OPERATIONAL RESILIENCE

Escalation Management Plan

The Worcestershire Acute Hospitals NHS Trust Escalation Management Plan outlines the framework and actions to manage operational pressures, ensuring patient safety and maintaining service delivery during periods of high demand. It is aligned with the national Operational Pressures Escalation Levels (OPEL) framework and includes detailed roles, responsibilities, escalation triggers, and surge capacity protocols to support the Trust and wider health system.

Key elements of the escalation plan include:

- Purpose: Manage operational pressures and coordinate system-wide support.
- Integration with the national OPEL Framework (Levels 1 to 4).
- Defined actions and operational statuses for each escalation level.
- Leadership roles and responsibilities across clinical and operational teams.
- Surge capacity planning including temporary escalation spaces.
- Critical incident declaration protocols.
- System-wide coordination using SHREWD and daily assurance calls.
- Communication and implementation strategies.
- Detailed appendices with action cards, risk assessments, and templates.

Rhythm of the Day

Clinical Site Meetings (Effective 8th September 2025):

- 07:30 – Capacity Team Handover
- 08:00 – Senior Command and Control Meeting
- 10:00 – Clinical Site Meetings (Face-to-Face)
- 14:30 – Clinical Site Meetings (Face-to-Face)
- 15:45 – Capacity Matron / On-Call Manager Handover
- 18:30 – On-Call Teams: Questions & Challenges
- 19:30 – Capacity Team Handover
- 20:30 – Clinical Site Summary Meeting

- Meetings will be primarily face-to-face, with handovers and action logs managed via MS Teams.
- Increased Executive visibility in Emergency Department
- Overnight rota for on-site visits
- Onsite cover, senior manager 8am – 9pm. With dedicated ED management support
- Communication methods – Teams Chat and Whatsapp for fast escalation

EPRR/ON CALL RESPONSE

- 24/7 EPRR On-Call Service: Starting in October, EPRR will provide round-the-clock on-call support, including medical staffing assistance during weekends and festive periods.

Split Shift Coverage

- On-call managers will operate split shifts to maintain on-site presence from 08:00 to 21:00 daily.

Capacity Hub Enhancements

- Live Teams Actions Log: A real-time actions log will be implemented via MS Teams to track and assure all operational tasks, enhancing resilience, accountability, and visibility.

Meeting Format Adjustments

- Face-to-Face Engagement: Operational meetings will predominantly be held in person to improve engagement and decision-making.
- Virtual Handover Continuity: Virtual handover meetings will continue to support on-call teams and ensure seamless shift transitions.
- Site-Specific Actions

Readiness Checklist

- Drop-In Sessions: Available at WRH from 26th–29th August for access queries.
- Touchpoints: Scheduled for the week commencing 1st September.

Task Planner / Action Log

- All sites will utilise MS Teams Task Planner to track and update actions from clinical site meetings.
- Drop-in support sessions will be available for staff requiring assistance.

Staff Wellbeing

Staff Wellbeing

•Sickness, health and wellbeing programme to be launched with various workstreams to improve proactive and positive health and wellbeing and reduction of sickness absence.

•Prioritise and encourage Wellbeing Conversations and develop support for managers to develop team wellbeing approaches. Including increased communication regarding wellbeing conversations and their importance.

•Review and relaunch Personal Wellbeing Action Plan.

•Prioritise and encourage the Wellbeing Passport to understand individual health and wellbeing needs.

•Development of staff physical health programme in partnership with Public Health Worcestershire.

•World Mental Health Day support and events across all sites on 10th October 2025, including launch of new mental health support card developed by Public Health Worcestershire.

•Further promotion of staff wellbeing and relaxation spaces to encourage breaks and rest from work.

•Free physical health checks available for staff throughout winter to encourage proactive management of health and wellbeing.

•Development and launch of Suicide Prevention and Postvention Toolkit.

•Launch of Neurodiversity Hub and Neurodiversity Staff Support Group.

•Launch of Reasonable Adjustments Toolkit.

•Ongoing promotion of wellbeing support available for physical, psychological, social and financial wellbeing.

Risks

- Failure to deliver demand management plans across the system
- Financial implications associated with increased Bank and Agency during Winter Period
- Flu and Seasonal illness outside of variation. Late onset of flu (as seen in 24/25) and increased RSV impacting of frailty and vulnerable ward areas
- Further Industrial Action
- None delivery of individual schemes across the system
- System-wide reduction of beds
- Ability to recruit to vacancies over Winter months
- Staff wellbeing

Minutes for Quality Governance Committee

Thursday 31st July 2025 at 10.00 am
Via MS Teams

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

Guest			
	Mike Cornes	Deputy Divisional Director of SCSD	**Apols**
	Helen Harris	Associate Director of Nursing and Quality ICB	✓
	Tracy Pearson	Deputy Chief Operating Officer	✓
	Daniel Hastie	Associate Chief Nurse for UEC Transformation	✓
	Amrat Mahal	Director of Nursing for Women & Children	✓
	Fazia K	Chief Pharmacist	✓

