Intrapartum & Non-Birthing Categories
01/08/2025 to 31/08/2025

Categories	Number in Categories	Percentage
Cat I	48	51%
Cat II	8	9%
Cat PN	38	40%
Cat X	0	0%
TOTAL	94	

*The % is rounded to nearest whole number

Birthrate Plus 6 monthly desktop audit

The three-year Birthrate Plus audit is currently in draft and is awaiting Divisional approval. As the audit report is slightly delayed the desktop exercise has been completed,

The current recommended establishment is presented below:

Methodology Birthrate Plus (Ball & Washbrook)
Guidance RCM Staffing Standard 2009

Trust name					**Differentiated ratios**	%
					Tertiary	38 to 1
Service Type					DGH > 50% categiores IV & V	42 to 1
					DGH < 50% categiores IV & V	45 to 1
				Community excluding home and stand alone mlu births		98 to 1
				Home and stand alone mlu births		35 to 1
Leave allowance (%)						24.0%
Existing establishemt clinical midwives and clinical element managers/specialists						210.00
Exisiting establishment non clincial managers/specialist elements						33.89
Existing establishment band 3 and above *currently* included in 10% skill mix (those with appropriate qualifications, skills and competency used currentlyto replace midwifery times, includes nursery nurses, RGN's, MSW's)						-

Case Mix Ratio	No. Hospital Births	Home Births & Standa Alone MLU Births	Exports	Imports		
42:01:00	4800	300	200	500		
Hospital Midwives (no of hospital births / differntiated ratio (42))					A	114.29
Community Care (No of hopsital births - exports + imports /98)					B	52.04
Home Births & Stand Alone MLU births (No of births/35)					C	8.57
Total Clinical Midwives Required (A + B + C)					D	174.90
Assessed Ratio (Total births/ clinical midwives required)						29.16
Additional % required for non clinical element managers/specialists						20%
Additional number required for non clinical element managers/specialists						34.98
DAU/ANC/NIPE/USS						17.59
MCOC -Community element						26.00
Total Midwives required						253.47

Non - clinical Midwifery Roles

Within the tool a ten percent increase in midwifery time is applied to support governance, specialist and leadership roles (20 WTE locally). This % increase has not been amended in the tool following the national changes. There are 23 additional roles funded by NHSE and the local council to support the Trust to deliver and meet national targets.

Funded establishment

The total requirement to deliver a safe maternity service is 253.47 WTE. The current funded midwifery establishment is 257 WTE therefore no additional funding is currently required.

Staffing incidents

There were no staffing incidents reported via datix

Medication Incidents

There were twelve medications no harm incidents

1. CD stick not checked correctly
2. Pt self -administered wrong dose of insulin
3. Delay in prophylactic IVABs
4. IVABs given to soon (baby)
5. Inadequate pain relief prior to procedure
6. Incorrect VTE assessment
7. Incorrect pharmacy order
8. Incorrect infusion rate
9. Missing CD x 1 tablet
10. Delayed medication due to inappropriate referral to Maternity Hub for IM Steroids
11. CDs delivered to wrong ward
12. Insulin not prescribed correctly (pt self-administering)

Monitoring the midwife to birth ratio

The ratio in August was 1:20 (in post) and 1:19 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Maternity SitRep

The maternity SitRep continues to be completed twice per day. The report is submitted to the capacity hub, directorate and divisional leads and is shared with the Chief Nurse and deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. The regional SitRep is submitted daily.

National Maternity SitRep

The national COVID SitRep was stood down in October 2023. A revise national maternity submission is now available and completed each fortnight; it is expected that the regional SitRep will be rolled out across England – this is planned to for implantation in Q3.

Unify Data – this data was not available at the time of writing this report

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

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	84%	n/a	100%	n/a
Antenatal Ward/Triage	87%	95%	77%	100%
Delivery Suite	93%	93%	27%	70%
Postnatal Ward	90%	85%	88%	91%
Meadow Birth Centre	88%	69%	67%	90%

Daily staff safety huddle

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

Vacancy

There are two unfilled midwifery roles (Fetal Medicine & Sonography Lead) and no unfilled clinical roles vacancy rate now at 0.5%. There are 12WTE MCA posts vacant with 6 WTE in the pipeline – further interviews are planned.

Sickness

Sickness absence rates for midwives are reported at 5.83% and 3.63% for non-registered staff – this is a further drop for both groups.

The following actions remain in place:

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

Turnover

The rolling turnover rate is at 3.5% for midwives and at 14% for non-registered staff – this a sustained position.

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- SitRep report completed three times per day
- Monthly ‘drop - in’ sessions led by the DoM.
- Safety Champion walkabouts
- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

Risk Register –staffing

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

Conclusion
To maintain safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. The escalation policy was utilised on 12 occasions to maintain safety. The community and continuity of carer midwives were not required to support the inpatient team. No red flags were reported via the acuity app; the supernumerary status of the shift leader at the onset of the shift and 1:1 care in labour were achieved. Of the 12-datix reports for medication incidents submitted, there was no harm reported. Sickness absence rates for midwives remains above the Trust target and are expected to fall further as there is a high level of confidence that staff are being supported as per the Absence Policy. This is the first month that the rate for non-registered staff has been below the Trust target for a number of years. The vacancy rate is 0.5% for MWs and 19% for MCA's. Further recruitment is planned for the MCAs.
Recommendations
The Board is asked to note the content of this report for information and assurance.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**14 October 2025**
Title of Report:	Safer Staffing report - Nursing
Lead Executive Director:	**Chief Nursing Officer**
Author:	Clare Alexander, Workforce Lead Nurse
Reporting Route:	NWAG
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during August 2025 with numerical data presented for July 2025.

Recommended Actions required by Board or Committee

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

Executive Director Opinion[1]

Staffing on Neonatal and all Adult in patient areas have been maintained at safe levels throughout August in 2025, with fill rates above the national 95% and CHPPD at 8.9, which sits with national variation. In paediatrics whilst BAPM level were not achieved on 100% of shifts, professional judgement indicates that areas and staffing were safe.

There were 25 insignificant or minor incidents reported, all were deemed insignificant and minor harms relating to nursing / midwifery staffing being largely reported as near misses due to staff absence, rather than patient harm.

The reduction in turnover continues for both registered and un-registered nursing (7.36% and 12.17%) respectively and there is a clear pipeline for RN recruitment.

Due to the continued increase in UEC pressures, additional capacity has continued to be utilised, with PDU being open throughout August 25 and Avon 1 winter pressure ward remaining open with substantive recruitment and funding on ADI. Spend associated with additional capacity was static in month 4 however.

Nursing is currently on trajectory to achieve the internal CPIP target of agency spend of 2.6% of total staffing spend, with July sitting at 2.99%. Price Cap Compliance (PCC) has been increasing gradually and now sits at 96.6% compliance (from 96% in June) across all nursing and midwifery groups with

[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.

remaining non-compliant group being subject to ongoing work and scrutiny. Working towards agency will “switch off” once establishments allows.

NHS
Worcestershire
Acute Hospitals
NHS Trust

1. Introduction/Background

Workforce Staffing Safeguards have been reviewed, and assessments are in place to report to Trust Board on the staffing position for Nursing for August 2025 with financial figures for July 2025.

This assessment is in line with Health and Social Care regulations:

- Regulation 12: Safe Care and treatment
- Regulation 17: Good Governance
- Regulation 18: Safe Staffing

2. Content of report

Harms

In August 2025 there were 25 insignificant or minor incidents reported. The insignificant and minor harms reported relating to nursing / midwifery staffing and were largely reported as near misses due to staff absence, rather than patient harm. All incidents were included in NWAG Divisional reports and assurance of mitigation where appropriate has been given.

Safe Staffing

Nurse staffing 'fill rates' (reporting of which was mandated since June 2014)

"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwifes in hospitals which are filled'.*
National rates are aimed at achieving 95% across day and night RN and HCA fill.
Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where able to do so.

Current Trust Position July 2025 data			What needs to happen to get us there
	Day % fill	Night % fill	This month has seen fill rates fall slightly (1-2 % from last months (second consecutive month of slight reduction) across both grades and shifts) However, both registered and non-registered national targets of 95% have been met with the last dip below 95% for RN October 2023.
RN	98%	102%	
HCSW	99%	111%	

Care hours per patient day (CHPPD)

In line with National guidance, in addition to the measurement of unified data (filled and unfilled hours), care hours per patient day (CHPPD) are calculated for each inpatient area and uploaded monthly to NHSE.

The Trust's average CHPPD for July 2025 was stable at 8.9 which has been stable for the past 6 months, after gradually increasing from 8.4 in January 2024.
The average national for CHPPD is 9.1 with a variation of **6.33 to 15.48**, of which the Trust sits comfortably within this range.

5 clinical areas were above the maximum variation level seen nationally; this will generally be consistent month on month:

- ICU WRH

- ICU AGH
- Meadow birth suite
- NICU
- Ward 1 KTC

All these units are specialised, necessitating staffing to maximum number of beds and acuity rather than actual activity.

No area fell below the lower limit of 6.3 and the lowest individual ward was PDU at 6.8. Narrative has been sought from the divisional governance lead who has highlighted that whist there have been no significant clinical incidents in month, they have noted a number of eternal service concerns relating to discharge process. Investigations have linked these to the high levels of temp staffing usage in the area but not specifically to fill rates.

Nurse to bed ratio

All adult in-patient wards and departments are staffed in line with guidance from NICE / RCN and where appropriate, specialist advisory bodies.

Turnover

Current Trust Position **WTE** **July 2025 data**	**Previous month** **June 2025**	**Model Health system data Mar 2025 Benchmarking**
RN 7.36%↓ HCSW 12.17 %↓	RN 7.55% HCSW 12.43 %	RN 8.8 % HCSW 19 %

The turnover rate continues to follow the downward trend for registered and unregistered nursing, observed over the past 12 months. With the figures above demonstrating improvements compared to last year's performance (8.46% RN and 14.89% HCSW July 24).

Vacancy (Trust target 6%)

July 2025 data

Current Trust Position **WTE** **July 2025 data**	**Previous month** **June 2025**	**Model Health system data Mar 2025 Benchmarking**
RN 4.9% (111.4 WTE)↑ HCSW 12.5 %↑ (145.03 WTE)	RN 4.52% (102.19 WTE) HCSW 12.34 % (143.22 WTE)	RN 6.% HCSW 11.2%

The registered nurse pipeline shows an expected 64 registered nurses Band 5 experienced and newly qualified, joining the Trust in the next 4 months in addition to other recruitment activity that is ongoing. HCA pipeline remains strong with established recruitment approaches alongside apprenticeships and collaborative working with the ICS.

To note, there are 18 WTE confirmed HCA starters in September, with a further 41 in the pipeline due to start October / November / December 25. The monthly generic assessment centres for HCA's led by Workforce are now established with good involvement from ward managers and are proving an effective approach to the scale of recruitment required. Workforce lead nurse will be planned against actual starters on a weekly basis to provide assurance on pipeline effectiveness.

Staffing of the wards, to provide safe staffing has been mitigated by:

- deploying staff across all wards / departments to ensure safer staffing levels are achieved
- employing use of bank and agency workers.

Overall, the Trust is in a strong position with registered nursing and support to nursing both ranking in the first quartile for model health system.

International nurse (IN) recruitment pipeline

Given the current workforce recruitment profile, focused bespoke international recruitment to areas requiring specialist skills, such as theatres may prove to be the most beneficial to the Trust, and this is the approach being taken. To confirm there have been no international Nurse arrivals in this financial year.

Domestic and international nursing recruitment

A recruitment event took place on the 5th and 6th of April, for the September 2025 qualifying cohort and interest in this event was strong. 148 students booked interviews with a high turnout rate and 102 being

deemed appointable on the day (32 for urgent care, 34 for surgery and 38 for specialist medicine). This was the first joint venture with the Health & Care Trust and feedback was positive. Currently 54 firm offers have been made and work is ongoing to secure placements for the remaining candidates. Due to some candidates accepting positions in other trusts the remaining number to allocate in currently 25. A recruitment trajectory will be developed to the end of the financial year, to allow us to accurately predict vacancy and effectively recruit from the February 2026 qualifying co-hort from University of Worcester.

Generic HCA assessment centres were paused In August due to historic poor attendance at interview in this month. The next centre is booked for September 19th with the advert receiving 150 applications so far.

Bank and Agency Usage
July 2025 data

Bank and agency usage, total combined RN & HCSW has risen to 566.39WTE in July (from 529.96 WTE in June).

Financially this has translated to an increase in overall increase in spend of £148,678 across bank and agency for registered and unregistered nursing. The largest increase has been seen in Registered nurse bank spend at £94k higher than previous month. This has been offset slightly by a £12k reduction in agency with the latter showing a 30% reduction in agency spend form the same period last year.
With a positive recruitment pipeline for RNs for Autumn, work will be focused on switching agency off for registered nursing once areas are fully established and tighter controls on bank spend and escalations once maternity leave cover is in place.

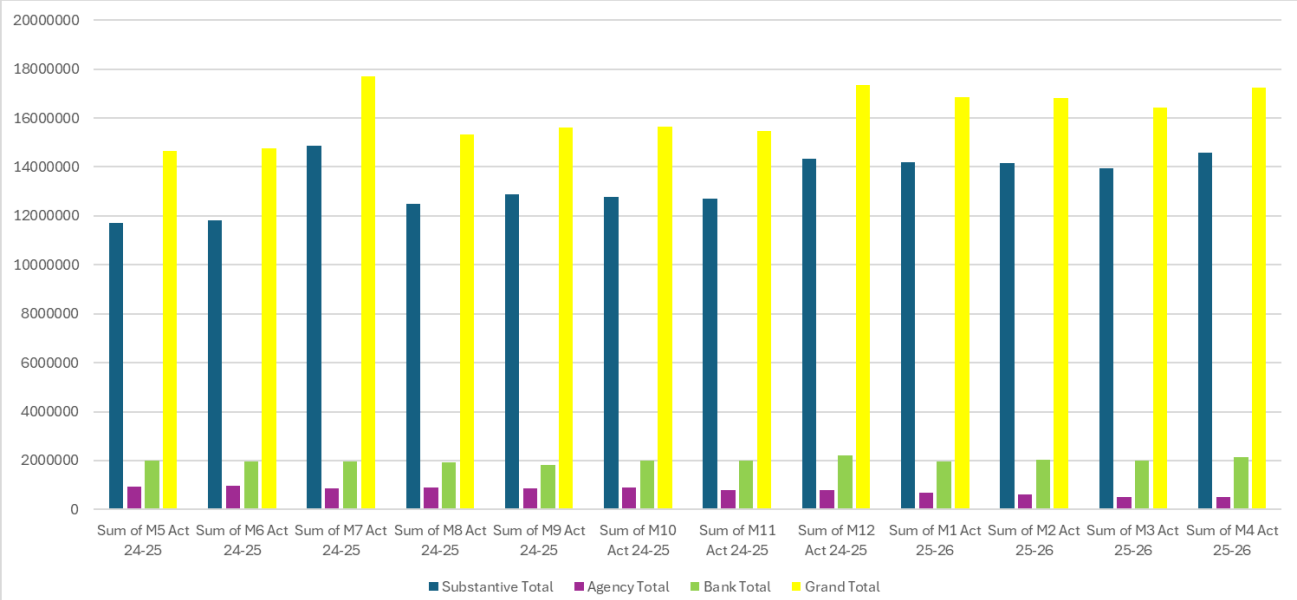
Triangulated data for sickness / vacancy and maternity leave gives a slightly increased overall absence of 309.87 WTE (from 299.64 WTE) for registered (not including midwifery) and 288.58WTE (from 268.96 WTE) for un-registered nursing. These trends are reflective of the relatively static vacancy number combined with an increased sickness level in month. Recruitment team have been asked for an updated pipeline to be prepared weekly and other options to expedite both recruitment and on boarding will be worked through.
Price cap compliance (PCC) for general nursing continues to be strong at 96.6% across all RN codings used Trust wide.
This is the 3rd consecutive month which has seen an improvement in compliance, with areas of current non-compliance focused in mental health, chemo and paediatrics.

