding Committee on the 28th May 2024. Assurance provided that the necessary standards have been maintained.

19.7 Lucy Letby Inquiry
The National Statutory Inquiry remains ongoing. Initial findings from the internal review of the Countess of Chester by Facermelius shared via relevant Trust forums.
Initial findings in relation to:
- Leadership – Trust adopted a position of denial, slow to act
- Patient Safety – not clinically led
- Governance – throughout the process
- Safeguarding – delay in referrals to Police /LADO etc

Findings, as they emerge will continue to be reviewed by the Trust to inform any necessary action.

19.8 Local Authority Designated Officer (LADO) Managing Allegation Training
Training availability promoted internally.

19.9 360 Assurance
360 Assurance is an NHS hosted service (hosted by Leicestershire Partnership Trust) delivering internal audit, assurance, counter fraud and consultancy work to a large number of organisations,

predominantly within the NHS. The Integrated Safeguarding Team are currently undergoing a 360 assurance exercise with a focus on managing allegations. This will be reported on in future reports.

20.0 Policy Development

Action required: All policies reviewed in accordance with Policy revision schedule

A Policy review schedule is monitored via the Integrated Safeguarding Committee. Risk Register ID4119. Work undertaken over 2024/25 includes:

- Mental Health Act Policy – updated, published Nov 2024
- Ano-genital warts in pre-pubertal children – reviewed & published Jan 2025
- Safeguarding Supervision –Adults, Children & Young People – reviewed and published March 2025
- Adoption SOP – reviewed, updated and published March 2025
- Safeguarding Children Policy – review, updated and published March 2025
- Safeguarding & Social Media Policy – developed and published February 2025. Assurance provided to NHSE as a requirement of the PSCAT assurance upload.
- CP-IS SOP – reviewed, updated & published Sept 2024
- FGM-IS SOP - reviewed, updated & published Aug 2024
- Chaperone Policy - reviewed, updated & published Sept 2024
- Use of Safety Mittens - reviewed, updated & published March 2025
- Deprivation of Liberty Safeguards - reviewed, updated & published
- Self-Harm Policy - reviewed, updated & published
- Safeguarding Adults Policy - reviewed, updated & published April 2025
- Missing inpatient guideline – interim holding document developed March 2025, pending full Policy review

21.0 Priorities / Forward Plan 2025/26

- Regulatory - Safeguarding mandatory training compliance -90% Trust requirement –all levels adults & children
- Contribute to the work /priorities of the Worcestershire Safeguarding Adults Board(WSAB), Worcestershire Safeguarding Children Partnership(WSCP) and associated sub groups
- Embed the CARM exit plan into work streams
- Martyn's Law – contribute to the work required to achieve compliance
- Policy review and update in accordance with review schedule
- Deliver audit schedule in accordance with audit programme
- Continue to look for opportunities to improve safeguarding systems & processes to ensure they are robust –internal & external
- Multi-agency partnership working
- Embed system changes as a result of revised guidance / legislation
- Continue to provide a robust safeguarding service in light of National reform to NHSE and ICB

Conclusion

This report provides assurance that the Trust continues to meet its legislative and statutory requirements in the Safeguarding of Adults, Children and Young People who access services from the Trust. The report details the level of assurance offered for each of the work streams and what needs to happen to move to the next level of assurance as part of the quality improvement journey.

Recommendations

The Integrated Safeguarding Committee is asked to receive, for assurance, the Safeguarding Annual Report 2024/25 and the forward plan for 2025/26.

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.

Modern Slavery and Human Trafficking Act 2015 Statement

1. Background

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its business.

Every organisation in the UK with a total annual turnover of £36m or more, is required to produce a slavery and human trafficking statement for each financial year.

Statutory guidance supports organisations in how to meet the requirements of the Act: *Slavery and human trafficking in supply chains: guidance for businesses, Government guidance for organisations (updated March 2025).*

As an NHS Provider with a turnover for 2024/25 of £807m, Worcestershire Acute Hospitals NHS Trust is required to make a public statement as to the actions we have taken to detect and deal with forced labour and trafficking in our supply chains - the Transparency in Supply Chains obligation.

The Act requires a slavery and human trafficking statement to be approved and signed at Governing Body level. This ensures senior level accountability, leadership and responsibility for modern slavery and gives it the serious attention it deserves.