Item	Title
QGC/25/1	**Welcome and Apologies for Absence**
	Ms Moore welcomed all present at the meeting. Apologies from: Sarah Shingler Chris Douglas Mike Cornes Rachel Dunne
QGC/25/2	**Declarations of Interest**
	No declarations of interest declared.
QGC/25/3	**Minutes of the last meeting**
	The minutes of the meeting held on the 26th of June 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. Ms. Smart raised concerns about patients being required to travel to Stratford for both dermatology appointments and blood tests. She shared a case where a patient was told local blood tests weren't possible, which turned out to be incorrect. Helen Harris confirmed there is a contract allowing local blood tests and is now working with the contracts team to address the issue. Ms. Smart suggested ensuring consultants are aware of the contract and that appointment letters clearly inform patients of their options, especially given the vulnerability of many patients.
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. Jeffery formally escalated concerns regarding staff health and well-being due to increased and prolonged activity, as well as leadership issues at the local level. She

	highlighted ongoing challenges with triage capacity and meeting KPIs and reported difficulties in opening a second theatre in maternity, both out of hours and, more recently, during hours. She confirmed that actions were in place to address these issues and agreed to provide an update at the next meeting.
QGC/25/6	**Quality & Safety**
QGC/25/6.1	**Perinatal Services Safety Report**
	Ms. Jeffery highlighted that the perinatal mortality rate remains in line with national figures. She acknowledged ongoing challenges with medical staffing compliance in training and confirmed the Trust remains green on the heat map, aligning with other Foundation Group partners. No further items were raised from the report. Ms. Sinclair endorsed Ms. Jeffery's earlier comments and shared feedback from a recent safety walkabout, where staff expressed distress. She commended Ms. Jeffery's prompt response and raised concerns about triage pressures and midwifery staffing. She questioned whether current staffing levels remain appropriate given the workload and suggested reviewing the baseline. She also referenced a potential business case for appointing substantive staff to cover maternity leave across nursing. Ms. Jeffery reported that the draft Birthrate Plus review may underestimate rising birth rates and triage pressures. A follow-up meeting is planned, and increased midwife staffing is likely to be recommended. She confirmed that maternity leave is typically covered substantively in community teams, but funding is not ring-fenced and bank cover is increasingly difficult. The current leave rate is around 3%, though this may rise due to a young workforce. She also raised concern about 800 student midwives qualifying in September with limited job opportunities.
QGC/25/6.2	**Perinatal Incident Report**
	Ms. Jeffery reported that, for the period covered, there had been two stillbirths and no neonatal deaths. Seven moderate incidents had been reported. She noted that the number of open actions was decreasing and that some incidents were being re-reviewed to ensure all learning was captured.
QGC/25/6.2.1	**CNST MIS Year 7 Quarter Report 25-26**
	Ms. Jeffery presented the quarterly perinatal mortality review tool (PMRT) reports for Q1 and Q4, noting they were included in the paper. Ms Jeffery requested the committee formally acknowledge the current position and agree the action plan, which remains unchanged from the previous year except for newly secured funding to onboard ANNPs to support the middle grade rota. She confirmed receipt of midwifery safe staffing reports over the past two months and the current report, which includes reference to Birth Rate Plus. An updated Birth Rate Plus report is expected next month following a scheduled meeting. The committee also received and previously agreed the CQC co-produced action plan. Ms. Jeffery noted the maternity CQC survey for this year has been received but remains embargoed until next month. Concerns were raised regarding the recruitment of MVNP members, which is impacting efforts to hear the voice of families. This has been escalated to the Regional Chief Midwifery Officer, with a meeting scheduled to seek resolution. Finally, the committee received the Trust claims scorecard and confirmed that safety champions have met individually, with the perinatal leadership team and the Quad at a minimum of bi-monthly. From an MNSI perspective, it was noted that families have

	received information on the roles of the relevant bodies and that duty of candour was performed as documented in the report.
QGC/25/6.3	**Maternity Safe Staffing**
	Ms. Jeffery presented the June staffing report, confirming all shifts were safe, though staff continued to experience significant pressure. She noted that while acuity tools are in place across antenatal and postnatal wards, data reliability remains an issue due to inconsistent completion—particularly on the postnatal ward. Work is ongoing with Birth Rate Plus to improve accessibility and compliance. She explained that staff are frequently redeployed from wards to the Delivery Suite, which is reflected in the acuity tool data. While KPIs for midwives are improving and sickness rates are nearing the Trust's 4% target, MSW staffing still requires attention. Sickness among MSWs has halved over the past two quarters, and six MCAs are due to join, which should reduce the current vacancy rate of nine. Ms. Jeffery acknowledged that the team raising concerns via the Freedom to Speak Up route is the same team under pressure. She also highlighted discrepancies between recorded breaks and actual hours worked, suggesting limitations in the current acuity tool. The Birth Centre continues to perform well, with no harm incidents reported and the midwife-to-birth ratio met. However, support staff shortages persist in the Delivery Suite and postnatal ward due to vacancies.
QGC/25/6.4	**Nurse Safe Staffing**
	Ms Smith provided assurance that safe staffing levels were maintained throughout June across paediatric and adult inpatient units. Spend on additional unfunded capacity is decreasing, and turnover and vacancy rates continue to improve. Fill rates remain stable, and staffing-related incidents have reduced with no associated patient harm. Progress is being made on reducing bank and agency usage, with compliance to price cap targets on track. Agency spend has dropped to 3.28% of overall staffing expenditure, reflecting focused efforts across all divisions. Ms Smart raised concerns about boarding patients not receiving appropriate specialty care. Mrs. Smith acknowledged the issue and confirmed a referral system exists, though specific cases may require review. Mrs. Moore suggested tracking length of stay for outliers as a metric. Mr. Walton confirmed that internal professional standards and clinical oversight guidance had been refreshed. He emphasized the importance of actionable data and supported rationalizing audit practices. Escalation processes were clarified, including a direct reporting route to senior leadership. Mrs. Sinclair questioned the volume of audits and data collection, suggesting it may detract from care delivery. Mrs. Moore and Mr. Walton agreed, highlighting the need for streamlined, meaningful data use. Mr. Purser added historical context, advocating for minimal, high-level data that informs quality without burdening staff
QGC/25/6.5	**Emergency Quality & Safety Report**