Chemotherapy - current Trust chemo rates are at regional price cap levels set as part of the improvement project but above national levels hence the ongoing breach declared.
Paediatrics – An improvement in compliance in this group should be seen for 1st of September when all Tier 1 Paeds agencies will come to price cap. Concurrently, tiers 2 & 3 will be merged and come in at 10% over price cap for a period of 3 months. After this, notification has been given that they will be required to supply at price cap in order to remain on framework.

Overall nursing pay costs in month 4 are £16.3m, an increase of £0.2m compared to June.
Substantive nursing pay spend of £13.7m in July is an increase of £0.1m compared with last month, this is mainly within Medicine and relates to an increase in enhancements and costs associated with industrial action cover.

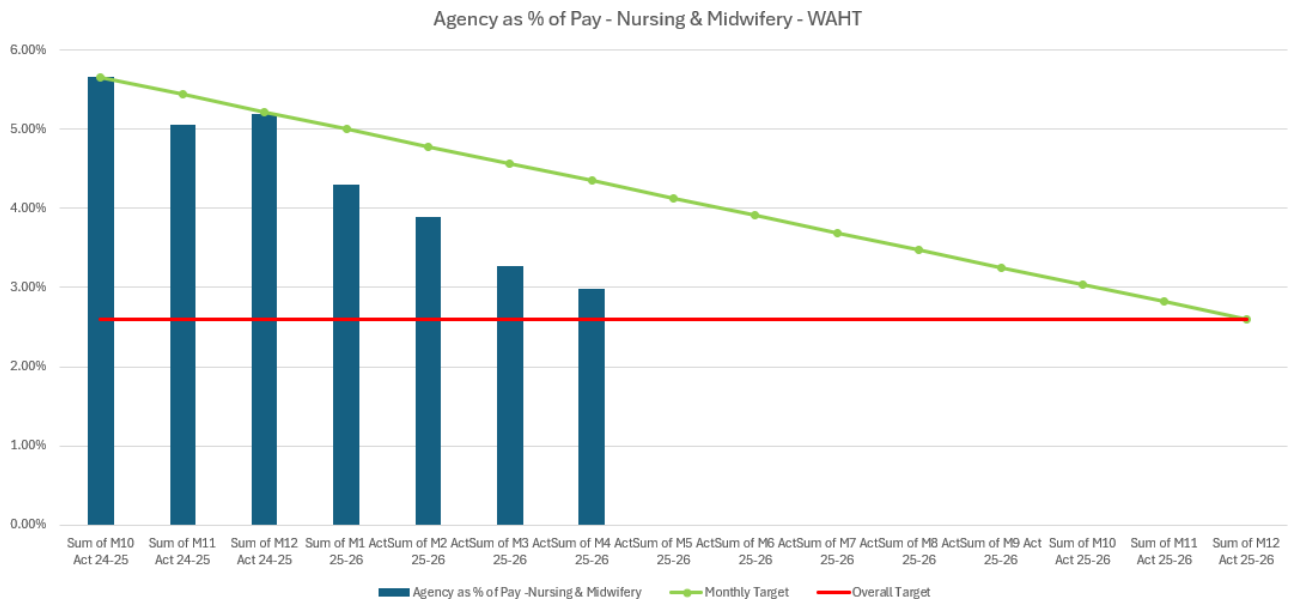
Bank spend of £2.1m in July is an increase of £0.1m compared with last month, relating to an increase in bookings to cover sickness/specialling/maternity.
Agency spend of £0.5m in July is consistent with spend in June.

Graph showing trend of substantive / bank and agency spend



Reduction of agency spend & average hourly rate, remains a focus. The removal of tiers 2 and above for RN00, RN04 and RN08 continues with the last 2 agencies in tier 2 now having clarified their positon with 1 coming to price cap and one being removed from the cascade on June 23rd 2025

Agency reduction trajectory
Work towards the internal target of 2.6% of overall staffing spend is well underway in Nursing and Midwifery with July seeing a 2.99% spend. Monthly costs and overall annual trajectory can be seen in the slide below.



Sickness

July 2025 data (% reflects updated headcount)

Current Trust Position July 25	**Previous Month Position** **June 25**	**Model Health System data Nov 2024 Benchmarking**
RN 5.52% ↑ (116.47 WTE) HCSW 8.46 % ↑ (114.55 WTE)	RN 5.34% (112.45 WTE) HCSW 7.03 % (95.74 WTE)	RN 6.4% HCA 11.52 %

Absence (July 2025 data)

- 309.87 WTE RN total absence due to vacancy, sickness and maternity leave (increased from 299.64 in June), reflects the slight increase in registered sickness, versus bank and agency use of 276.33 WTE (decreased marginally from 257.03 WTE in June).
- 288.58 WTE HCSW total absence due to vacancy, sickness and maternity leave (increased by 20 WTE from 268.96 in June) versus bank and agency usage of 290.06 WTE (increased by 17 WTE from 272.93 in June.)

The Trust currently has 82 RNs and 29 HCSWs on maternity leave (slightly decreased from June 25). The options paper focusing on recruiting into maternity leave for theatres as a pilot has been drafted

and the CNO has requested that further financial analysis is completed prior to presentation. Confirmation has been given by finance that this is being prioritised, whilst a combined ATR for recruitment to maternity leave across both arms of the medical divisions has been approved and offers have been made.

Additional Capacity Usage / Costing

Other focuses of additional capacity are MSDEC overnight / Discharge lounges extended hours and the reopened PDU. Details for financial implications are below for the month of July 25.

Ward	Month	Registered		Unregistered		Total	
		Hours	Cost	Hours	Cost	Hours	Cost
Medical SDEC WRH	July	46.5	£1427.92	na	na	46.5	**£1427.92**
Discharge Lounge AGH	July	6	£196.02	11.5	£303.80	17.5	**£499.82**
Discharge lounge WRH	July	na	na	na	na	na	**na**
PDU	July	2801	£80,127	2699	£56,055	5.500	**£136,182**
Grand Total	July	2853.5	£81,750.94	2710.50	£56358.80	5,564	**£138,109.74**

Compared to June, we have seen a marginal increase in spend with Month 4 costs up by of £281.74p.

Escalation and Assurance Report

Report from: Nursing workforce / NWAG
Date of meeting: September 2025
Report to: Board

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Maternity leave**
Rating rationale	**Overall maternity leave remains stable – however, this continues to pose quality, safety and financial risks, as unable to formally substantively recruit (at risk) into maternity leave posts. Paper is being drafted for the substantive recruitment to maternity leave posts and is with finance for input. Reassurance has been given by finance that this is being prioritised as part of a push to move CPIPs towards delivery and this has now been returned to Workforce lead by finance for last amendments.**
Outcome	**Ongoing**
Item/Topic	**Additional capacity usage & costings**
Rating rationale	**Overall spend on additional unfunded capacity (surge areas and PDU) has seen a marginal increase this month of £281.74 due to slightly higher use of MSDEC at WRH. It is acknowledged that this is one area which continues to pose a financial risk to divisions and CPIP targets. This will be monitored as ongoing as we move into Autumn and Winter.**
Outcome	**To continue to be monitored**

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Vacancy**
Rating rationale	**July has seen a slight increase in both registered and unregistered vacancy, as we await the commencement in post of the newly qualified co-hort recruited in April. It is noted that HCA on-boarding has also slowed, despite a healthy pipeline and this has been acknowledged by recruitment team who will make this a focus in coming months. Following the increase seen in month 1 related to substantive funding and business cases. Recruitment pipelines for both groups remain strong with cohesive work being seen across all division to address the gap.**
Outcome	**Good level of assurance re pipeline and plans in place for increased focus on on-boarding of unregistered staff.**
Item/Topic	**Bank & Agency usage**
Rating rationale	**Overall nursing pay spend in July is £16.3m, an increase of 0.2m from June. £0.1m of this has be seen in substantive spend, mainly in medicine and relates to an increase in enhancements and costs associated with industrial action. Bank spend has also seen an increase of £0.1m month on month, reflecting an increase in bookings related to maternity / sickness and specialing. The focus remains to continue to build on agency reductions and to use recruitment trajectories to enable divisions to achieve traction in the reduction of bank usage.**
Outcome	**Ongoing monitoring including impact of unfunded additional capacity and waiting list initiatives**
Item/Topic	**Sickness**
Rating rationale	**Sickness levels for RN and HCSW have seen a slight rise in July (registered 0.18% and unregistered 1.43%) and remain above the Trust target. Focus will continue on staff sickness management and support, with health and well-being support being offered across all staff groups.**
Outcome	**Continued active management**

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: Nursing workforce / NWAG
Date of meeting: September 2025
Report to: Board

Assure: Including assurance items rated green	
Item/Topic	**Harms**
Rating rationale	**25 staffing related incidents have been reported, none resulting in patient harm. This is patent seen since the re-introduction of the 401 Senior Sister beep at WRH which supports with out of hours staffing and safety escalations.**
Outcome	**Good assurance noted**
Item/Topic	**Safer staffing fill rates & Care Hours Per Patient Day (CHPPD)**
Rating rationale	**Nurse staffing fill rates have met the national target across both day and night shifts for RN and HCSW shifts during the month and CHPPD remains stable and within the national variance limits**
Outcome	**Good assurance noted**
Item/Topic	**Turnover**
Rating rationale	**Turnover for RN remains below the Trust target and continues to reduce for nth registered and un-registered nursing Month 4.**
Outcome	**Positive reduction in turnover noted**

Advise: Items received for information or approval	
Item/Topic	**None**
Summary	
Outcome	

Alert: Including assurance items rated red and matters requiring escalation

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

Minutes for Quality Governance Committee

Thursday 28th August 2025 at 10.00 am
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director (Chair)	✓
Required Attendees	Sarah Shingler	Chief Nursing Officer	✓
	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	Apols
	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	**Apols**
	Chris Bryne	Healthwatch	✓
	Emma King	Director of Estates and Facilities	
Attending			
	Samantha Bucknall	EA to Chief Nursing Officer (minutes)	✓
	Nikki O'Brien	Deputy Chief Information & Performance Officer Digital Information	✓

Guest			
	Mike Cornes	Deputy Divisional Director of SCSD	✓
	Helen Harris	Associate Director of Nursing and Quality ICB	✓

Item	Title
QGC/25/1	**Welcome and Apologies for Absence**
	Ms Moore welcomed all present at the meeting.
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 31st of July 2025 were confirmed as a factual representation of the meeting and approved.
QGC/25/4	**Action Schedule**
	Actions reviewed and updated.
QGC/25/5	**Escalations from Chief Nursing Officer, Chief Medical Officer & Director of Midwifery for items outside of standard report / not on the agenda**
	No additional escalations were raised beyond the agenda items.
QGC/25/6	**Quality & Safety**
QGC/25/6.1	**Maternity Safer Staffing**
	Ms. Jeffery presented the July Safe Staffing Report, noting a slight increase in midwife sickness, improving turnover, and low vacancy levels—except within the MCA group, where six recruits are currently in progress. Due to rising acuity, staff have been redeployed more frequently, with additional support from community colleagues. A concern previously raised by the MCA group has been addressed and is expected to improve with the incoming staff. Ms. Jeffery also reported declining a national offer to convert Band 2/3 roles into Band 5 midwifery posts, citing financial implications and the importance of maintaining the current workforce model. Ms. Moore supported this decision and confirmed it will be escalated to the Board for awareness. Further discussion highlighted increased demand and acuity, with approximately 300 more admissions this quarter compared to the same period last year. Ms. Sinclair noted a rise in triage activity, particularly related to reduced foetal movement referrals and limited scanning availability. Ms. Moore stressed the need to evaluate whether current staffing levels are adequate, especially in light of national efforts to boost birth rates. She proposed a comprehensive review of workforce requirements and a rebasing exercise to define optimal staffing levels for safe, high-quality care, considering regulatory expectations and service complexity.

QGC/25/6.2.1	**Nurse Safe Staffing**
	Ms. Shingler presented the nursing staffing and performance report, covering July activity with data from June. Safe staffing levels were maintained across neonatal and adult inpatient areas. In paediatrics, although BAPHAM standards were not met for 100% of shifts, professional judgment confirmed the areas remained safe. Escalation areas from winter remain in use; however, there has been a reduction in overnight use of discharge lounges at Worcester and the medical SDEC for golden discharges. Agency and bank usage is decreasing, and the Trust remains on track to meet internal nursing CPIP targets—despite the continued operation of additional open areas. Maternity leave continues to present staffing challenges. Each division is now submitting proposals to the Trust Management Board to explore over-recruitment as a solution, with expected progress in the coming months.
QGC/25/6.3	**Emergency Quality & Safety Report**
	Ms. Shingler provided an update on the ED Safety Champion process, noting that the first visit took place the previous day and was positively received. The first formal meeting with the Divisional Management Team and safety champions is scheduled for tomorrow. In response to previous concerns about the time-consuming nature of the ED report, the Healthcare Standards Team has developed a KPI dashboard incorporating all relevant indicators. This will enable safety champions to identify areas off track and offer support on a monthly basis, with quarterly reporting into QGC for assurance to the Board. Ms. Moore asked about automation of the dashboard via electronic systems, and Ms. Shingler confirmed that a significant portion is being automated. Ms. Sinclair reflected on the initial visit, describing it as calm and largely positive. She noted that further refinement of the process may be needed, including adjustments to timing, and confirmed that feedback will be incorporated into the framework already established by Ms. Shingler.
QGC/25/6.4	**IPC Q1 Report**
	Ms. Watkins presented a positive Quarter 1 IPC report, noting ongoing pressures from winter-related infections and preparations for the NHSE visit on 16 September. Infection thresholds have been adjusted for the year, with MRSA remaining at zero tolerance—though one case was reported involving shared care with QE, prompting improved documentation between sites. Operational updates included plans to replace aging bedpan washers with macerators, with drainage and storage challenges being addressed. Food macerators linked to past CPE issues have been removed, and remedial work is underway with ISS. Cleaning accountability is being improved by replacing “I am clean” stickers with structured checklists. Additional work includes reviewing couch roll use, enhancing vascular device care, and introducing bed cradles to support hand hygiene at the point of care. Staff hand moisturiser is also being provided. A monthly IPC newsletter has launched, covering cleaning practices and device care, with the next issue focusing on catheter care. Ms. Moore welcomed the proactive approach and supported continued momentum ahead of winter.