2. Modern Slavery

Modern Slavery is an umbrella term that encompasses slavery, human trafficking, forced and compulsory labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force vulnerable individuals into a life of abuse, servitude and inhumane treatment. A large number of active organised crime groups are involved in modern slavery. However, it is also committed by individual opportunistic perpetrators.

There are many different characteristics that distinguish slavery from other human rights violations, however only one needs to be present for slavery to exist.

Someone is in slavery if they are:

- forced to work - through mental or physical threat;
- owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse;
- dehumanised, treated as a commodity or bought and sold as 'property';
- physically constrained or has restrictions placed on his/her freedom of movement.

Contemporary slavery takes various forms and affects people of all ages, gender and races. Victims are often hidden away, may be unable to leave their situation, or may not come forward because of fear or shame.

It looks likely that the number of victims of modern slavery globally will continue to rise over the coming years. Many victims are found working in the construction industry, agriculture, sex industry, nail bars, car washes, and cannabis farms. Children are found working in all of these situations, as well as in sexual slavery.

Many victims have been trafficked from overseas, and their exploitation often begins en route. British victims tend to have fallen on difficult times, making them vulnerable to the lure of well-paid work complete with decent accommodation, which often proves to be a cruel lie.

Most victims are 'recruited' in person, although some who find themselves trapped in the sex industry have been ensnared through online job adverts and social media websites.

In some cases, victims are threatened and can suffer extreme violence as the criminals exert control. Many have their identity documents confiscated and have most of their earnings withheld as 'payment' for living costs or for their journey to the UK.

Although some larger organised crime groups are involved, people are also trafficked by looser collaborating networks often involved in additional forms of serious criminality, including drugs and firearms trafficking.

The importance of spotting the signs early, raising awareness and reporting are therefore key, in order to safeguard victims and bring the traffickers to justice (National Crime Agency).

3. Worcestershire Acute Hospitals NHS Trust Statement of intent

Worcestershire Acute Hospitals NHS Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both identification, combatting it, and supporting victims.

Worcestershire Acute Hospitals NHS Trust is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our Supply Chain.

This statement sets out actions taken by Worcestershire Acute Hospitals NHS Trust to understand all potential modern slavery and human trafficking risks in accordance with the Statutory Guidance.

Worcestershire Acute Hospitals NHS Trust adheres to safer recruitment principles, in line with NHS Employers' Standards, including the requirements in respect of identity checks, work permits and criminal record checks.

4. Partnership working

Where concerns in relation to modern slavery or human trafficking are identified, Worcestershire Acute Hospitals NHS Trust commits to working with the relevant authorities in order to safeguard those at risk.

5. Organisational Structure

Worcestershire Acute Hospitals NHS Trust is a large acute and specialised hospital Trust that provides a range of local acute services to a population of more than 600k people in Worcestershire as well as caring for patients from surrounding counties and further afield. The Trust's catchment population extends beyond Worcestershire itself, as patients are also attracted from neighbouring areas including South Birmingham, Warwickshire, Shropshire, Herefordshire, Gloucestershire and South Staffordshire.

The Trust provides hospital based services from three main sites; the Alexandra Hospital in Redditch, Kidderminster Hospital and Treatment Centre, and Worcestershire Royal Hospital in Worcester as well as some community based services.

We employ in the region of 8000 staff and volunteers who support the organisation to deliver the services we provide. Our annual turnover was £807 million for the financial year 2024/2025.

6. Our Policy on Slavery and Human Trafficking

When procuring goods and services, we apply standard NHS Terms and Conditions for clinical and non-clinical procurement and NHS Standard Subcontract (for clinical outsourced service procurement). Both require suppliers to comply with relevant legislation related to PPN 02/23 "Tackling Modern Slavery in Government Supply Chains".

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking via the Atamis e-commerce Procurement tool which contains a risk assessment tool and relevant Supplier Questionnaires. The top 80% of suppliers nationally, affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain.

All members of staff have a personal responsibility to work with the procurement department in order for the successful prevention of slavery and human trafficking. The procurement department takes responsibility where a National Framework Agreement or formal exercise in line with standing financial instructions (SFI) has been undertaken.