	Ms Smith noted ongoing challenges with overcrowding and high acuity in both emergency department waiting areas, with patients continuing to receive care in corridors. While some improvement has been seen in meeting fundamental care needs, certain areas remain a concern. Action plans are in place and being progressed by the divisional management team, with outcomes expected by the end of the month. To support improvement, the introduction of emergency department safety champions is being considered, modelled on the maternity safety champion walkarounds. A paper outlining this proposal is included on the committee's agenda.
QGC/25/6.6	**End of Life Care Report**
	Ms. Walton confirmed progress against the 20/20/25 strategy, with a forward focus on improving support for families of patients dying in hospital. This will be a key priority over the next one to two years. Incorporating end-of-life processes into ward accreditation is also a major aim for the next cycle and will form part of the 2025–2030 end-of-life strategy. In response to a query from Ms. Moore, Ms. Walton confirmed that patient preferences regarding place of death are reviewed as part of the existing process, with data captured and fed back through survey mechanisms.
QGC/25/6.7	**ED Patient Safety Champion Process**
	Ms. Smith introduced a proposal to implement Emergency Department safety champions, designed to create opportunities for staff to raise patient and staff safety concerns and agree system changes to reduce risk. The initiative reflects a strong commitment to safety and shared learning, with walkabouts planned monthly at the Alexandra Hospital in Worcester and bimonthly at the Minor Injuries Unit in Kidderminster. The first walkabout and check-in meetings are scheduled for August, with outcomes to be reported through QGC and alongside the ED quality and safety report. Ms. Smith suggested reviewing the reporting structure to ensure walkabout findings are prioritised, noting that direct engagement with staff and patients often reveals more than data alone. Feedback from these walkabouts will also be shared with the Nursing, Midwifery and AHP Board. Terms of reference and process documents are included in the committee papers. Ms. Sinclair queried whether the walkabouts would be unannounced, similar to the maternity model. Ms. Smith confirmed they would not be scheduled in advance, ensuring authenticity and meaningful engagement.
QGC/25/6.8	**WAHT IPC Visit Feedback**
	Ms. Watkins provided an update on the NHSE letter, which has been received and included in the report. The Trust has responded, with the reply also attached to ensure accuracy and outline follow-up actions. NHSE has acknowledged receipt, though the final version is still pending and will be circulated once available. Each division now has its own action plan, reviewed weekly, and weekly announced visits are taking place with senior Trust staff and ICB representatives, whose attendance has recently resumed. NHSE will deliver a session on "positive confirming challenge" to senior leaders, followed by a walkaround, with another session planned for September. Estates issues are being addressed with ISS, Equans, and Ms. King, including concerns about sink splashing in treatment rooms. The Trust is exploring splash