QGC/25/6.5	**Fundamentals of Care Q1 Report**
	Ms. Shingler presented the Q1 report, noting the move to an exception and assurance format for clarity. One red-rated concern was highlighted around IPC, already escalated into intensive support. Amber-rated issues included ongoing mixed sex accommodation breaches in both ITUs due to bed pressures. Work is underway to improve patient flow, supported by divisional nurses and the quality matron. Falls prevention remains a concern, with compliance at 90% and an increase in overall falls—though not those resulting in harm. Monthly refresher training and online resources are in place, and increased audits and spot checks have improved visibility of compliance. The focus has shifted from reducing harm (down 60%) to reducing frequency, while balancing efforts to prevent patient deconditioning through mobility initiatives. Ms. Moore raised the potential for weight monitoring to be integrated into electronic records, allowing for dashboard tracking of ward-level compliance. This was confirmed as in progress. She also noted emerging technologies such as wearable airbag suits being trialled internationally to prevent falls in older adults. Concerns around staff relationships and neurodiversity adjustments continue to be addressed via the People and Culture Committee. Nutrition remains a priority, with repeat weight monitoring for complex patients still below required levels despite improvement.
QGC/25/6.6	**Blood Transfusion Q1 Report**
	Ms Walton presented the Trust Transfusion Committee report was presented, highlighting ongoing efforts to ensure the transfusion service remains safe and effective. Key areas of focus include a compliance and gap analysis review of the new transfusion safety standards, continued progress on actions following the infected blood inquiry, and a commitment to securing representation from the surgical division within the committee.
QGC/25/6.7	**Learning From Deaths Q4 Report**
	Ms. Walton presented the Q4 report from the Learning from Deaths Committee. The Trust's SHMI remains within expected limits. Previous concerns about rising SHMI at the Alexandra site have stabilised, now sitting just below the "above expected" threshold. Analysis suggests this variation is multifactorial, likely influenced by patient population, medical service profiles, and the transfer of high-acuity patients to Worcester, who still contribute to Alexandra's SHMI (Summary Hospital-level Mortality Indicator). It was noted that SHMI data lags by 6–9 months, limiting its usefulness as a real-time indicator. A general increase in SHMI across the Trust is also being monitored, with early analysis suggesting that SDEC activity may be impacting the metric. As SDEC is classified as outpatient care, it alters the denominator of the SHMI calculation by excluding lower-risk patients, which may contribute to the observed trend. This aligns with patterns seen in consultant episode data. Mr. Walton confirmed that no concerns have been flagged within any diagnostic groups. All Regulation 28 responses have been completed, with input from Ms. Shingler the nursing team, and the patient safety team. The committee's ongoing focus will be on SJRs, as mortality review processes are still not at the desired level. The report was concluded as a summary of current progress and priorities.
QGC/25/6.8	**Patient Experience & Engagement Report Q1 Report**

	Ms. Shingler reported an amber-rated concern regarding FFT response rates, with improvement work underway. Real-time inpatient surveys, over 1,000 monthly—are providing more actionable feedback, though may impact FFT participation. Green-rated areas include strong use of online accessibility guides, improved patient experience scores, and effective ward-level action planning. The "Big Quality Conversation" will launch in Q2. Volunteer numbers have doubled following a Board challenge, with the discharge response service expanding. Volunteers are increasingly supporting earlier patient discharge and have been positively received. Mr. Byrne noted Healthwatch is engaging with carers and patients, raising concerns about discharge planning and carer support, especially in ED. Ms. Shingler acknowledged these issues, noting upcoming changes to discharge responsibilities and the launch of Hospital at Home in October to support safe community care.
QGC/25/6.9	**Mealtime Patient Experience Report**
	Ms. Shingler shared an update on the adult inpatient mealtime experience improvement project, inspired by a visit to Leeds where VMI methodology was successfully applied at ward level. The Leeds team's engagement led to the commissioning of a similar initiative within the Trust, aligned with Regulation 28 concerns around nutrition and care planning. Led by Deputy Chief Nurse Alison Robinson, the project focused on five key areas: signalling mealtime with a bell, conducting safety huddles with ward staff, preparing patients appropriately, ensuring hygiene, and documenting food intake. These measures addressed gaps in nutritional care and patient safety, with audit results showing clear improvements and strong ward-level commitment. Ms. Moore asked about documentation of food intake, which Ms. Shingler confirmed is recorded on food charts at the patient's bedside. Ms. Moore suggested exploring AI-based tools that photograph meals before and after to assess consumption, potentially reducing staff burden and improving accuracy. Ms. Shingler agreed this could help remove subjectivity and welcomed further exploration.
QGC/25/6.10	**Quality Priority Q1 Report**
	Ms. Shingler provided an update following the publication of the Trust's 2024/25 Quality Account. The quality priorities have been refreshed in alignment with key performance indicators, reinforcing the link between quality and operational performance. A new dashboard reporting format has been introduced for quarterly updates to QGC, indicating whether each priority is on track, in progress, or off track. Early-year results show positive progress in infection prevention and control, mortality outcomes, and patient experience. Continued focus is required on patient flow, timely mortality reviews, and embedding improvements in patient assessments and communication—all of which have been discussed earlier in the meeting.
QGC/25/7	**Performance Reports**
QGC/25/7.1	**Integrated Performance Reports**
	Mr. Douglas was unable to present due to other commitments. The report was taken as read, with members invited to raise questions. Ms. Shingler highlighted ongoing improvement in complaints compliance, particularly the 25-day response target. Surgical services remain a challenge, but leadership and staffing changes are now in place, supported by additional resources. Compliance is expected to be achieved within the next 6–8 weeks.

	Ms. O'Brien provided updates on three key areas. Sepsis reporting is progressing toward an electronic solution, with a new form in development and testing. Implementation may be slightly delayed due to EPMA rollout, but the paper process remains in place and patient safety is not impacted. Breast cancer performance has improved in the short term, with work underway on a sustainable capacity model. Fractured neck of femur performance has also improved, reaching 59.9%—up from 35% last month—following changes in theatre management. While not a year-end figure, the team hopes this progress will be sustained through August.
QGC/25/8	**Governance and Risks**
QGC/25/8.1	**Risks (15 & above)**
	Ms. Shingler presented a comprehensive risk report, noting some duplication errors and confirming that nine risks rated 15 and above are currently assigned to QGC or to herself and Ms. Walton. Progress is being made on key risks, including cath lab equipment failure and systemic anti-cancer therapy manufacturing capacity. Nutrition nurse capacity remains a significant concern, with the lack of a complex nutrition team contributing to serious safety risks, including a Regulation 28 notice and multiple formal complaints. A business case has been developed, though challenges remain due to unrecorded activity and limited financial savings. The case will be submitted to Trust Management Board on Wednesday, with a formal request for approval based on safety grounds. If not approved, escalation to the Board via QGC may be necessary. The part-year financial impact is just under £180,000, and further work is underway with Ms. O'Brien's team to quantify expected outcomes. Ms. Shingler also noted delays in gastroenterology outpatient appointments. An ATR form is due to go through panel next week for an additional consultant post, with actions underway. She concluded by highlighting encouraging progress in divisional engagement with risk management. All risks noted in the report were actively discussed by divisions at FPE'S, reflecting a positive shift in understanding and ownership. While there is still work to do, the direction of travel is reassuring.
QGC/25/8.2	**Escalations from the Improving Safety Action Group**
	Ms. Shingler presented the escalation and assurance report from ISAG, noting that while the update was brief, it reflects meaningful progress. ISAG continues to serve as the forum where cross-divisional safety concerns are addressed collaboratively. Two key issues were highlighted: the ability to amend medical records, which has been picked up by the digital team and is expected to return to ISAG next month with a proposed solution, and medication labelling, which was escalated from the Medicine Safety Committee. These examples demonstrate that the governance processes led by Ms. Shingler and Ms. Walton are embedding well and functioning effectively. She added that it was reassuring to see how far the organisation has come in terms of risk management.
QGC/25/8.3	**Escalations from the Patient Safety Incident Review Group**
	Ms. Shingler presented a PSI investigation report concerning a 42-year-old patient who died following unrecognised hypotension and tachycardia. Key issues included missed escalation, poor documentation, and suboptimal management. A coroner referral is underway. The action plan reflects learning from previous cases and is monitored via ISAG.

	Committee members raised concerns about the adequacy of actions. Ms. Moore and Ms. Smart questioned the use of email in urgent clinical scenarios and called for stronger reinforcement of key safety practices. Ms. Harris noted that PSIRG had flagged the need for more robust, system-level actions. Ms. Sinclair raised concerns about clinical oversight and whether the patient's vulnerability had been fully considered. Ms. Shingler confirmed that investigations involve clinicians and divisional governance boards, with final sign-off through the Patient Safety Incident Review Group. She also assured the committee that both system-level changes and individual education have been delivered. Ms. Moore added that this case was particularly disturbing and asked that the assurance around individual learning be formally noted. **ACTION: Ms. Shingler to revisit the PSI action plan in light of comments raised by PSIRG, ensuring all learning has been fully addressed. Ms. Apps to contact Ms Harris to confirm next steps. The revised action plan will be resubmitted through Patient Safety Committee) once reviewed. Confirmation of coroner submission status to be clarified with Ms. Walton**
QGC/25/9	**Regulatory and Accreditation Reports**
QGC/25/9.1	**Professional Bodies Report**
	Ms. Shingler presented the standard quarterly update on referrals to professional regulatory bodies. As of the current reporting period, there are nine open cases with the NMC, four of which involve staff still employed by the Trust and remain under HR oversight. The oldest active case dates back to 2023. An additional five cases relate to former staff. For the Health and Care Professions Council, there are eight open cases, five of which involve current employees. From an assurance perspective, of the 17 registrants referred between 2021 and January 2025, 15 identify as white and one is recorded as having a disability on ESR.
QGC/25/10	**AOB**
	No AOB
QGC/25/10.1	**Next Meeting Date 25th September 2025**
QGC/25/11	**Reflections on the meeting**
	Ms. Moore reflected on the meeting, noting significant progress across multiple areas. She welcomed the decision to escalate midwifery staffing concerns to the Board, acknowledging that while the issue remains challenging, it is important that the Board is fully informed and engaged.
QGC/25.11.1	**Meeting closed at 11:27**

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 11 September 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 Review: Safeguarding**
Rating rationale	The review was rated significant assurance, with three medium and two low priority recommendations. Governance was robust but there were some concerns regarding training compliance driven by front line pressures. Recommendations reflected the need to improve this, particularly within the medical and dental workforce, and to monitor compliance in more granular detail to understand which areas required more focus.
Outcome	The Committee welcomed the overall positive report but recognised the challenges regarding training. **Actions:** • Review compliance targets for different areas, roles and levels of training to ensure this is appropriately targeted. • Append the report to the next safeguarding report to the Quality Governance Committee.
Item/Topic	**Annual Local Security Management Report**
Rating rationale	The report provided assurance on the Trust's compliance with the reduction in violence and aggression standard in 2024/25. The standard, which was introduced in 2020, was complex and required multi-disciplinary involvement. A full time Local Security Management Specialist had been appointed whose work included encouraging staff to report incidents. The Trust engaged with Foundation Group partners to share learning.
Outcome	**Action:** Review governance arrangements for local security management to ensure sufficient oversight without unnecessary duplication
Item/Topic	**Responding to External Audit Value for Money Recommendations**
Rating rationale	The report described the key changes that had been made and additional plans in place to improve the approach to ensure financial delivery for the current year. These included: • More support for operational teams to delivery plans. • Two new committees that would report to the Financial Recovery Board on productivity improvements and agency reduction. • A self-assessment against a new NHSE Grip and Control checklist and a new Well-Led Finance Toolkit. • NHSE intensive support for the agency reduction plan. • Mitigation workshops to return CPIP delivery to trajectory. • Review of business case benefits realisation, leading to potential disinvestment if appropriate. • An earlier planning process for next year, which would be the first of a three-year plan which was expected to be more effective than the one-year approach. There was confidence that the plans to hit the annual target were realistic; however, the proportion of non-recurrent schemes was likely to be high.
Outcome	The Committee was assured by the new arrangements, particularly the focus on collaboration across the ICS.
Item/Topic	Financial Governance
Rating rationale	• **Contract Management Report** The purpose of the report was to provide assurance on the contract management arrangements, including the replacement of contracts ahead of expiry, following the implementation and development of a register of all contracts to provide better visibility and oversight. • **Tender Waiver Report** The strengthened arrangements described above had contributed to a general improvement in procurement functions resulting in a lower volume and value of waivers in quarter 1 compared to the same period last year.
Outcome	The Committee was encouraged by the improvements and streamlining in contract management and procurement processes.

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: 11 September 2025
Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	**Emergency Preparedness, Resilience and Response (EPRR) Mandatory Core Standards Report**
Rating rationale	The Trust's annual self-assessment was *substantial compliance*. This included partial compliance with three standards, for which action plans were in place. There were no non-compliant standards. The position was an improvement on the previous year, reflecting significant progress over the last three years. A peer review had been undertaken by the Trust's ICS NHS trust partners and the ICB had reviewed the self-assessment. The Trust participated in testing exercises locally, regionally and with members of the Foundation Group. The Health and Safety Team was closely involved in the work, including a schedule of desktop and live fire drills and evacuation exercises at each Trust site.
Outcome	The Committee was assured by the self-assessment status of substantial compliance and the positive progress demonstrated since 2022.
Item/Topic	**Internal Audit Progress Report**
Rating rationale	Work was progressing according to plan. One report was on the agenda and three more were expected to be ready for the November meeting. Good progress was being made on recommendations from previous audits. The Trust had requested an additional review of NHS Professionals controls to provide assurance regarding pre-employment checks of agency staff. Preparations for the joint review with Herefordshire and Worcestershire Health and Care Trust on patient flow and discharge were progressing well. The review was expected to start in quarter 4. Once complete, the process and benefits of undertaking a joint review would be considered to identify any learning.
Outcome	The Committee welcomed the timely implementation of recommendations, was assured on progress of the plan, and approved the amendment to the annual plan with the additional risk-based review. **Action:** Ensure the Chief Operating Officers are involved in the joint review.
Item/Topic	**Counter Fraud, Bribery and Corruption Report**
Rating rationale	Contract performance to date was positive. However, the majority of days allocated to reactive work had already been used, so this would be reviewed. There had been 7 referrals since the previous report; the main theme was working whilst sick. New legislation was now in place imposing a corporate duty to prevent fraud.
Outcome	The Committee was assured by progress against the plan and the reactive work undertaken to ensure fraud risks were appropriately managed.