All staff and volunteers working within Worcestershire Acute Hospitals NHS Trust, receive mandatory safeguarding training at a level in accordance with their job role.

All staff and volunteers are contractually obligated to work in accordance with Worcestershire Acute Hospitals NHS Trust policies and procedures.

7. Reporting concerns

Worcestershire Acute Hospitals NHS Trust has systems in place to encourage the reporting of concerns and has a named Freedom to Speak up Guardian and Freedom to Speak Up (raising concerns) Policy. This is further supported by Freedom to Speak Up champions across the organisation.

Safeguarding concerns in relation to modern slavery and human trafficking are reported in to a first responder organisation such as the Police, adult or children's Social Care Safeguarding teams or directly to the Modern Slavery Helpline.

The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. Modern slavery is a complex crime and may involve multiple forms of exploitation.

Worcestershire Acute Hospitals NHS Trust has an integrated safeguarding team available to staff to provide signposting, advice and support.

8. Associated Policy & Procedure

The Trust has a number of Policies and Procedures that support this statement:

- Safeguarding Adults, Children and Young People
- Recruitment and Selection
- Procurement Strategy
- Freedom to Speak Up

9. Due Diligence within our Supply Chain

Our Supply Chain is made up of a number of large multi-national companies, Small to Medium Enterprises (SME's) and small local suppliers who make up a total of 2500 live suppliers to the Trust at this current time.

The location of supplier premises and manufacture locations are spread globally but the vast majority are situated in the European Union, where it is estimated that several hundred thousand people work for the aforementioned suppliers although not all these people work on Worcestershire Acute Hospitals NHS Trust related goods and services.

Due to the nature of our business and our approach to governance and risk management, we assess that there is low risk of slavery and human trafficking in our business and supply chains. However, we will continue to periodically review the

effectiveness of our relevant policies, procedures and associated training to ensure that the risk remains low.

Therefore, to identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we will:

- Purchase a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour;
- Utilise national Contracts and Framework Agreements that contain specific clauses around this subject;
- Where possible, build long standing relationships with suppliers to improve transparency and mitigate any risks;
- Procurement approach informed by risk levels, using SQ (Standard selection Questionnaire) declarations, the Social Value Model, Key performance indicators (KPIs) and Contract terms;
- The Trust will request all suppliers to comply with the provisions of the UK Modern Slavery Act (2015), through agreement of our 'Supplier Code of Conduct', purchase orders and tender specifications. All of which will set out our commitment to ensuring no modern slavery or human trafficking related to our business;
- Uphold professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply;
- The Trust will request all suppliers to comply with the provisions of the UK Modern Slavery Act (2015), through acceptance of the standard Terms and Conditions of contract for the procurement of goods and services;
- As an NHS Provider, the Trust undertakes audit in accordance with NHS financial reporting standards.

10. Training

Worcestershire Acute Hospitals NHS Trust recognises safeguarding as a high priority for the organisation and has clear policies and procedures in place in relation to safeguarding children, young people and adults. Modern slavery and human trafficking is included in all levels of mandatory safeguarding adult and children training.

Clear links to support / resources are available for staff on the Trust Safeguarding Hub on the Trust intranet.

The procurement department's senior procurement team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPs code of professional conduct.

In order to upskill staff to raise awareness and apply the process to drive risk mitigation, NHS bitesize training and Government Commercial College training on modern slavery is also promoted.

11. Risk Assessment

Worcestershire Acute Hospitals NHS Trust considers the principal risks related to slavery and human trafficking and identifies them as:

- Reputational
- Lack of assurances from suppliers
- Lack of anti–slavery clauses in contracts
- Training staff to maintain the trust's position around anti-slavery and human trafficking.

In relation to slavery or human trafficking, any instance would be treated as a breach of law, our supplier standards and/or our local policies and therefore acted upon accordingly.

12. Aim

The aim of this statement is to demonstrate that Worcestershire Acute Hospitals NHS Trust follows good practice and that all reasonable steps are taken to prevent modern slavery and human trafficking.

13. Executive Directors' Approval

The Executive Director Lead for Safeguarding has considered and approved this statement on behalf of the Board and will continue to support the requirements of the legislation.

Signed:

xxxxxxxxxx

Sarah Shingler
Chief Nursing Officer

Wells,Jo
09/07/2025 09:23:00

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

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

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