	guards and reviewing IV preparation areas. A follow-up visit from NHSE is confirmed for 16th September.
QGC/25/6.9	**Sepsis and Deteriorating Patients**
	Mr. Hastie update on the implementation of the new sepsis pathway aligned with the updated NICE guidelines. A full digital wireframe has been developed to show how observations will be entered and how the appropriate clinical pathway will be triggered through Sunrise. This integrates with the new sepsis flow document, which now includes mandated fields to improve data accuracy and reporting. A new sepsis training package, aligned with national guidance, is in testing and due to launch in mid-August for all staff. The digital team is also working to ensure compatibility with maternity systems such as BadgerNet and early warning systems. Optimisation is scheduled to begin in early August, ahead of the EPMA go-live. One limitation identified is the inability to configure individualised observation parameters in the current Sunrise system; this will be addressed in future with the introduction of Order Comms in 2026. As an interim measure, a free-text field has been added to allow clinicians to document patient-specific baselines. This update reflects strong digital engagement and a coordinated approach to improving sepsis recognition and response across the Trust.
QGC/25/7	**Performance Reports**
QGC/25/7.1	**Integrated Performance Reports**
	Ms Pearson updated on urgent and emergency care, cancer, electives, and diagnostics performance. Demand through UEC remains high for the fourth consecutive month, with EAS performance improving slightly to 66.1% in June. Improvement initiatives are underway, including plaster technicians, triage enhancements, and PDSA cycles. Notable progress has been observed at the Alexandra Hospital. In cancer services, breast has shown marked improvement following implementation of a recovery plan, with FDS rising to 75% from 70% in May. A target of 80% is anticipated. However, 31- and 62-day performance remains challenged, particularly in skin, due to delays in launching the tele dermatology system, which is expected to go live in August. Elective care is broadly in line with plan. The number of patients waiting 65 weeks has reduced to 19, with general surgery resolved and ophthalmology nearing resolution. ENT, MaxFax, and Gastro remain areas of concern, with recovery plans focused on mitigating 52-week breaches. In diagnostics, audiology has made significant progress, with August's recovery plan on track. The committee acknowledged the team's efforts in improving performance. Ms Smart raised concerns about MRI capacity. Ms. Pearson confirmed there is a shortfall compared to last year, partly due to the loss of a free mobile unit. This is impacting elective and cancer services. The team is working on a plan to increase capacity and exploring funding options, with short-, medium-, and long-term solutions being considered.
QGC/25/7.2	**GIRFT**
	Ms. Walton updated on the Governance programme. The focus moving forward is on increasing clinical team engagement and raising the profile of ongoing work. Emphasis was placed on ensuring the outcomes of GIRFT reviews are meaningfully integrated into quality improvement initiatives.

	To strengthen accountability and visibility, executive attendance is now being mandated at all GIRFT feedback sessions. This will ensure senior leaders hear directly from teams, understand local challenges, and can support improvements aligned with GIRFT standards.
QGC/25/7.3	**Children & Young People Picker survey**
	Ms. Mahal updated the committee on the 2024 Children and Young People's Patient Experience Survey, commissioned by the CQC and delivered by Picker. This updated version of the survey was developed with input from stakeholders across the organisation, including the paediatric team, and for the first time included children accessing services beyond inpatient care. The survey captured feedback from three groups: parents of children aged 0–7, children aged 8–11, and young people aged 12–15. Overall, the Trust performed well compared to peer organisations, with many areas showing improved experience and a few areas identified for further development. In response, the Trust has created its own inpatient experience survey using Picker's methodology, which is currently awaiting approval. Additionally, key findings have been embedded into the nursing quality audit process to support more proactive and real-time improvements in patient experience.
QGC/25/8	**Governance and Risks**
QGC/25/8.1	**Risks (15 & above)**
	Ms Smith gave an update regarding a static risk rated at 20, relating to cath lab equipment failure. Ms. Watkins confirmed that the division is still awaiting the signing of the DD variation, which is expected to take approximately three to six weeks. The service remains fragile, and while progress is pending, the division is hopeful that work will commence in September with completion anticipated by February.
QGC/25/8.2	**Escalations from the Improving Safety Action Group**
	Ms Smith shared an update on safety priorities currently being monitored, with oversight from the Chief Nursing Officer and Chief Medical Officer. Ms. Walton acknowledged concerns raised by Ms. Moore regarding the complexity and overlap of ongoing initiatives, particularly around sepsis and broader safety workstreams. Ms. Walton explained that ISAG was established to address recurring low-level themes from the Patient Safety Incident Review Group that impact multiple patients but do not form standalone trends. Sepsis was not included in ISAG as it is being addressed through a separate group. Both agreed that the volume of projects and initiatives may be creating confusion for clinical staff about where to raise safety concerns and which process to follow. Ms. Walton committed to reviewing the current structure and streamlining quality metrics and reporting outputs to ensure clarity and accessibility for staff across the organisation.
QGC/25/8.3	**Safety Alerts Report Q1**
	Ms. Smith gave assurance that the Trust is in a strong position regarding the management of national patient safety alerts. Two new alerts were received in Q1, and of the three total alerts reported, two have now been closed—including the most recent double A-grade alert. The remaining alert is progressing through its action plan with no concerns noted. Ms. Walton commended Steve Sugar from the patient safety team for his effective and organised management of the alerts, noting his valuable contribution.