Items for Information	
Item/Topic	**Governance Developments: Provider Capability Assessment**
Rating rationale	The Committee was briefed on a new requirement launched in September as part of the NHS Oversight Framework. This required all provider boards to undertake a self-assessment against six domains for submission to NHSE, which would publish a capability rating in December. This would determine the level of support appropriate for each trust and was also likely to provide an indicator of readiness for foundation trust status. The Trust's self-assessment would be submitted to the Board for approval in October.
Outcome	Noted

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

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Boardroom , Alexandra Hospital
Tuesday 5th August 2025 at 10:00

Present		
Chair	Karen Martin (KM)	Non-Executive Director
Members	Ali Koeltgen (AK)	Chief People Officer
	Stephen Collman (SC)	Managing Director
	Chris Douglas (CD)	Chief Operating Officer
	Ed Mitchell (EM)	Deputy Chief Medical Officer
	Sue Smith (SSm)	Deputy Chief Nursing Officer
	Justine Jeffery (JJ)	Director of Midwifery
	Neil Cook (NC)	Chief Finance Officer
Attendees	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Sue Sinclair (SSi)	Non-Executive Director
	Simon Murphy (SM)	Vice Chair
	Louise Pearson (LM)	Associate Director (Nursing) Workforce and Education
	Rachael Hayter (RH)	Director of AHPs
	Liz Faulkner (LF)	Deputy Chief People Officer
	Rich Luckman (RL)	Assistant Director of People & Culture
	Richard Haynes (RHa)	Director of Communications & Engagement
(Staff Story item only)	Carol Deakin	HR Manager
Apologies	Sarah Shingler (SS)	Chief Nursing Officer
	Jules Walton (JW)	Chief Medical Officer
	Donna Scarrott (DS)	DAWN Network Chair
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Colin Horwath (CH)	Non-Executive Director
	Julie Moore (JM)	Non-Executive Director

	Chairs Welcome and Apologies for Absence	
	KM welcomed all attendees to the meeting and the apologies received were acknowledged above.	
	Quorum and Declarations of Interests	
	There were no additional Declarations of Interest pertinent to the agenda. Declarations of Interest are available on the Trust's website. KM confirmed that: a) A Quorum of the P&C was present. b) There were no declarations of interest.	
	Action Log and Minutes of the previous meeting	
	The minutes of the last meeting held on the 3rd June 2025 were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly.	

	Staff Story – Reasonable Adjustments	
	CD presented the slides shared that detailed the importance of reasonable adjustments for staff, as well as examples of a positive experience and one where learning was identified. A task and finish group has been arranged (including the DAWN Network Chair) and will develop a SOP that will include training and a step-by-step guide for managers. The group is also liaising with Occupational Health and the Staff Psychological service regarding neurodiversity support. It was suggested that the Trust could utilise SOPs already in use across the Foundation Group, and AK explained the benefits of the task and finish group in allowing the Trust to understand common issues being experienced. KM acknowledged potential employment tribunal costs but emphasised increased sickness absence, the impact on the individual's wellbeing and their faith in the Trust, and this then influencing the culture and other colleagues. SC suggested exploring the numbers of staff groups coming forward to request reasonable adjustments, for example, where many are requesting specific software for dyslexia, this could be made readily available. AK explained formal complaints from staff regarding reasonable adjustments are rising, with MS adding that disability is now the second most common protected characteristic relating to FTSU concerns. SS also noted the issue of equality versus equity in terms of the colleagues of staff who have reasonable adjustments.	
	Staff Network Updates: DAWN Network	
	The Neurodiversity toolkit is now complete and will be available by mid-September. Work has commenced on a Neurodiversity Hub and a support group will also be created. The Network are working with the OD team to better understand staff's experience at work and felt that more promotion of the Network would be beneficial. The Terms of Reference for all Networks have been standardised and a schedule will be created to hold elections for Network Chairs over the next 12 months. AK cautioned against normalising a 6-month timeframe to make reasonable adjustments available and added that the Workforce Disability data from the staff survey shows staff with a disability to have a poorer experience of working in the Trust. AK highlighted the need for sponsorship and support from allies and to diversify the group and make more improvements based on staff experience. KM suggested sharing the dates of the Network meetings. SC highlighted the use of the word disability, despite the Network's name change to "diverse ability". SC suggested there could be an over-reliance on the Networks which are staff-led, to meet the Trust's EDI objectives. AK responded that the Trust has a comprehensive EDS22 action plan and WDES submissions that are submitted to the Committee.	
	Chief People Officer Report	
	AK highlighted the key points of the report. The BMA have a mandate that further industrial action can be taken at any point until January with little notice. Recent industrial action was timed to coincide with August rotation and annual leave however the Trust coped well, with no derogations and minimal cancellations. The RCN and Unite have rejected the 3.6% pay offer which could escalate. The 10-year plan has been published, and a workforce plan is expected to follow and will focus on digital, productivity and efficiency. Tighter control on apprenticeship funding and increased costs for overseas workers will mean the Trust will need to review its domestic supply and funding to grow staff skills. There continues to be pressure to reduce sickness absence, and the Trust is holding a workshop to explore the opportunities available and any new approaches. SSi queried if band 3 overseas	

applications are common and AK explained spousal applications are becoming more common.

AK advised that the Trust has now been notified that its offer to move band 2 Healthcare Support Workers to band 3, alongside a recognition payment has been accepted by Unison and the RCN. AK confirmed that there will still be band 2 roles within the Trust dependant on how the job description aligns to the national profile. AK noted that there has been sustained industrial action in Gloucestershire Hospital where Phlebotomists have not been uplifted to band 3.

People Strategy (People Experience Pillar)

RL reported progress on all previous commitments. The Women's Network began in early 2025, with strong attendance and collaboration with EmbRACE and LGBTQ+ Networks. Kindness into Action training is ongoing to promote respectful resolution, with 214 staff trained in July and 446 more scheduled. Following feedback, OD and HRBPs identified further candidates, but only 10-15% have responded. The latest staff survey found 81% aware of Trust values and 71% living them daily.

The Anti-Racism charter launches in November, involving all Networks. Planning for this year's Staff Survey is in progress, with WAHT aiming to be an early adopter. Supported Internships for young people with learning disabilities received positive feedback, and Long Service Awards saw 144 attendees at recent events. Sexual safety in healthcare training became mandatory in April 2025; compliance reached 86% by June. SC highlighted the need for better data tracking, such as monitoring grievances over employment tribunals, and suggested managers adopt goals to improve staff experience.

RH noted concerns about unkind behaviour during discussions of manager training attendance. AK observed that some individuals act unkindly even after completing civility and respect training. KM and AK highlighted the need for a balanced and firm, yet confidential approach to enforcing zero tolerance for unkindness. **Action: AK to explore management options going forward.** SC proposed sharing anonymised examples via Exec Live, and SS commented that those in authority, such as Doctors, are less likely to face consequences for poor behaviour.

Freedom to Speak Up Report (Quarterly)

The number of concerns being raised continues to rise, however those that are anonymous are decreasing. MS felt there needed to be improvement with follow ups this is also the focus of FTSU week this year. Compliance with Speak Up training continues to rise as well as the number of people expressing interest in becoming a FTSU Champion. There has been an increase in the number of concerns relating to disability and race. The National FTSU is stepping down and will not be replaced, however local FTSU Guardians will remain.

Due to a revamp of Trust Induction and the introduction of FTSU training as mandatory for all staff, the FTSU section will become more focussed on how staff can raise concerns and include a QR code to the portal.

SSi noted the number of staff who have raised concerns that would prefer not to state their ethnicity. MS explained that it is important that staff understand why this data is collected, and that currently, the portal reflects the National Guardian's office, however there may be some flexibility with this moving forward which could allow some text to be added that explains this to staff. SC agreed that this is concerning, and AK agreed that some staff will not feel safe to, whereas some may not want to be identified.

Job Planning

A medical job planning improvement guide has been circulated by the NHS and the action plan details the Trusts response. The Trust has already implemented Allocate software to assist with job planning, and smaller actions will now be worked on such as aligning job plans to the activity cycle of the organisation starting as of the 1st April. Efforts will then be made to align the Trust's performance and activity with the goals in approved job plans. The team will continue to focus on reducing the number of consultants working for example 15PAs per week due to risks to the individual's wellbeing and to the Trust. Other mechanisms are in place for those that wish to continue working this many hours.

SSi raised concern regarding surgery, and consultants completing appraisals without an appropriate job plan in place. KM asked whether the Trust can now benchmark its job planning compliance against other Trusts and EM was not aware of the data but agreed it would be beneficial to see. KM reiterated previous concerns regarding lack of assurance and express some caution as to whether the action plan can be completed by the due date. AK added that there had been some clarification post the Trust's submission and that some national data may be forthcoming. NC stressed the need for better transparency in job planning over the past year. LF identified a monitoring gap and noted ongoing work on national action plans aimed at improving oversight for the Trust. Full e-rostering implementation and clearer application of the Annual Leave policy will enhance productivity visibility. SSi suggested to proceed with caution, as some Consultants might be working beyond their compensation.

Medical Agency Reduction

AK explained the need for more formal governance and closer monitoring. A new Agency Reduction Programme Board is proposed to report to Financial Recovery Board. This will enable clear reporting of trajectory by Divisions, alignment to CPIPs and identifying gaps. To avoid duplication, KM agreed to continue updates via the Chief People Officer report, with any areas of concern being escalated. AK clarified that the new programme board will also include Nursing agency for oversight.

AHP Workforce Strategy

The new AHP Workforce strategy aligns to the National strategy for AHPs and the NHS Long term Workforce Plan (2023). Commencing reporting to NWAG has allowed monitoring of turnover, vacancies, sickness, mandatory training and appraisals. The national strategy outlines enhanced foundations that need to be considered such as championing diverse and inclusive leadership, having AHPs in the right place at the right time with the right skills, research innovate and evaluate, and harness digital technology.

RH outlined the actions to be taken to train, retrain and reform the AHP workforce. Further improvement can be made in career advancement for AHPs by recognising diversity of skills, having quality appraisals, access to training programmes and strong links with universities. Teams have contributed to the strategy and the final version will be shared with them. AHPs will continue to work across the wider multi-disciplinary teams and share what works well with each other. The Trust will look to achieve the AHP National Preceptorship Quality Mark, improving support for international AHPs and researching the AHP integration project with the university of Worcester.

SC commented that where beneficial, some elements will be merged with Nursing roles, but some will remain distinct. SSi noted concern regarding lack of AHP representation at divisional and Board level and RH felt that considerable progress

	had been made recently and that they felt support for AHPs. AK added that vacancies and turnover has reduced from 16.8% to 10.5%.	
	Education Board Update	
	The Education Board has operated for 18 months. The We Care programme is available to all healthcare support workers, and collaboration with the AHPs corporate team continues towards achieving the preceptorship quality mark for AHPs, Nursing, and Midwifery. T Levels will launch in September 2025 with local colleges. CPD funding increased from £800k last year to £955k this year, though study leave requests are relatively low. One Midwife and one AHP are pursuing PhDs. Clinical placement capacity, especially for Midwives, is being expanded due to around 20 students needing additional births for qualification. The professional development team supports EPMA, and a multi-professional educator group now reports to the Education Board. The Education Hub is live on the intranet; an Education App launches in October. The Safe Learning Environment Charter awaits TMB approval for its November launch. "People's Alchemy," a new training platform, will replace paper forms this winter. Work has begun on an Education Strategy for the Trust.	
	Governance	
	People & Culture Risk Register There remains 2 risks above 15 on the register. At the last meeting, it was noted that there was no assurance on either of the risks. The risks have been reviewed and whilst it is felt that level 16 is still necessary, there should be more assurance regarding how plans are progressing. The thresholds should be considered as to when the risks will be eligible to be downgraded and KM suggested that the gaps in controls should be reviewed as to whether a reduction in risk score is necessary. EM clarified that the risk of medical industrial action is located on the corporate risk register and **the location of Nursing industrial action risk will be confirmed.**	
	Any Other Business (AOB)	
	None raised.	
	Date of Next Meeting	
	The date of the next meeting is Tuesday 7th October, Colab Kidderminster Treatment Centre.	

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Private Board**
Date of Meeting:	**14/10/2025**
Title of Report:	Responsible Officer Report
Lead Executive Director:	**Chief Medical Officer**
Author:	Kira Beasley, Head of Chief Medical Officer
Reporting Route:	People & Culture Committee
Appendices included with this report:	Appendix 1: Submission to NHS England
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

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

Completion of the report will therefore:

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

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

c) act as evidence for CQC inspections.

Recommended Actions required by Board or Committee

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

Executive Director Opinion[1]

We continue to make improvements to the responsible officer function, including the job planning committee and medical professional standards group. We are in the process of developing KPI's to allow monitoring and early identification of issues / delays.

We are actively succession planning for our current Deputy Appraisal and Revalidation lead.

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

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

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

Section 1 Qualitative/narrative

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

Reporting period 1 April 2024 – 31 March 2025

1A – General

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

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

Y/N	Yes
Action from last year:	Ensure RO training is up to date.
Comments:	Refresher RO training has been completed.
Action for next year:	Ensure Deputy Chief Medical Officers are appropriately trained.

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

Y/N	Yes
Action from last year:	Continue to work closely with the Medical Resourcing team to ensure processes are streamlined.
Comments:	We have made significant progress this year, but we continue to develop new, streamlined processes.
Action for next year:	Continue to embed streamlined processes and advisory group.

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

Y/N	Yes
Action from last year:	New Medical Practitioners linked to the Trust to be notified to the RO monthly to ensure an introductory letter / meeting are enacted.
Comments:	Ongoing work with the medical resourcing team. We now have a monthly update of new practitioners.
Action for next year:	Embed the welcome letter, and induction process for new consultants.

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

Y/N	Yes
Action from last year:	Job plan reviews, including the amendments to SPA to be implemented / actioned across the Trust.
Comments:	This has been actioned and embedded.
Action for next year	Continue to work with our medical leadership teams to reduce job plans over 12 PA's.

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

Y/N	No
Action from last year:	Maintain and improve the RO group, including attendance and recording of decisions.
Comments:	This has been actioned, and we are working to improve the record keeping / availability of the RO group.
Action for next year:	Review the terms of reference for the RO Group. Audit of the current processes / information discussed at the RO Group .

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

Y/N	Yes
Action from last year:	Ensure that relevant induction processes and governance is in place.
Comments:	There is a Trust wide process for induction of all doctors. Locum doctors whose appraisal is due during their placement with us are supported to undertake their appraisal and provided with any relevant information. Where appropriate, feedback on the doctor's performance is provided to the relevant responsible officer.
Action for next year	Continue to monitor these processes trust wide.

1B – Appraisal

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

Y/N	Yes
Action from last year:	Complaints, and significant events information is being sent to individual doctors prior to appraisal by the appropriate team.
Comments:	Independent quality reviews of appraisals are undertaken by the Appraisal and Revalidation Lead to ensure standards are maintained and any issues / themes are dealt with appropriately. Complaints and significant events information is being disseminated appropriately prior to a doctor's appraisal to allow for reflection and learning.
Action for next year:	Inclusion of criteria such as productivity and clinical outcomes in appraisals (based on model hospital data)

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

Y/N	Yes
Action from last year:	Not applicable
Comments:	There is a process in place for reminding doctors when their appraisal is due, escalation to the deputy appraisal lead and responsible officer where appropriate.
Action for next year:	Not applicable

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

Y/N	Yes
Action from last year:	Continue to ensure that the policy is updated with any new national guidance releases.
Comments:	Policies in place and reviewed annually
Action for next year:	Continue to monitor and review national guidance to embed any amendments to policy if required.

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

Y/N	Yes
Action from last year:	Continue to monitor the number of prescribed connections and appraisers to ensure needs are appropriately met.
Comments:	The requirement for appraisers has increased due to the number of prescribed connections within the Trust. There is ongoing recruitment and training of appraisers. Our appraisers undertake 7 or 8 appraisals per annum.
Action for next year:	The current appraisal and revalidation lead is retiring in March 2026. Recruitment of a new appraisal and revalidation lead, linked to the deputy chief medical officer.