QGC/25/8.4	**Clinical Effectiveness**
	Ms Walton received the Q1 clinical effectiveness report. Ms. Walton confirmed that progress continues across the programme, with strong oversight and control in place. The clinical effectiveness team is increasingly embedding the “so what” factor into governance processes, ensuring that outcomes are meaningfully applied to improvement work. The committee acknowledged the team’s contribution and ongoing efforts in this area.
QGC/25/9	**Regulatory and Accreditation Reports**
QGC/25/9.1	**Medicines Optimisation & Controlled Drugs Safe Handling**
	Ms Khan gave an update on the medicine’s optimisation report & controlled drugs safe handing report, which included assurance on the proposed Level 6 rating. This recommendation is based on audit outcomes, training uptake, and risk mitigation measures. Controlled drugs and safe handling were also encompassed within the same report. No concerns were raised, and the committee acknowledged the report as providing appropriate assurance. The committee discussed the proposal to improve controlled drug (CD) governance through a process aimed at ensuring staff read, understand, and follow standard operating procedures, with the matter due to be taken to the Medicines Safety Committee. Ms. Harris questioned whether this should be addressed at an organisational level, raising concerns about how such compliance would be evidenced without leading to excessive auditing. In response, Ms. Walton acknowledged the challenge, noting that the issue had also been raised by the coroner. She highlighted the difficulty in verifying that staff have read and understood guidance without creating an overly burdensome audit process. Ms. Walton emphasised the need to balance accountability with practicality and invited suggestions from colleagues on how best to approach this issue.
QGC/25/10	**AOB**
	Ms. Walton updated on the recent period of industrial action, which ran from 06:59 on Friday through to 06:59 on Wednesday, affecting resident doctors (all grades below consultant). While the final participation figures are still being confirmed, early estimates suggest around 40% of eligible staff took part. This will be verified once staff confirm their absence reasons upon return to work. Safety was maintained throughout the five-day period, with no derogations required. Disruption to services was minimal, with only a small number of cancellations—four of which were pre-planned within a specific specialty. The Trust successfully navigated the industrial action period without significant impact on patient care.
QGC/25/10.1	**Next Meeting Date 28th August 2025**
QGC/25/11	**Reflections on the meeting**
	The Chair thanked all attendees and the executive team for their presence and contributions. Acknowledging the ongoing challenges faced by staff, the Chair noted the continued difficulty of the current period and expressed appreciation for everyone’s efforts.
QGC/25.11.1	**Meeting closed at 11:55**

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 10 July 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	**UEC Value for Money (VFM) Review**
Rating rationale	An independent VFM review of the UEC build project at Worcestershire Royal Hospital was commissioned by the Trust following an internal audit in 2023/24 which highlighted concerns. The review identified that the project did not fully meet VFM success criteria: • Economy: not achieved due to capital overspend, costs, project governance and original assumptions. • Efficiency: achieved – scheme achieved greater monetary benefits than planned. • Effectiveness: achieved, albeit full benefits not realised due to pressures caused by increased demand. Recommendations for improvements to future capital projects covered project governance, clarity of project roles and business case development processes. One of the recommendations was to prepare advance capital plans to enable business cases to be developed in short time frames should funding be released at short notice. A better approach to this was being developed with the NHSE regional team.
Outcome	The Committee welcomed the helpful report and was assured by the management plans to incorporate learning into processes going forward. **Action:** Report at a future next meeting on the plan for implementing the recommendations.
Item/Topic	**Internal Audit Review: PFI Development Assessment Forms**
Rating rationale	The review considered the process in place for the approval of Development Assessment Forms, which were completed when a change was required to a PFI building. The report rating was Moderate Assurance, with four medium and three low risk recommendations, which were all accepted. Improvement actions would ensure the Estates and Facilities Team were better able to manage the PFI budget. It was noted that the current position was already much improved and included enhanced executive oversight to ensure value for money. There was confidence in the ability of the leadership to make further improvements.
Outcome	**Action:** PFI Exit committee to consider how to obtain improved oversight of expenditure
Item/Topic	**Trust Response to External Audit Recommendations on Value for Money (VFM)**
Rating rationale	The CFO presented a summary of the Trust's management actions to the VFM recommendations, focusing in particularly on CPIP readiness at the start of the year. Actions being progressed included: • Development of a 3-year CPIP pipeline. • Workforce review. • System work on flow. Additional actions planned included a mid-year CPIP assurance review by Internal Audit with the aim of signing off next year's plan before 25/26 year-end.
Outcome	There would be a more detailed item at the next meeting describing the plans to strengthen arrangements to ensure delivery of the 2025/26 financial plan.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 10 July 2025
Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	**Internal Audit Progress Report**
Rating rationale	Final reports had now been issued for five reviews, which concluded the 2024/25 plan. Work had commenced on seven reviews as part of the 2025/26 plan. There were currently no outstanding recommendations.
Outcome	The Committee was assured by the progress made to date to deliver the 2025/26 internal audit plan. **Action**: Terms of reference for the procurement review to include procurement KPIs.
Item/Topic	**Internal Audit Review: Annual Planning**
Rating rationale	The audit reviewed annual planning processes at divisional level in 2024/25. The review was rated significant assurance with three low risk recommendations reflecting a robust, appropriately led process. Actions were in progress to address the recommendations though it was recognised that the 10 year plan had changed the annual process.
Outcome	The Committee welcomed the positive report.
Item/Topic	**Internal Audit Review: Performance and Accountability Framework**
Rating rationale	The review was rated significant assurance, with four low risk proposed actions and one advisory recommendation. The COO briefed the Committee in more detail on the plans to implement further improvements. In particular, an operational improvement board or similar would be established to provide oversight of more granular detail associated with performance when it was off-target, which would enhance oversight from service line to Board.
Outcome	The Committee welcomed the positive report on this fundamental part of the governance framework and noted the plans for continued improvement. **Action:** Schedule a more detailed report on performance and accountability framework developments for a future meeting.
Item/Topic	**Internal Audit Review: Data Security and Protection Toolkit**
Rating rationale	The mandatory audit was not rated but was reported as positive overall. The audit was based on 8 mandated indicators and 4 selected by the Trust. Five low-level risks were identified and actions were in progress on all recommendations. The DPST submission had now been made with 8/47 objectives not met but a plan in place. NHSE feedback had been incorporated into the plan, which the Information Governance Steering Group was overseeing. There was high confidence in completion of the plan within agreed timescales. It was recognised that the DPST had a particular focus on cybersecurity. The Committee was reassured that strong mechanisms and support were in place and there was good engagement with the NHS cybersecurity team.
Outcome	The Committee welcomed the positive report.
Item/Topic	**Counter Fraud Progress Report**
Rating rationale	Contract performance was good, with positive performance on all KPIs. However, at the end of Q1, half the contracted days had been used. This reflected proactive plan delivery; should extra days be required to support more reactive work than estimated this would be supported by the Trust. A review of controls in sensitive areas had been added to the plan.
Outcome	The Committee welcomed the positive position.
Item/Topic	**Fit and Proper Person Test Compliance Report**
Rating rationale	The annual compliance report was in line with the national framework. A framework-compliant policy was in place and a local audit demonstrated full policy compliance with some opportunities to improve the presentation of evidence. The framework required a 3-yearly review by Internal Audit; this was included in this year's plan and would commence shortly.
Outcome	The Committee welcomed the positive report.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 10 July 2025
Report to: Trust Board

Item/Topic	Annual Trust Register of Interests Report
Rating rationale	Further to the annual review of the Board's register of interest, the report presented the current Trust Register of Interest, which was based on a new declaration process on ESR, introduced at the Trust in Q4. The main focus was on 'decision making staff' who were required to make an annual declaration. Compliance was considered reasonable at this stage and a programme of communication to improve this was planned. None of the declarations so far raised any concerns. A number of cross-checking processes of declarations were undertaken in partnership with Counter Fraud.
Outcome	The Committee welcomed the positive progress and improvements in reporting based on the new system.
Item/Topic	**Annual Committee Review 2024/25**
Rating rationale	The report set out the Committee's compliance with its terms of reference, which were aligned with good practice. There was a small number of partially or unmet areas, which would be taken into account in planning for 2025/26.
Outcome	The Committee agreed to use the report to form the basis of an informal session on Committee effectiveness.

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 3rd June 2025 at 10:00

Present		
Chair	Colin Horwath (CH)	Non-Executive Director
Members	Ali Koeltgen (AK)	Chief People Officer
	Stephen Collman (SC)	Managing Director
	Jules Walton (JW)	Chief Medical Officer
	Ed Mitchell (EM)	Deputy Chief Medical Officer
	Justine Jeffery (JJ)	Director of Midwifery
	Neil Cook (NC)	Chief Finance Officer
Attendees	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Rachael Hayter (RH)	Director of AHPs
	Liz Faulkner (LF)	Deputy Chief People Officer
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Rich Luckman (RL)	Assistant Director of People & Culture
	Richard Haynes (RH)	Director of Communications & Engagement
	Bec Harris (BH)	LGBTQ+ Network Chair
(Staff Story item only)	Sarah Woodall (SW)	HR Business Partner, Surgery
	Shelly Horton (SH)	Matron, Surgery Division
	Zoe Scott Lewis (ZSL)	Deputy Director of Operations, Surgery
Apologies	Karen Martin (KM)	Non-Executive Director
	Sue Sinclair (SSi)	Non-Executive Director
	Julie Moore (JM)	Non-Executive Director
	Simon Murphy (SM)	Vice Chair
	Sarah Shingler (SS)	Chief Nursing Officer

	Chairs Welcome and Apologies for Absence	
	CH 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. CH 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 1st April 2025 were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly.	
	Staff Story – Staff Survey	
	Results shared at Divisional Board meeting then disseminated to teams to analyse their own results and develop actions plans. Suggestion boxes have been set out on	

wards to encourage feedback and ideas from both patients and staff. Some actions taken include consolidating the staff wellbeing services into one accessible word document and circulating for all staff along with the Flexible Working Policy. Directorates are also accessing support from OD team.
Progress against actions is reported to Divisional board every 2 months.

AK asked whether staff on wards can feel the difference and can link the improvements back to the staff survey, and SH responded that the staff survey results are referenced regularly at ward meetings as well as PDRs, and that they are committed to working through the suggestion box at each meeting.
JW noted the reference to some negative feedback to policies, and SH provided an example of earrings and other jewellery under the Uniform Policy. JJ advised that the CNO and DCNOs had been involved in the creation of the policy and had robust reasoning for each decision. The stance is aligned across the region, but JJ was open to review. SC emphasised the need to review the results collectively as a multi-disciplinary team.

Staff Network Updates: LGBTQ+ Network

There are now 76 members and attendance at Network meetings is strong with both Chair and Vice Chair joining to show their support. Since the Supreme Court ruling, there has also been an increase in people joining the Network. The Trust's response to the ruling has been well-received by members.

Terms of Reference across Networks and the wider ICB are being standardised. There will be attendance at Pride events in Worcester and Malvern, with the potential to attend some in Redditch, and BH encouraged Board members to attend where possible.
Rainbow badge training continues as well as progress against the action plan, with 386 current champions, and dedicated sessions arranged with Theatres as part of their culture plan. BH felt that more awareness at Board level could enhance progress with key points of the Rainbow Badge Action plan.