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

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

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

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

Y/N	Yes
Action from last year:	Assurance to be provided more regularly at the Medical Professional Standards Group, which will report by exception to the People and Culture Committee.
Comments:	Quality Assurance of appraisal outputs undertaken and will be reported going forward. Annual Medical Appraisal and Revalidation report is submitted to the Trust Board and People and Culture committee to provide assurance.
Action for next year:	Audit of the current processes

1C – Recommendations to the GMC

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

Y/N	Yes
Action from last year:	Continue to work with the GMC and ensure all recommendations are documented appropriately following discussion at the RO Group.
Comments:	Recommendations are made to the GMC in a timely manner & regular meetings with the ELA in place. All recommendations to the GMC are discussed at the responsible officer group to ensure all appropriate action has been taken.
Action for next year:	Embed co-ordination of appraisal information with appraisal and revalidation team to ensure sufficient information requirements are met for timely revalidation recommendations

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

Y/N	Yes

Action from last year:	Continue to ensure the GMC recommendations are feedback to the doctor before submission.
Comments:	RO standard procedure is to confirm deferrals in writing with doctors. Trust process for non-engagement is followed, including communication with doctor and the GMC.
Action for next year:	Ensure appropriate communication and welfare support is provided to doctors where recommendations to the GMC are made.

1D – Medical governance

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

Y/N	Yes
Action from last year:	Continue to express the importance of involvement in the governance processes. Feedback to individual clinicians regarding complaints and Serious incident involvement to be sent to doctor's prior to their appraisals for review and discussion with appraisers.
Comments:	Clinical governance processes are in place and are supported by clinical governance teams in each division. Clinicians are regularly invited to be involved in clinical governance.
Action for next year:	Include clinical outcomes via model hospital data in appraisal information

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

Y/N	**Yes**
Action from last year:	Conduct and performance issues are discussed at the responsible officers group, we will continue to action where required and ensure decisions are logged.
Comments:	We have a policy for managing performance and conduct within the Trust and is in line with Maintaining Higher Professional Standards. We

	have implemented a responsible officer advisory group to ensure monitoring.
Action for next year:	Continue to discuss conduct and performance at the Responsible Officer group, ensuring appropriate action is taken and feedback to the relevant clinician is given

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

Y/N	Yes
Action from last year:	Centralised report to be produced for each doctor individually to support their appraisals.
Comments:	We provide all relevant information to doctors for appraisals
Action for next year:	Reduce number of deferrals due to insufficient information by ensuring information is available in a timely manner

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

Y/N	Yes
Action from last year:	Capability, conduct, health and fitness to practice issues are discussed at the responsible officers group as part of the medical professional standards committee, we will continue to action where required and ensure decisions are logged.
Comments:	Implementation of the responsible officer group, investigations are conducted in line with policy

Action for next year:	Continue to action and monitor responding to concerns in line with Trust policy

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

Y/N	Yes
Action from last year:	Newly formed Responsible Officer group will provide quality assurance, will report to the People and Culture committee and Trust Board annually.
Comments:	Annual reports to the People and Culture committee, including quality assurance
Action for next year:	KPI's for MHPS Investigations to be developed and reported to the responsible officer group

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

Y/N	Yes
Action from last year:	None
Comments:	Appraisal and Revalidation Team support the completion of MPIT forms on behalf of the Responsible Officer to transfer information. If urgent the RO will contact the other RO.

Action for next year:	Monitoring of KPI's related to MPIT requests including timeliness of connections

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

Y/N	Yes
Action from last year:	Monitor through Medical Professional Standards Group, report annually to People & Culture / Trust Board.
Comments:	The medical professional standards group provides oversight and governance to ensure the response is fair and consistent.
Action for next year:	Continue to monitor and assess safeguards and clinical governance arrangements through the medical professionals group. Introduce KPI's.

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

Y/N	Yes
Action from last year:	Continue to engage, learn and implement opportunities for improved governance.
Comments:	The Trust has implemented the new patient safety framework (PSIRF) which is reported weekly. National Patient Safety Alerts and Regulation 28 (local and regional) have also been integrated. The Trust has engaged with GIRFT and NCEPOD audits & reviews.
Action for next year:	Continue to engage, learn and implement opportunities for improved governance.

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

Action from last year:	Review the Messenger report, undertake a gap analysis and action as appropriate.
Comments:	We have implemented new Trust values and leadership development through the Chief People Officer.
Action for next year:	Review medical leadership structure and introduction of leadership development specifically aimed at our medical leaders

1E – Employment Checks

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

Y/N	Yes
Action from last year:	To ensure that the process for checks prior to employment for both doctors in training and non-training are completed in a timely manner to prevent delays / restrictions when commencing in post.
Comments:	Processes are in place to ensure minimal delays / restrictions. Internal audit has been completed.
Action for next year:	Continue to monitor pre-employment checks to ensure there are minimal delays and restrictions

1F – Organisational Culture

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

Y/N	Yes
Action from last year:	Embedding of Exec Rounding into the Trust. Improving the response rate to the NHS Staff Survey. Introduce See Me, Rainbow Badge and Listen Up Training. Further CMO and Clinical Leaders engagement with teams.
Comments:	Staff survey for 2024, 46% overall response rate (3,485 responses), 15% increase year on year, equating to 57% more respondents compared to 2023.Training on Rainbow badge and Listen Up has continued along with training and support on Active bystander, Sexual Safety in Healthcare and putting our Values into action.
Action for next year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict. Launching the Anti racism charter, embedding this approaching into our work and polices and procedures.

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

Y/N	Yes
Action from last year:	Launching and embedding our new Trust Values into the Trust. Improving the response rate to the NHS Staff Survey. Introduce See Me, Rainbow Badge and Listen Up Training.
Comments:	Staff survey for 2024, 46% overall response rate (3,485 responses), 15% increase year on year, equating to 57% more respondents compared to 2023. We've launched our new Values and Behaviours this year. Involving over 500 of our people to help make them authentic and meaningful.
Action for next year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict. Launching the Anti racism charter, embedding this approaching into our work and polices and procedures.

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

Y/N	Yes
Action from last year:	Regular FTSU updates on concerns/themes and resolution to Divisions through FTSU/HRBP Monthly Divisional updates. Introduce See Me, Rainbow Badge and Listen Up Training. Development of a new Early Resolution HR policy.
Comments:	We've launched our new Values and Behaviours this year. Involving over 500 of our people to help make them authentic and meaningful. Training on Rainbow badge and Listen Up has continued along with training and support on Active bystander, Sexual Safety in Healthcare and putting our Values into action. The NHSE early resolution policy has not been launched as yet.
Action for next year:	Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict. Launching the Anti racism charter, embedding this approaching into our work and polices and procedures.

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

Y/N	Yes
Action from last year:	Ensure that professional standards are communicated with doctors frequently, any concerns can be raised with the Chief Medical Office or Divisional Leadership teams by any doctor or doctor in training.
Comments:	Feedback is gathered through the appraisal process. Formal complaints procedure is available for all staff.
Action for next year:	Continue to embed professional standards, including appropriate communication regarding any changes

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

Y/N	Yes
Action from last year:	Continue to monitor & assess the parity in concerns, investigations and disciplinary processes.

Comments:	None
Action for next year:	Continue to monitor & assess the parity in concerns, investigations and disciplinary processes as part of the Responsible Officer Group.

1G – Calibration and networking

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

Y/N	Yes
Action from last year:	Engage with other responsible officers within the foundation group to provide peer reviews.
Comments:	The responsible officer attends network meetings and regular meetings with other responsible officers within the foundation group.
Action for next year:	Explore options for cross group responsible officer committee to ensure consistency

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	602
Total number of appraisals completed	467
Total number of appraisals approved missed	0
Total number of unapproved missed	44
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	143
Total number of late recommendations	3
Total number of positive recommendations	131
Total number of deferrals made	12
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	17
Total number of trained case managers	13
Total number of concerns received by the Responsible Officer[2]	6
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March (working days)	1047
Median duration of concerns processes closed (working days)[3]	233
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	2

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

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

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	94
Total number of new employment checks completed before commencement of employment	557
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

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

General review of actions since last Board report

There has been a high level of activity within the Trust, including the introduction of our new values / behaviours. These were developed with staff feedback to ensure sufficient engagement with staff.

A new medical leadership group has been formed, giving the Chief Medical Officer an opportunity to discuss Trust priorities with medical colleagues and ensure our doctors voices are heard. This also provides an opportunity for two-way communication, education and development with our medical workforce.

The appraisal and revalidation team remain as a vital part of our workforce, providing appropriate support to the RO and Appraisal and Revalidation Lead.

Quality assurance checks of appraisals have been completed by the Appraisal and Revalidation lead. These are discussed at the appraiser networking meetings.

Actions still outstanding

- None

Current issues

- The retirement of the current appraisal and revalidation lead, and recruitment of a 2nd Deputy Chief Medical Officer could cause issues if there are no suitable applicants.

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

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

- Ensure Deputy Chief Medical Officers are appropriately trained.
- Continue to embed streamlined processes and advisory group.
- Embed the welcome letter, and induction process for new consultants.
- Continue to work with our medical leadership teams to reduce job plans over 12 PA's.
- Review the terms of reference for the RO Group.
- Audit of the current processes / information discussed at the RO Group
- Continue to monitor induction processes for locum or short term doctors processes trust wide.
- Inclusion of criteria such as productivity and clinical outcomes in appraisals (based on model hospital data)
- Continue to monitor and review national guidance in relation to medical appraisal to embed any amendments to policy if required.
- Recruitment of a new appraisal and revalidation lead, linked to the deputy chief medical officer.
- Continue to engage with our medical appraisers.
- Audit of the current processes for appraisals
- Embed co-ordination of appraisal information with appraisal and revalidation team to ensure sufficient information requirements are met for timely revalidation recommendations
- Ensure appropriate communication and welfare support is provided to doctors where recommendations to the GMC are made.
- Include clinical outcomes via model hospital data in appraisal information
- Continue to discuss conduct and performance at the Responsible Officer group, ensuring appropriate action is taken and feedback to the relevant clinician is given
- Reduce number of deferrals due to insufficient information by ensuring information is available in a timely manner
- Continue to action and monitor responding to concerns in line with Trust policy
- KPI's for MHPS Investigations to be developed and reported to the responsible officer group
- Monitoring of KPI's related to MPIT requests including timeliness of connections
- Continue to monitor and assess safeguards and clinical governance arrangements through the medical professionals group. Introduce KPI's.
- Continue to engage, learn and implement opportunities for improved governance.
- Review medical leadership structure and introduction of leadership development specifically aimed at our medical leaders
- Continue to monitor pre-employment checks to ensure there are minimal delays and restrictions
- Improve our culture by embedding our new Values into our everyday practice. Encouraging feedback and facilitated conversations to resolve workplace conflict.
- Launching the Anti racism charter, embedding this approaching into our work and polices and procedures.
- Continue to embed professional standards, including appropriate communication regarding any changes
- Continue to monitor & assess the parity in concerns, investigations and disciplinary processes as part of the Responsible Officer Group
- Explore options for cross group responsible officer committee to ensure consistency

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Significant progress has been made within the Trust over the previous 12 months. The Medical Professional Standards Group has been successful in ensuring appropriate action is taken and we will be developing KPI's to ensure appropriate compliance with Trust policy. Quality checks of appraisals have allowed for feedback, learning and engagement of our appraisers. We will continue to engage with our consultants to ensure our processes are embedded and suit the needs of our organisation.

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

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

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**14/10/2025**
Title of Report:	Patient and Public Forum bi-annual report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Rosemary Smart, Chair of the Patient and Public Forum, Kimara Sharpe, Vice Chair, members of the Patient and Public Forum (PPF) and Anna Sterckx, Head of Patient, Carer and Public Engagement.
Reporting Route:	Trust Board
Appendices included with this report:	Patient and Public Forum report and the Terms of Reference Hearing Loop Report PPF Work Plan
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

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

The Patient and Public Forum Terms of Reference states that the PPF Chair and Chief Nursing Officer will provide a twice-yearly report to the Trust Board outlining the business of the Forum and progress made against development and delivery of the Patient Voice and Involvement Strategy.

Recommended Actions required by Board or Committee

To NOTE the progress made with the ongoing development of the Patient and Public Forum in terms of activity, partnership with the Trust and community engagement, in particular the Hearing Loop report and standard of Outpatient letters.

Executive Director Opinion[1]

The PPF is an active and dedicated group who meet regularly and support a wide range of activities within the Trust. The group is growing in numbers and the activities allow triangulation. The group are keen to work alongside VSCE colleagues moving forward.

[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.

Patient and Public Forum bi-annual report: October 2025

1. Purpose of the report

The Patient and Public Forum Terms of Reference states that the Patient and Public Forum Chair and the Chief Nursing Officer will provide a twice-yearly report to the Trust Board outlining the business of the Forum and progress made against development and delivery of the Patient Voice and Involvement Strategy. The first report was presented at the April 2025 Trust Board meeting.

Executive summary

The Patient and Public Forum (PPF) is an autonomous diverse group representing our patients and the people of Worcestershire.

Our purpose is to act as a critical friend to the Trust with a view to improving patient experience and supporting our staff. This is achieved in many ways. Committee representation, supporting the Trust with the ward accreditation programme, clinical and estate audits are some of our many activities listed in the report.

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

Report

We currently have 17 members. Two of our new members however have paused with starting in role for personal reasons. We are hopeful that they will join us in soon. We are meeting a new prospective member in early October.

This compares with 12 active members in April (at first reporting to Trust Board) and 2 further members on sabbatical for health reasons in December 2024.

Following a focused recruitment drive, we now have members in their 20s, 30s and 40s, as well as members 50+. Our members come from a variety of backgrounds, and are students, in work and retired. Some of our members have physical disabilities and hidden disabilities.

All PPF members are Trust registered volunteers who complete mandatory training and an enhanced DBS before being accredited.

One member has continued in their role as a Patient Safety Partner. A new PPF member has joined them in this role (starting in September) as the Trust's second Patient Safety Partner. These roles are carried out in addition to their role as a PPF member.

Members meet bi-monthly with the Trust at formal meetings. At these meetings, the PPF value the conversation with Trust members, which members feel gives rise to a better outcome for our patients. The PPF also have member meetings in between, to plan and monitor their work schedule. A work plan was developed at the beginning of the year (attached in the appendix of this report).

There are two action logs generated within PPF activity – one is generated through the formal meetings with updates provided at those meetings and a "You Said We Did" log to track actions raised outside meetings and support with feeding back.

Activities overview from April – September 2025:

- Active engagement with 17 Committees and steering groups

- Active participation in 34 Audits, Walkarounds and Visits
- **Committees:** SCSD board meeting, DREAMS, Women's and Children's, Discharge Response Steering group**,** Nutrition and Hydration, Quality Governance Committee, Fundamentals of Care Committee, Strategic Programme group, Dementia Steering Group, Hospital at Home weekly Steering Group meeting, AI Ethics, Executive Risk Management, Patient Carer and Public Engagement steering group, TIPCC, Digital, Transitional Steering group and Patient Safety Incident meetings.