AK referenced complaints from the public and the potential division between staff and asked if more could be done to ensure the Network is an inclusive space for everyone. BH advised that reassuring staff that they are safe and supported fosters psychological safety. AK added that the Trust is inclusive in terms of supporting people to have differing views, as long as it is not to the detriment of any group. **RL spoke on the intersectionality of similar issues being seen across all the Networks, and that there is opportunity for the Networks to work together with OD to promote a compassionate, values-led, safe space.**

Chief People Officer Report

Governance update on the Registration Authority for noting by Committee.

The national pay award and Very Senior Manager framework has been published. Correspondence from NHS England has been received regarding the importance of agency reduction. Pending publication of Nursing profiles, ***NHS England are seeking assurance that Trusts have robust job evaluation processes. Agreed as a future agenda item.*** Communication is also being received from regional teams regarding the number of vacancies being advertised, specifically Corporate and infrastructure, given the target to reduce headcount. The Trust can expect more scrutiny and pressure going forward.

The Resident Doctor ballot closes on 7th July regarding pay, and there will need to be 2 weeks' notice for any strike action.

NC shared that while previously, the Trust had been advised that any impact above 2.5% would be a local cost pressure, there has now been communication to neutralise the impact of any pay award.

CH expressed disappointment regarding level 7 apprenticeships, and queried the numbers affected. AK advised that the scale is unclear but the impact on both clinical and non-clinical development will be considerable. Regarding the potential for the Trust to still invest in the courses, AK advised that this would be a business case review for each investment and that some clinical roles will be able to access funding through tariffs not available to non-clinical roles.

Supreme Court Ruling

National implications remain unclear in the wake of the ruling, particularly given that legal challenges are mounting. Whilst the position has been for Trust's to avoid significant changes before national guidance is issued, a small Working Group has been established. The group includes representatives from across the Trust and the LGBTQ+ Network with lived experience. Staff and patient data systems, patient pathways, and toilet and changing spaces will be affected and whilst these cannot be addressed yet, an audit is being carried out to understand the scale of gender-neural changing facilities across the Trust, noting existing challenges with space across the site and that the Trust may still be required to provide single sex facilities too.

Leadership & Values (Pillar 1 of People Strategy)

Embedding the values into HR processes, like PDR documentation has commenced. Leaders will be essential to role model values in meetings and Exec Live to bring the values to life. The values-led culture programme will emphasize the importance of kindness in the workplace. The early resolution work will start in autumn for 2 years; a policy is needed first and then training can be rolled out to teach managers how to have facilitated conversations and resolve issues quickly and informally.

Relaunching advocate groups are being relaunched with the new values and NHS Elect free webinars are being introduced for staff.
The Trust received a certificate from NHS England as recognition of its achievement in improving the response rate. Where the results identified hotspot areas that needed support, OD interventions are underway.
Research shows that organisations with an engaged and happy workforce perform better, and that investing in staff improves the quality of care for patients. Due to the efforts put into the survey last year, the Trust achieved 584 more responses than SWFT (response rate of 52%), 1732 more than GEH (58%), and 2058 more than Wye Valley (34%).

CH asked how the Trust's resolution process benchmarks against others and RL highlighted that there will be a considerable amount of poor behaviour that is informal, and therefore HR are not aware of. These poor behaviours create friction and underperformance and require leadership. Whilst the level of formal HR casework is not higher than average, data across FTSU, WRES and WDES and the Staff Survey, indicates that people are not leading with values. This will be addressed in several ways including early resolution training and tools to deal with conflicts before they escalate, but also the Kinder Culture work to teach staff how to lead with values.
AK added that harm caused to staff by lengthy HR processes is not measured or investigated in the same way as harm caused by clinical incidents. ***Agreed to bring***

HR casework data to Committee every 6 months. CH suggested for future that a breakdown of each initiative's timescales, progress and any barriers would be helpful for assurance.

WRES and WDES

The data is informed by Staff Survey results, data from HR systems, and casework on employee relations. The action plans are in draft as the team are beginning to involve Staff Networks in the OD interventions to improve the experience of their members.

RL highlighted key indicators requiring improvement: BME staff experiencing harassment/bullying/abuse in the last 6 months, likelihood of disabled staff compared to non-disabled staff being appointed or shortlisted in the recruitment process, percentage of disabled staff experiencing bullying/harassment/abuse from patients, percentage of LBGTQ+ experiencing bullying/harassment/abuse from patients.

Considerable improvements have been made over the last year on reasonable adjustments, and the results of the Staff Survey and the WDES show the improvements have made a difference to staff. In regard to BME staff experiencing bullying/harassment/abuse at work, the Trust is looking to sign Unison's Anti Racism charter and make a pledge to actively be anti-racist. The WDES also showed an improvement in disabled staff feeling that the organisation offers equal opportunities for promotion and career development, and this could be related to the improvements in reasonable adjustments.