April 2025:

- **Audits:** Care Excellence Accreditation (CEA) visit to Acute Frailty, Personal hygiene audit WRH and at ALX, and Safety Walkaround theatres Worcestershire Royal
- **Patient Experience week** engagement
- **Review of the Quality Account**

May 2025

- **Audits**: Hearing Loops at the Alexandra Hospital, Care in the Corridor WRH ED and Post Falls Assessment
- **Visits:** Hazel and Aconbury, Outpatients: Linden Suite
- **Reviewing patient leaflets**
- **CEA & QAV:** Riverbank and Neonatal unit
- **Safety walkaround:** ALX AMU
- **Workstream meetings**: Hospital at Home Clinical Operational Workstream and Director of Estates and Facilities to progress the dropped kerb

June 2025

- **Visits**: SDEC, CEA QAV visit to Head and Neck Unit
- **Meetings**: Single Point of Access steering group, Foundation Chairs' meeting and Communication Passport
- **Audits and surveys**: Hearing loop audits WRH and KTC, Pharmacy Planning and Care in the Corridor at WRH and at ALX and Visiting Times survey.

July 2025

- **Meetings:** UEC Transformation Steering group, Hospital from Home Weekly action group, IT and Waiting Boards in ED, Frailty and Data IT.
- **Audits:** CEA/QAV audit of Aconbury 4 and Hazel wards, Safety walkaround and Care in the Corridor ED WRH, Trauma Clinic Larkspur, Acute Respiratory Unit and Leadership and Safety workaround
- **Visits:** Mulberry Unit

August 2025

- **Audits**: Safety Walkaround Beech Trauma, WRH

September 2025

- **Audits**: CEA – Gynaecology Clinic Review, Care in the Corridor – WRH A & E, Safety and Leadership Walkabout – Laurel
- **Co-Production:** Healthwatch / Sensory Matters, Conference planning and delivery
- **CNO stakeholder** shortlisting and interviews

Achievements:

- **Monitoring outpatient Trust cancellation rates**. This is a major project initiated by a PPF member, which reviews the appointments cancelled by the Trust which is proportionately a large number. Most data presented to other meetings concentrates on the cancellations by patients. We are pleased this is now on the Trust's agenda. There was a slight reduction in the last figures – still a long way to go.

- **New AccessAble Guides** for KTC show the line (instigated by the PPF) to navigate people to Ophthalmology.
- **10 out of the 11 actions raised by the PPF outside meetings have been closed** July-September – one of the achievements was that requested for signage in lifts and corridors travelling to Aconbury 4, was delivered. One action remains open as this relates to wider developments with the new Trust Induction – to include *Communication* and *Reasonable Adjustments*.
- **Two members completed a hearing loop audit in** 47 Outpatients and Reception areas across the three sites. A report has been presented to Estates and Facilities and a meeting expected in October.
- **Co-production** of new signs to welcome "Accredited Assistance Dogs" – signs have been delivered and are in the process of going up across sites – this was preceded by a new Trust Policy on Animals in a Healthcare Setting.
- **In line with the Patient Voice and Involvement Strategy** and development with the Terms of reference, external organizations were invited to the PPF meeting in September – Healthwatch and Age UK. This supports a link with the local community and provides a mechanism to understand the patient experience as well as potential joint working.
- **Subject Access Requests and Freedom of Information**: the PPF instigated a process change to support people to have to only apply once for both their clinical files and their images. The PPF are pleased with the very effective, quick response from the Trust.

Areas for Improvement :

- There have been improvements in speed of responding to actions, however this is spasmodic.
- The Stroke Pathway which is being developed at present with the Herefordshire and Worcestershire Health and Care Trust still does not cover the oversight of patients at Evesham Rehabilitation ward, out of hours or having adequate Stroke proficient nurses on at weekends. The PPF has feedback that the initiation of twice weekly Stroke Consultant visits to the rehabilitation unit has been much appreciated by some members of staff there.
- Review of outpatient letters. The PPF were engaged in the review of letters through the Outpatient Transformation Programme two years ago. Despite requests, they did not see the completed outcome of this work. Recently a number of our members or relatives have received letters requesting attendance at Outpatients and we note that the templates are very different from each other and one even referred to COVID restrictions.

If we are involved in something or share feedback and ideas, we always want to be updated and understand what the outcome is. This relates to all PPF activity and we would appreciate if it were more timely and consistent.

- The PPF are volunteers and we can have issues with ability to undertake some tasks due to lack of capacity. To support this we have recruited more members. We have a process in place to support new members to help their induction, which can mean that processing and welcoming a new member can take some time. We are pleased that we have a third member who we are due to meet shortly.
- Members access engagement opportunities through a Teams channel. However, despite numerous methods to support members to access this, the Channel seems to work differently on different devices. Training sessions and alternatives have not resolved the issue for some members.

Risk:

- We are concerned with the abolition of HealthWatch and would like to be involved in any local initiatives concerning the overarching view of patient experience in Worcestershire.

Thanks:

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

- Amy Gray, Healthcare Standards Lead
- Anna Sterckx, Head of Patient, Carer and Public Engagement

- Charlie Snead, Volunteer Support Officer
- Effie Gridley, Healthcare and Quality Standards Officer
- Janet Neate, Head of Volunteering
- Julie Webber, Patient Experience Lead Nurse
- Natalie Wellings, Patient Experience and Engagement Support Officer
- Patience Ngumbo, Quality Matron
- Rachael Beasley Suffolk, Healthcare Standards Lead
- Russell Hardy, Chair of the Board of Directors
- Sarah Shingler, Chief Nursing Officer
- And all the other staff who have been so accommodating and supportive when members are visiting their areas

Finally, we would like to welcome Hayley Flavell to the position of Chief Nursing Officer and look forward to working with her.

A number of our members knew Mark Yates and we would like to offer our condolences to his family on his sudden and unexpected death. He will be missed across the health community.

2. Recommendation(s)

We would like to extend the invitation to attend a Patient and Public Forum meeting to any Board member.

The PPF would like the Board to take particular note of the Hearing Loop report (which can be found in the appendix of this report) and the standard of Outpatient letters.

To see the progress made with the ongoing development of the Patient and Public Forum in terms of activity, partnership with the Trust and community engagement.

Appendix

1. Hearing Loop Audit:
2. The Patient and Public Forum Terms of Reference:
3. PPF Work Plan:

Patient Public Forum Audits of Hearing Loops

July 2025

Merleen Watson, PPF Member
& Healthcare Standards Team

Background of audits

Between 07/05/2025 and 09/06/2025, members of the Trust's Patient and Public Forum (PPF) completed hearing loop audits across 47 outpatient and reception areas at Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital.

Audit Questions

1. Can you see a hearing loop in this area?
2. Is there an easily visible loop sign?
3. Is the hearing loop switched on? A warning light should be visible
4. Does it have a 'Do not remove medical device' sticker?
5. Do staff know how the loop works?
6. Is the loop made available for the patient to take with them into their consultation?
7. Are staff with a hearing impairment aware that a loop could be a considerable help in communicating with patients?
8. Do staff know who to contact if the loop is not working, how is the loop tested to check the quality of sound, and how often?

Locations of Hearing Loops during review

Areas with a hearing loop	Areas without a hearing loop		
All Sites	Worcestershire Royal Hospital	Alexandra Hospital	Kidderminster Hospital
• Clover (WRH) • Redwood Suite (WRH) • X-ray 2 (WRH) • ENT/Lindon (WRH) • Working Well training room (WRH) • Audiology (ALX) • Outpatients (KTC) • Imaging (KTC) • Sorrel (WRH)	• Pharmacy (WRH) • X-ray L1 (WRH) • Clinical investigations (WRH) • Antenatal Clinic (WRH) • Ultrasound (WRH) • Radiotherapy Suite (WRH) • Endoscopy (WRH) • Hawthorne (WRH) • Rowan (WRH) • ITU reception (WRH) • Mulberry Suite L2 (WRH) • A&E Reception (WRH) • Working Well reception (WRH) • Charles Hastings Education Centre: Teaching, Teaching room 15, reception, Restaurant, LT, Seminar 1 (WRH)	• Children Clinic (ALX) • Orthopaedic centre (ALX) • Pharmacy (ALX) • A&E (ALX) • Children Centre (ALX) • Main entrance (ALX) • Garden Suite (ALX) • Discharge Lounge (ALX) • Urology investigations (ALX) • Endoscopy (ALX) • Anti-natal clinic (ALX) • Pre –op (ALX)	• Children's Clinic (KTC) • Maternity Hub (Gynae) (KTC) • Ophthalmology (KTC) • Renal Dialysis (KTC) • Millbrook Suite (KTC) • Minor injuries (KTC) • Main Entrance (KTC)

Audit Results

Question	Answers	
1. Can you see a hearing loop in this area?	**22.5%** *(of 40 answers)*	• 9 Yes (22.5%) • 30 No (75%) • 1 N/A (2.5%)
2. Is there an easily visible loop sign?	**49%** *(of 41 answers)*	• 20 Yes (49%) • 21 No (51%)
3. Is the hearing loop switched on? A warning light should be visible	**56%** *(of 18 answers)*	• 10 Yes (56%) • 6 No (33%) • 2 N/A (11%)
4. Does it have a 'Do not remove medical device' sticker?	**1%** *(of 20 answers)*	• 1 Yes (5%) • 16 No (80%) • 3 N/A (15%)

Question	Answers	
5. Do staff know how the loop works?	**16%** *(of 19 answers)*	• 3 Yes (16%) • 15 No (79%) • 1 N/A (5%)
6. Is the loop made available for the patient to take with them into their consultation?	**20%** *(of 20 answers)*	• 4 Yes (20%) • 12 No (60%) • 4 N/A (20%)
7. Are staff with a hearing impairment aware that a loop could be a considerable help in communicating with patients?	**5%** *(of 20 answers)*	• 1 Yes (5%) • 17 No (85%) • 2 N/A (10%)
8. Do staff know who to contact if the loop is not working, how is the loop tested to check the quality of sound, and how often?	**0%** *(of 18 answers)*	• 18 No (100%)

PPF Findings

Reflections from on-site reviews and conversations

1. Overall, the results are very disappointing, although not surprising.
2. Staff were very keen to discuss how they could help hearing-impaired patients and colleagues but were unsure of the best way. The flag system was not widely recognised.
3. Where loops were found, there were issues of position (portable loops will not work through screens), a lack of microphones (counter loops) and overall lack of awareness of how loops work to benefit both patients and staff. Staff also questioned who to contact if there was a problem with a loop and how a loop should be properly tested. There were no labels located indicating that the equipment should not be unplugged.
4. Where loops are currently available, they should be restored to full working order and staff trained to ensure the loops are correctly used to benefit all. A regular programme of formal testing (using a loop tester, not a hearing-impaired person!) should be introduced and findings recorded.
5. It was very apparent that the majority of staff (and by association, volunteers) would benefit greatly from deaf awareness and communication training. This should be an integral part of induction for all staff and volunteers, reinforced annually.
6. Given the overall lack of loops at the direct points of contact surveyed, it is reasonable to assume that there are few, if any, available in wards. This presents the Trust with an opportunity to review other communication systems as a possible replacement for loops to ensure best practice in meeting the needs of all patients, in line with the Accessible Information Standard.

Patient and Public Forum

TERMS OF REFERENCE

Remit	Section 242 of the NHS Act 2006 places a duty on NHS Trusts to involve current and potential service users or their representatives in: • Planning services they are responsible for • Developing and considering proposals for changes in the way those services are provided • Decisions to be made that effect how those services operate. The legacy of the Mid Staffs enquiry is to ensure an effective critical friend which is working with the Trust to ensure excellent patient centred care. The Patient and Public Forum [PPF] exists as a group of patients, carers and/or patient/carer public representatives, who work in partnership with the Trust to support continued improvements and to reflect patient and carer experiences. The PPF acts with an independent 'fresh eyes' approach, providing honest, constructive and candid feedback from quality and safety visits, audits, engagement events and attendance at committee meetings/steering groups. The overall purpose of the PPF is to ensure that the voices of patients, relatives, carers and the public are heard by the Trust and acted on in order to achieve the highest quality patient centred care.
Accountability Arrangements	The PPF is established as part of the Quality Governance arrangements approved by the Trust Board, is accountable through the Chief Nursing Officer to the Trust Board. The PPF is constituted by the Quality Governance Committee, which is a sub-committee of the Board. The Chief Nursing Officer has delegated authority from the Trust Board and is authorised to investigate any activity discharged through the PPF terms of reference. Consequently, the PPF may seek and secure the information it requires from any employee and all employees are directed to co-operate with any request made by the Trust. The Chair and Vice-Chairs of the PPF group are appointed by the members of the Forum for a period of 3 years, after which a further term may be considered.
Responsibilities	The Patient and Public Forum will:

	Oversee the priorities set by the Trust that relate to patient, carer and community involvement, engagement and co-design, including the development and implementation of the Patient Voice and Involvement Strategy. Drive the cultural changes needed in participation, co-design, engagement and shared decision making with patients and service users. improve how we engage with the communities we serve, both adults and children. Support staff to foster and promote a culture of collaboration and co-production with patient/service users on strategy, assurance, governance and quality improvement through improvement projects and committees. Increase participation and feedback from seldom heard voices within our community. Ensure provision of equal and equitable services to all patients and service users. Work with services; to improve the way that patients and carers are involved in and supported to be an equal partner in the design, development and delivery of services. Work alongside Divisions to review current patient experience and feedback performance data and measures, help review current practices and best practice initiatives to ensure that standards of care provided are of the highest quality. Identify links with other initiatives and involves and listens to patients and carers. Ensure there is training for all staff in involvement and co-design; ensuring the patient and carer voice and experience is central to the work we do. Be responsive to insight received through patient, carer and community engagement, feedback and complaints. Participate in networking, collaboration and shared learning amongst professionals and patients/ carers, engaging with the Trust's Improvement System. Ensure we provide an effective volunteer service and that volunteers are fully engaged, supported and utilised.
Membership / Attendance Wells Jo 10/10/2025 13:47:24	The PPF will be a diverse group which is reflective of the local population of Worcestershire; this includes age, ethnicity and protected characteristics. **Patient and Public Members** (50% of the membership) • The PPF is open to members of the public who have had experience of using our services and also to members of our local population who have an interest in how local services are run. • PPF Members will all be registered as volunteers at Worcestershire Acute Hospitals Trust and will be required to complete all registration processes whilst recognising that PPF members are not the same as other Trust volunteers and have different roles and responsibilities. **Trust members at formal meetings (x6/year)** (20% of the membership) • Chief Nursing Officer

- Head of Patient, Carer and Public Engagement
- Patient Experience Lead Nurse
- Quality Matron
- Patient Experience and Patient Engagement Administrator
- Volunteers Manager
- Armed Forces Network Veterans representative

Voluntary, Community and Social Enterprise Sector (30% of membership)

- VCSE Alliance Lead (Worcestershire)

  Representative from local organisation working with people from minority ethnic communities

  Representative from local organisation working with people who are homeless

  Representative from an organisation working with refugees
- Representative from Age UK in Worcestershire
- Representatives from ICB Patient Engagement Team
- Representative from Worcestershire Mencap
- Representative from Carers Support
- Healthwatch representative

To be considered for invitation to specific meetings:

- Specific representation from organizations working with people experiencing health inequalities as listed above

Attendees

- Non-Executive Director – Board Patient Voice Champion
- Communications team representative

Other individuals will be invited to formal meetings as the agenda requires including:

- Deputy Chief Nursing Officer
- Deputy Chief Medical Officer
- Chief Executive Officer Managing Director
- Trust Board Chair/Non-Executive Directors.

As a minimum, the CEO/MD will be expected to attend one meeting a year.

The Chair and the Vice Chair will be supported at additional meetings by the Head of Patient, Carer and Public Engagement to support progression with action plans and to develop joint agendas for formal meetings.

Attendance

Patient and Public members will be required to attend a minimum of 50% of all meetings.

Voluntary, Community and Social Enterprise Sector members to attend alternate meetings.

Trust staff members will be required to attend a minimum of 50% of all meetings and be allowed to send a Deputy to one meeting per annum.

If a member does not attend for three consecutive meetings without a valid explanation, they will be removed from the membership.

	Trust members may wish to bring colleagues along to the meeting to talk to specific issues or to provide subject matter expertise. This will be agreed with the Chair at agenda setting. Trust members may wish to bring colleagues to the meeting for professional development purposes, for example to observe the meeting and listen to its business. This will be agreed in advance with the Chair.
Chair	The meeting will be chaired by the Forum Chair (Patient/Public Member); in their absence this will be taken by one of the Vice Chairs.
Quorum	The quorum will be 35% of members plus Chair/Vice Chair
Reporting Arrangements	The PPF is accountable to the Quality Governance Committee. Minutes will be reported to Quality Governance Committee once they have been approved by the Chair along with exception reports as agreed by the membership of this Group. Members are requested to report on all engagement including Trust committee and steering group engagement at each formal PPF meeting preferably through written updates, which are circulated with the agenda. The group will receive regular formal feedback from Trust colleagues via this group. The PPF will report directly back to the Healthcare Standards Team following audits. PPF members will receive copies of the reports after shared visits. The Trust will report back to the PPF at quarterly meetings as relevant. The PPF Chair and Chief Nursing Officer will provide a twice yearly report to the Trust Board outlining the business of the Forum and progress made against development and delivery of the Patient Voice and Involvement Strategy.
Frequency of Meeting	The Forum will meet with the Trust six times a year. Between forum meetings the PPF will be able to access opportunities which include meeting with Specialist/lead staff, attending Divisional meetings, steering groups and participating in audits.

Administration	Administrative support will be delivered by a dedicated member of the Patient Experience and Engagement team whose duties in this respect will include: • Preparation of Annual Schedule of Business. • Agreement of agenda with Chair. • Ensuring accurate minutes are taken and keeping a record of matters arising and issues to be carried forward. • Ensuring the agenda, papers, and corresponding minutes reflect confidential items. Unless otherwise agreed, notice of each meeting, including venue, time, date, agenda and supporting papers, shall be provided to members no later than seven working days prior to the date of the meeting. The Chair shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.
Date Approved	Quality Governance Committee 30.05.2024, presented by the CNO, following partnership between CNO and PPF to review. The ToR have in addition been discussed and approved at Trust Management Board.
Date Review	The Forum will provide an annual report outlining the activities it has undertaken throughout the year. A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met. The terms of reference will be reviewed annually or sooner if required and any significant changes approved by the Quality Governance Committee.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
PATIENT AND PUBLIC FORUM
Workplan – April 2025 to March 2026

As an independent voluntary body, the role of the Forum is to:

- monitor and review the services provided by the Trust from a patient and public perspective
- ascertain the views of patients, users and carers and pass them on to the appropriate authorities
- prepare and carry out a published Work Plan for each year, resources permitting
- update the Directors and Management on Forum projects and activities and make representation on matters of concern.

Ongoing activities

- **Efficacy audits**: these are audits which review the implementation of standard cleaning practices in all patient areas at all three hospitals. Lead for the Trust – Helen Mills
- **PLACE inspections**: To participate in the Patient Led Assessments of the Care Environment annually and to review the Action Plans as appropriate. Lead for the Trust – Helen Mills
- **Quality Assurance Visits**: To review the ward environment and ascertain the experience of patients and staff. Lead for the Trust – Amy Gray
- Ad hoc tours and visits
- **Cleanliness walkabout**: Review of the cleanliness of all public areas from a patient perspective. Lead for the Trust – Helen Mills
- **Follow up actions agreed in the reports and monitor the outcomes and learning**

Specific actions for 2025-26

- Undertake a recruitment drive
- Work with the Trust to ensure that signage matches across the site and with letters inviting patients for appointments
- Review process for seeing patients referred to the ED by GPs
- Continue to monitor OP cancellation (by the Trust) rates

Rosemary Smart & PPF members
March 2025

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**14/10/2025**
Title of Report:	Provider Capability Assessment
Lead Executive Director:	**Chief Executive Officer**
Author:	Gwenny Scott, Company Secretary
Reporting Route:	n/a
Appendices included with this report:	1. Provider Capability Self-Assessment Template 2. Provider Capability Full Assessment
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

As part of the NHS Oversight and Assessment Framework, NHS England will assess NHS trusts' capability, to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards have been asked to assess their organisation's capability against a range of expectations across six areas derived from the Insightful Provider Board.

The purpose of this is to focus the attention of trust boards on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability and assign a capability rating to the trust as follows:

Green	High confidence in management
Amber-green	Some concerns or areas that need addressing
Amber-red	Material issue needs addressing or failure to address major issues over time
Red	Significant concerns arising from poor delivery, governance and other issues

Guidance has been provided, which includes indicative examples of the evidence that boards should use or lines of enquiry they might consider taking to assess whether they can positively self-certify against each criterion.

A self-assessment template has been provided, within which there are three options for each of the six domains: confirmed, partially confirmed or not met. For any domain which is not 'confirmed' the self-assessment must describe the reasons and the actions being taken by the Board to improve.

A self-assessment has been undertaken by the Executive Directors. The completed template is at attachment 1. To support the Board's decision making, the rationale and evidence used for each line of enquiry is set out in attachment 2.

Going forward, the assessment will be an annual requirement aligned to annual reporting and planning timescales for submission each quarter one.

Recommended Actions required by Board or Committee

The Board is asked to review attachments 1 and 2 and approve the self-assessment for submission to NHSE.

Executive Director Opinion[1]
The Executive Directors contributed to the self-assessment process and approved submission to the Board.

[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.

Worcestershire Acute Hospitals NHS Trust
Provider Capability Self Assessment October 2025

Self-assessment criteria	Indicative evidence or lines of enquiry	Response	Evidence	Assessment	Action Required
I. Strategy, Leadership & Planning					
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure?	The Trust's financial plan and those of its partner trusts in the ICS were developed as both local, standalone plans and as part of the wider ICB plan (including capital). The Board was well sighted on and involved in the development of the plan from both perspectives through workshops and meetings of the Board and the Financial Recovery Board. The Trust participated in the dvelopment of the ICS Joint Capital Resource Plan 2025/26 (published July 2025).	Operational Plan reports to Board March 25, ICS Planning Update to Financial Recovery Board (FRB) May 2025	Confirmed	
	Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?	The Digital Strategies of all the NHS providers in the ICS link with the ICS Digital Strategy. Programmes of work in common include Shared Care Record, NHS App and Patient Portal.	ICB Digital Strategy; Trust Digital Strategy; ICB Board reports.	Confirmed	
	Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?	In March 2025 the Trust launched its new 5-year Strategy, which is built on 5 strategic pillars, including 'collaboration: building strong connections and pathways'. This encompasses collaboration internally, within the system and within the community. Key partners include our ICS community healthcare trust partner, primary care and the voluntary care sector. This strategic approach reflects the importance of the whole healthcare economy working together to manage increasing demands and time pressures across the NHS to optimise patient experience and outcomes and deliver services as efficiently as posssible. Key workstreams are: ICS Primary-Secondary Interface, Working Better Together for our Patients, ICS Health Inequalities Strategy, Length of Stay and Discharge programme, fragile services work with Wye Valley NHS Trust. The Board regularly engages with Public Health to better understand drivers of health inequality based on deprivation through workshop sessions.	Trust Strategy 2025-30, ICB papers; Trust Integrated Performance Reports; Trust Board workshop public health presentations.	Confirmed	
	Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	The Trust's strategy development is undertaken in line with the ICS strategy and in collaboration with the ICB. In response to the most recent national planning guidance the Trust is building on its strategy with the development of a clinical services strategy.	Trust Strategy, ICS Strategy, ICB board papers	Confirmed	
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	· Is the trust currently complying with the conditions of its licence?	The licence currently has enforcement undertakings related to UEC (see below). The Annual Governance Statement includes details relevant to other aspects of compliance, including a summary of how risks to compliance are managed. The Annual Internal Audit plan provides assurance on a number of general licence conditions including corporate governance, financial management and fit and proper person regulations.	F&PE papers; Board papers; AGS, Internal Audit Plan.	Confirmed	
	· Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?	The Trust is meeting the requirements of the licence undertakings (related to UEC) , as monitored by the Finance and Performance Executive (observed by non-executive directors) and the Board. The Trust is not participating in the PIP.	Integrated Performance Report	Confirmed	
3. The board has the skills, capacity and experience to lead the organisation	· Are all board positions filled and, if not, are there plans in place to address vacancies?	All positions are filled but the MD is currently acting into the CEO role temporarily during the substantive CEO's secondment to NHSE.	website	Confirmed	
	· What proportion of board members are in interim/acting roles?	2 non-voting executive positions are interim; the MD is currently Acting CEO.	website	Confirmed	
	· Is an appropriate board succession plan in place?	For executives, the deputy chief officer tier provides a succession plan for several roles. The Trust's succession plan is being incorporated in a single Foundation Group succession plan. For non-executives, a succession plan is renewed upon each appointment to ensure consistency, stability and appropriate refreshing of the Board. This is supported by a model of associate non-executive director appointments.	Remuneration Committee papers; NED term planning documents.	Confirmed	
	· Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	Each area is aligned to an executive director who leads an operational and management structure aligned to a governance structure and performance management framework.	Trust structure, governance structure, executive role descriptions.	Confirmed	

4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served	· Is the trust contributing to and benefiting from its NHS trust collaborative?	The Trust collaborates with its ICS, Foundation Group and community partners to support achievement of many of its objectives, particularly 'collaboration'. Examples include working with WVT on shared services such as stroke to help resolve fragility, work with the community trust on discharge to community beds and hospital at home and improvement work and a joint procurement function with the Foundation Group.	ICB and Trust Board papers	Confirmed	
	· Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?	The MD/Acting CEO is a partner member of the ICB. Other executives and non-executives are members of ICB committees. The Trust is part of the Foundation Group with its ICS partner (Wye Valley) and together they meet as a FG Board with the other partners where there is a particular focus on system challenges, common issues and shared learning. There is also a Foundation group Strategy Committee which has membership from all 4 trusts. There are regular informal meetings between executives of the three NHS trusts in the ICS to consider system challenges. The Trust Board is represented on the membership of the Worcestershire Health and Wellbeing Board.	ICB and committee papers/minutes; FG Board minutes.	Confirmed	
	· Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	Examples include: partnership working with WVT on fragile services; shared leadership resources between trusts; partnership working with H&C Trust on patient flow/discharge from acute to community; contribution to the development and implementation of the Worcestershire Health and Wellbeing Strategy, which is aligned to the Trust strategy.	Board reports.	Confirmed	
II. Quality of care					
5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	· The trust can demonstrate and assure itself that internal procedures:				
	o ensure required standards are achieved (internal and external)	The Trust has a Healthcare Standards Team which leads on establishing processes to oversee achievement of regulatory standards, including a ward accreditation process. The Trust has established a comprehensive quality governance struture to oversee quality standards and provide assurance to the Board via the Quality Governance Committee (QGC). This includes subcommittees covering the three domains of quality, plus dedicated committees covering key regulatory matters including infection control, safeguarding, controlled drugs and medical devices. QGC also receives regular reports as necessary from departments/services on the implementation of action plans to address CQC recommendations following inspections.	QGC papers; Trust Governance Structure; Quality Account.	Confirmed	
	o investigate and develop strategies to address substandard performance	The Trust has well-established arrangements, overseen by QGC to manage complaints, incidents and risks, respond to and learn from feedback and use benchmarking to identify opportunities for further improvement. Through this oversight and triangulation with performance and workforce information, the Trust develops annual quality priorities for inclusion in the Quality Account and prioritised oversight by QGC throughout the year.	QGC papers; Quality Account	Confirmed	
	o plan and manage continuous improvement	The Trust has a Strategy and Planning Directorate which supports the development and implementation of projects and improvement work using the Worcestershire Improvement System, the Trust's single improvement methodology. This has been aligned to the Trust's new values in 2025.	QGC papers; Improvement System Hub information; Improvement Board papers.	Confirmed	
	o identify, share and ensure delivery of best practice	In addition to the use of national benchmarking information such as model hospital and GIRFT, the Trust uses internal approaches such as 'Improvement Walls' (where improvement programme outcomes are displayed for sharing purposes) and system based learning through Transformation Tuesdays. The Trust also has the benefit of regular benchmarking through the Foundation Group, both through formal review of data at Board level and through collaboration on improvement schemes such as a joint annual improvement event - Transformation Week.	Board and FRB papers; FG Board papers.	Confirmed	

	o identify and manage risks to quality of care	The Trust's risk management framework includes an Executive Risk Management Committee (ERM) which meets regularly to oversee progress in managing risks at divisional and corporate department level, including regular 'deep-dives'. An annual internal audit of risk management provides independent assurance to the Board; the most recent report was rated significant assurance. Significant strategic risks influence the development of both quality priorities and strategic plans to ensure a prioritisation of resources and Board focus. The QGC maintains oversight of risks to quality as described above.	ERM papers; Internal Audit Report; QGC reports	Confirmed	
	· There is board-level engagement on improving quality of care across the organisation	Improving the quality of care is central to the Trust's strategy and Board and committee business. At an individual level, board member engagement includes board level safety champions for maternity/neonatal (and the development of an equivalent role for the Emergency Department) and regular safety walkabouts to wards and clinical areas. Each Board meeting includes a patient story and a quarterly report is presented to the Board by the chair of the Patient Participation Forum.	Board and QGC papers.	Confirmed	
	· Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients	As well as standard reporting on quantative metrics and information pertaining to quality, qualitative information considered by the Board, its committees and individual members includes the work of the Board safety champions, safety walkabouts and other informal visits to teams and departments and patient and staff stories at board meetings.	Board papers	Confirmed	
	· Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community	One of the Board's 5 strategic priorities is to meet the needs of the Trust's patients and communities, which recognises the need to work with patients and partner organisations across the whole patient pathway in order to improve the health of our communities. A number of programmes of work are in progress which are aligned to this including Single Point of Access, integrated therapies (acute and community), outreach teams, urology assessment unit and community beds. Our efficiency programme is also aligned to our strategy, reflecting the opportunities to simultaneously improve care and reduce cost by working better together with partners, particularly those that deliver care in the community.	Board and FRB papers; Trust Strategy.	Confirmed	
	· Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust	The Board uses a range of external data for learning and benchmarking, including instances when things have gone wrong, including recommendations from national reviews. The Trust also participates in peer reviews by regional speciality networks and shares learning with its Foundation Group partners.	QGC and FGB papers.	Confirmed	
	· Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement	The Worcestershire Improvement System has been in place for several years and includes toolkits, guidance and training for staff, as well as a supportive team. All clinical teams are also trained and involved in PSIRF which is focused on improvement following incidents. Learning and improvement are key elements of staff appraisals - medical and non-medical. The Trust holds a regular well-attended Transformation Tuesday event to showcase and share system wide learning about improvement work. The Trust holds a week-long improvement event each year in partnership with its Foundation Group partners. Staff survey results on the People Promise 'we are always learning' were significantly higher than the previous year and comparable with the peer group.	Board report on staff survey results. Trust information on PSIRF and improvement system.	Confirmed	
6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	· Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?	The Board, both directly and through the QGC, triangulates a range of data relating to patient experience including formal patient feedback (surveys, complaints, FFT, patient stories), informal direct patient feedback (safety walkabout discussions between board members and patients/families), information pertaining to the patient experience (such as data about waiting timesand feedback from staff) and input from stakeholders who regularly attend QGC meetings - Patient Participation Forum and Worcestershire Healthwatch.	QGC papers; Board papers	Confirmed	

	· Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?	The Trust works with the ICS on delivering its health inequalities strategy and separately works with Public Health Partners to target resource in areas of deprivation and known inequality of access to Health Services. Within Trust services there is a focus on areas such as elective waits for children and young people. The Board engages with staff networks which provide a valuable perspective on patient experience through a health inequalities lens. There is however a need to improve the collection of Trust patient data about protected characteristics to enable improved analysis to understand whether there are any differences in experience or variations in access to services between different patient groups.	Board workshop reports; ICS Health Inequalities and progress reports to ICB; QGC reports.	Partially Confirmed	Improve collection of patient charactersistics data (particularly ethnicity). Embed review of patient experience data by protected characteristics and deprivation in standard reporting.
	· Is the board satisfied that it receives timely information on quality that is focused on the right matters?	The QGC sets an annual reporting schedule designed around reports from subcommittees, progress reports on implementing the annual quality priorities and reports on current and emerging areas of quality risk. Each meeting of the QGC includes an opportunity for the chief nurse and chief medical officer to highlight any new or emerging concerns ourside of the reporting cycle. The CNO and CMO engage closely with the NED QGC Chair, ensuring they are apprised of any important issues outside of meetings. The QGC agrees on the key matters that require escalation to the Board each month.	QGC papers, minutes and reporting schedule	Confirmed	
	· Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?	The QGC receives detailed reports on FFT results and responses, complaints and PALS contacts and learning. Board members also engage directly with patients through ward visits and the Patient Participation Forum.	QGC papers	Confirmed	
	· How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?	The Trust has an active Patient Participation Forum (PPF), members of which visit the Trust's sites to review the environment and talk to patients about their experience and share their observations and feedback with the Trust. The PPF presents a quaterly report to the Trust Board and is represented at meetings of the Quality Governance Committee, where the chair of the PPF makes an active contribution to discussions. Patient stories are also used to provide an improved understanding of quality and operational issues from a patient perspective and identify opportunities for improvement.	QGC and Board papers	Confirmed	
	· Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?	The skills and experience of the voting members of the Board are complemented by a non-voting membership to ensure there is specialist executive leadership and non-executive support and challenge covering all elements of the Trust's strategy and operations. In relation to quality, both executive and non-executive members include a wide range of expeerience, including clinical expertise and senior leadership experience in health or social care.	List of expertise etc set out in annual report	Confirmed	
	· Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?	The QGC recieves regular reports on complaints management and has focused on improvement in this area, particularly in response times and follow up of actions. An internal audit was commissioned in 2024/25 and the review showed significant improvement on a review the previous year, with further development plans already in place. For 2025/26 the QGC agreed that one of the Trust's quality priorities would be to continuously learn from patient feedback with indicators including a reduction in the proportion of people who are not satisfied with the initial response to their complaint and an increase in the proportion of upheld complaints that have associated actions.	Internal Audit report; reports to QGC	Confirmed	
III. People and culture					
7. Staff feedback is used to improve the quality of care provided by the trust	· Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?	The staff survey results and the WRES and WDES data and action plans are scutinised in detail by the Board and the People and Culture Committee. Results were used to inform our People Strategy which includes as a priority the development of an 'inclusive community which enables staff to bring their whole self to work'.	Staff Survey report to Board; P&CC papers	Confirmed	
	· Does the board engage with staff forums to continually consider how care can be improved?	Examples of this include: non-executive engagement with the staff EDI networks, NED and Exec maternity and neonatal safety champions, presentations at Board workshops from staff networks and on initiatives supported by staff networks, and safety walkabouts to wards and departments. In 2024/25 the Trust consulted widely with staff on the development of its values and 5-year strategy.	Perinatal reports to Board; Board workshop presentations; Trust strategy documents; safety walkabout reports to QGC.	Confirmed	

	· Can the board evidence action taken in response to staff feedback?	Action plans at Trust and divisional level are developed in response to the staff survey; WRES and WDES action plans are in place. The Trust's new strategy (including People Strategy) and values are based on staff feedback through both analysis of staff surveys and direct counsultation. Staff are also consulted on key developments impacting their experience, for example car parking and reasonable adjustments for staff with a disability or long-term condition.	P&CC papers.	Confirmed	
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	· Does the trust regularly review skills at all levels across the organisation?	Skills review is led by the professional education team. A mandatory training oversight steering group is undertaking a review of mandatory training needs. The appraisal process focuses on training and skill development needs at an individual level. The Board receives monthly staffing reports for nursing and midwifery staff.	Reports to P&CC and Board	Confirmed	
	· Does the board see and, if necessary, act on levels of compliance with mandatory training?	Mandatory training levels are monitored at divisional level at Finance and Performance Executive meetings (observed by non-executives), where actions necessary to achieve improvements are considered. Trust level data is included in the integrated performance report (IPR) to Board. The People and Culture Committee (a Board committee comprising executive and non-executive membership) receives reports from the Educaiton department. The QGC considers mandatory training rates in areas such as safeguarding, infection control and fire safety and monitors actions to improve where necessary.	FPE, Board, P&CC and QGC papers.	Confirmed	
9. Staff can express concerns in an open and constructive environment	· Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?	The Freedom to Speak Up Guardian attends meetings of the People and Culture Committee and contributes to discussions as well as providing a regular report. The Board receives an annual FTSUG report. There is a Non-exec FTSU lead who engages with the FTSUG including a joint walkabout once a quarter to proactively engage with staff.	FTSU reports to P&CC and Board.	Confirmed	
	· Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?	The FTSUG has access to all executives and engages with the relecant executive in relation to complex/sensitive cases, with oversight as appropriate from the NED lead, MD and CPO.	FTSU policy and reports to Board.	Confirmed	
	· Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?	The FTSU process is set out in a policy and described to all new staff on induction. The staff intranet includes full details on how to contact the FTSUG, including through direct email and through an anonymous portal. The FTSUG attends meetings of all staff networks. There is a network of FTSU Champions across the Trust.	FTSU Policy and reports to Board and PCC.	Confirmed	
	· Is there a safe reporting culture throughout the organisation? How does the board know?	The Board reviews a range of information that provides assurance on the safety culture, including incident reporting levels and FTSU reports, which describe the number of cases, including an increase since the introduction of a portal. The proportion of FTSU cases relating to patient safety is low. On the staff survey question related to the health and safety climate the Trust's result was in line with the benchmark average and this has improved year on year since 2022. The Board triangulates this information with its own observations through direct engagement with staff and patients. The role of MatNeo Board safety champion provides a direct route to board on safety issues; this role is being introduced to the Emergency Department.	Staff Survey report, perinatal safety and FTSU reports to Board.	Confirmed	
	· Is the trust an outlier on staff surveys across peers?	The Trust's national staff survey results were at or above average on all people promise elements (save one) and had improved on all elements compared to the previous year. The Trust was slightly below average on 'we are always learning' in relation to the appraisals sub-score. Improvement plans are in place linked to the new People Strategy.	Staff Survey results/report to Board.	Confirmed	
IV. Access and delivery of services					
10. Plans are in place to improve performance against the relevant access and waiting times standards	· Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?	The Trust monitors performance closely and takes swift action where necessary to improve in collaboration with the ICB and system partners. The Board receives reports each month on performance and progress on plans. Performance is on trajectory to deliver the plan.	IPR to Board;	Confirmed	
	· Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this?	The monthly Board Integrated Performance Report includes detail of the drivers of performance behind plan. This is also considered by the QGC to allow triangulation with quality indicators. The main challenges impacting performance are well known to the Board and inform strategic development which is reviewed each year.	IPR to Board	Confirmed	
	· Is there a plan to deliver improvement?	Performance is on trajectory to deliver the plan, with recovery plans in place for individual areas where necessary.	IPR to Board.	Confirmed	

11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	· The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place	The Trust works with the ICS on delivering its health inequalities strategy and separately works with Public Health Partners to target resource in areas of deprivation and known inequality of access to Health Services. Within Trust services there is a focus on areas such as elective waits for children and young people. The Board engages with staff networks which provide a valuable perspective on patient experience through a health inequalities lens. There is however a need to improve the collection of Trust patient data about protected characteristics to enable improved analysis to understand whether there are any variations in access to services between different patient groups.	ICB papers.	Partially Confirmed	Improve collection of patient characteristics data (particularly ethnicity). Embed review of access data by potected characteristics and deprivation in standard reporting.
12. Appropriate population health targets have been agreed with the ICB	· Is there a clear link between specific population health measures and the internal operations of the trust?	The Trust engages with the ICS on its approach to population health management and this is factored into our strategy which is focused on collaboration and our communities.	Trust Strategy; ICB papers	Confirmed	
	· Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	The Trust consulted widely with staff on the development of our strategy which aligns to the ICS strategic shift from treatment to prevention. There are many examples of teams contributing to this such as those working on admission avoidance pathways, the Hopital at Home Team, Alcohol Liaison Team and Safe Space. The Trust is engaged with the Worcestershire Place Partnership and the ICB on Neighbourhood Health. The Trust's updated clinical strategy is currently in development and includes a requirement for all teams to consider the health of the wider population as well as the health of people on the waiting list.	Trust Strategy	Confirmed	
V. Productivity and value for money					
13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	· Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:				
	o review its performance against peers	The Foundation Group four boards meeting provides an opportunity for benchmarking on key operational performance and quality indicators. The Integrated Performance Report considered by the Board at each of its standard meetings includes a full suite of data within a dahsboard which includes national and regional benchmarks where available to highlight any variations for consideration.	IPR report and dashboard. FGB performance reports.	Confirmed	
	o identify and understand any unwarranted variations	Detailed reports to the Board at both formal meetings and informal workshops provide an understanding of drivers and plans to address variations in performance against target and benchmark.	Board and workshop papers	Confirmed	
	o put programmes in place to reduce unwarranted negative variation	Improving performance on UEC and elective care are central to the Trust's annual plan, wider strategy and Board and committee agendas. Recovery plans are put in place at speciality level where required. Progress on delivery of plans is included in the regular IPR to Board and discussed at divisional F&PE meetings which are observed by non-executives.	Board reports - operational plan, IPR, winter plan.	Confirmed	
	· The trust's track record of delivery of planned productivity rates	Historically performance was below target but the Trust achieved significant improvements in 2024/25 and has established improved arrangements for delivery and oversight to ensure this improvement trajectory continues.	Financial Recovery Board reports	Confirmed	
VI. Financial performance and oversight				Confirmed	
14. The trust has a robust financial governance framework and appropriate contract management arrangements	· Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data	The internal audit plan comprises core areas, including risk management, data security and financial controls, and risk based reviews selected via a prioritisation process. This typically includes a review of data quality, which is focused on an area selected as a priority for independent assurance.	IA Plan 25/26	Confirmed	
	· Have there been any contract disputes over the past 12 months and, if so, have these been addressed?	No	n/a	Confirmed	
	· Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?	The Trust's workforce, activity and financial plans are developed alongside each other and triangulated. Delivery is monitored via an Integrated Performance Report by the Board and Financial Recovery Board. A key element of the efficiency programme is a reduction of agency staff usage. A reduction has been achieved year to fate in line with target but NHSE has identified the Trust as at risk of delivery for the full year and will therefore provide intensive support via the NHSE regional team. The Trust has established an Agency Programme Board to oversee delivery of the programme in detail.	IPR, Oct 25	Partially Confirmed	Implement strengthened agency reduction oversight arrangements.
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	· Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?	Quality Impact Assessments are undertaken on efficiency programmes and related investment decisions. The Divisional Finance and Performance Executive meetings oversee performance on financial efficiency alongside key quality indicators. All such plans are reviewed by the Trust Management Board (TMB) before approval.	F&PE papers; example reports to TMB.	Confirmed	

	· Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?	The process for quality impact assessment is set out in the Quality Impact Assessment Policy.	Quality Impact Assessment Policy	Confirmed	
	· Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?	The Board very closely tracks financial performance at every Board meeting. In 2024 the Board established a Financial Recovery Board which meets monthly and enables detailed scrutiny of performance and recovery plans. Non-executives also observe divisional Finance and Performance Executive meetings which enables a detailed understanding about the drivers of performance at a divisional level.	Finance report to FRB; IPR to Board	Confirmed	
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	· Is the board contributing to system-wide discussions on allocation of resources?	Executive and non-executive members of the Board are members of the ICB and the ICB Finance Committee where these discussions take place. The ICS CFOs and planning leads regularly meet outside the formal governance structure to collaborate on the development of plans.	ICB and ICB committee papers.	Confirmed	
	· Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?	The Trust's financial plan and those of its partners trusts in the ICS were developed as both local, standalone plans and as part of the wider ICB plan (including capital). The Board was well sighted on and involved in the development of the plan from both perspectives through workshops and meetings of the Board and the Financial Recovery Board. The Trust participated in the dvelopment of the ICS Joint Capital Resource Plan 2025/26 (published July 2025).	Financial planning reports to Board; Operational Planning Board Assurance statement. ICB financial plan and delivery report May 2025. ICB Joint Capital Use Resource Plan 2025/26	Confirmed	
	· Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	Collaboration for the benefit of patients and our communities is a central theme of our strategy. The Trust is working closely with its system partners on a number of programmes such as length of stay and community discharge, fragile services and primary/secondary care interface.	Trust Strategy; ICB papers; Board papers	Confirmed	

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Partially confirmed**	*There are gaps in the collection of protected characteristic data which limits the ability to analyse and report to the Board on variations in experience for patients with protected characteristics. The Board has agreed two actions:* *1. Improve collection of patient characteristics data (particularly ethnicity).* *2. Embed review of patient experience data by protected characteristics and deprivation in standard reporting.*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*There are gaps in the collection of protected characteristic data which limits the ability to analyse and report to the Board on variations in access for patients with protected characteristics. The Board has agreed two actions:* *1. Improve collection of patient characteristics data (particularly ethnicity).* *2. Embed review of patient access data by protected characteristics and deprivation in standard reporting.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Partially confirmed**	*The Trust is at risk of not achieving its annual target for reduction in use of agency staff. The Trust has put in place strengthened oversight arrangements to address this.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Signature

Name

Date

Wells Jo
10/10/2025 13:47:24

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