A Board Workshop will be held in September dedicated to EDI including reciprocal mentoring, career advancement and wellbeing. AK cautioned the Committee against complacency; whilst some results have improved, the Trust is still reporting a poorer experience for these staff groups. It was suggested that crosscutting the data by staff group might enable a better understanding of the experience of specific groups. SC raised the need for reciprocal mentoring to not only take place amongst Executives, but at all levels.
SC suggested triangulating the Staff Survey and WRES/WDES action plans action plans. **Action for RL to consolidate the action plans in 6 months when submitting EDI report.**

Workforce Reductions Approach

Operating models and targets across corporate and infrastructure areas are being reviewed, in order to understand the opportunity for potential workforce reductions. The approach is to achieve as much as possible by natural turnover however attrition rates will make this difficult. Discussions have been held with system partners to cease recruiting to vacancies where possible, and where recruitment is needed, for this to be advertised internally across the system first. Core activity and priority areas are being identified, as well as those areas where value added is less significant. There are some opportunities such as agency reduction, and a plan to review the core establishment to ensure the right people in the right place.

The Trust's current Management of Change process is extensive, and may require a significant amount of time when multiple changes are taking place, therefore the policy will need to adapt so that HR can become more agile and responsive. Where corporate and infrastructure support is scaled back, the impact on divisional colleagues will need to be considered. The Trust will consider group-wide opportunities to avoid duplication and increase efficiency.
The workforce growth since 2019 is considerable and is being reviewed. Some technology and digital advancements could provide solutions and opportunities.

	Job Planning Action Plan	
	Progress has been made, with compliance now at 69%. A considerable number of the 12+ PA issues have been resolved or are almost at resolution. A weekly consistency panel is now in place to review 12+ PA job plans and to ensure that new job plans align with the criteria. There are gaps in assurance with medicine and surgery divisions and the reasons are currently unclear. Divisions are aware of the financial impact of resolving the 12+ PA disputes.	
	Medical Agency Reduction	
	Fortnightly meetings are taking place with divisions to closely monitor medical agency spend. There has been some good progress with Urgent Care converting some agency doctors to direct engagement. Workforce plans are almost complete which should provide a better understanding of actions needed. There is a risk regarding medicine and surgery divisions as outliers, whereby agency bookings listed as due to vacancies, do not correlate with the number of vacancies. The gap between agency usage and the number of current substantives needs to be better understood to inform recovery plans. Some difficult conversations may be required with clinical leads where the necessary progress is not being observed. ***The committee did not feel assured and agreed to escalate the issue to Board.*** JW added that the drivers are not fully understood; bank and agency are used to deliver patient care and cannot be removed without an alternative in place. Processes and policies may have contributed to this issue over a sustained period. SC noted that some services or staffing levels may be referred to as 'unsafe' where this may not be the case. There is a need for the right number of staff in the right places in order to deliver the services.	
	Local Clinical Excellence Awards	
	Under the 2003 Consultant Contracts, it is a contractual right for consultants to be considered for a clinical excellence award. As per the pay award agreed in 2024 to end industrial action, the clinical excellence awards will cease after this round.	
	Governance	
	People & Culture Risk Register The register is reviewed monthly and there are no new risks at 15 or above. The Committee's lack of assurance with medical agency reduction will be included in the register. There is a new level 12 risk regarding the impact of delivering the 25/26 workforce plan, and with workforce reductions, there is potential that the risk will increase further as the target operating models develop.	
	Any Other Business (AOB)	
	None raised.	
	Date of Next Meeting	
	The date of the next meeting is Tuesday 5th August, Boardroom Alexandra Hospital.	

Escalation and Assurance Report

Report from: PFI Exit Committee
Date of meeting: 1 September 2025
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	
Summary	The Committee considered several matters and agreed to highlight the following to the Board: • **Resource Plan** Given the current focus on corporate efficiencies and the lack of central funding, a joint solution with Wye Valley NHS Trust would be considered and a proposal presented to the Committee at the December meeting. • **Joint Condition Survey** It was intended that an independent survey would be jointly commissioned and funded by SPC and Equans. The survey would combine elements of Equans' self-reporting of known issues with a traditional full survey, particularly for areas where assurance was needed. A compliance survey would be conducted initially by SPC (as previously agreed) and this would inform the condition survey. There was confidence that the planned deadline for completion of the survey (December 2026) would be met. • **Managed Equipment Service (Siemens)** There were concerns regarding the risk of inheriting equipment at book value in 2031, with potential significant costs and lack of transparency in asset management. The Committee acknowledged that this was a complex issue with limited current resource allocated to it and with broader issues and opportunities beyond the PFI contract. It was agreed that the MES would be a separate workstream, reporting to this Committee. An update on a potential MES strategy led by the COO would be provided at the next meeting. An update was also provided to the Committee from a DHSC representative regarding a new approach to supporting PFI exit that had been developed by the National Infrastructure and Service Transformation Authority (NISTA). This would include the assignment of a lead to advise and support the Trust for the full period prior to exit.
Outcome	The Committee was content with progress to date and agreed that the matters outlined above would be standing agenda items for meetings going forward. Meeting length would be extended to 90 minutes from now on to ensure that all matters could be adequately considered.

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.

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