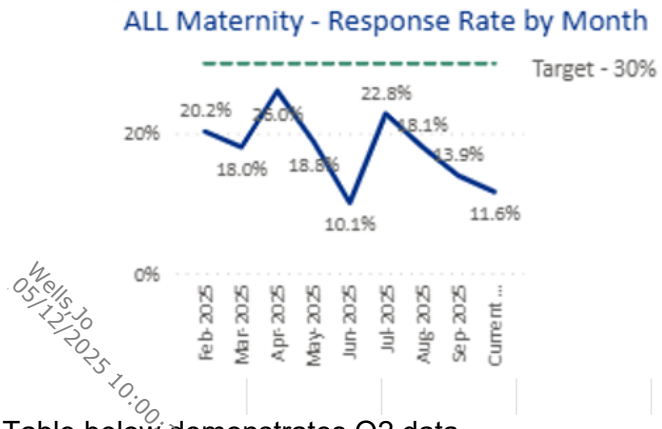
In addition 22 formal and informal complaints were received – the formal complaints are green, the informal are purple. Though most are under the subject of 'clinical treatment', as has been seen previously, the sub-subjects are all vastly different in nature.

ID	Specialty	Subject (primary)	Sub-subject (primary)
101891	Maternity (formerly Obstetrics)	Communications	Communication with patient
101891	Maternity (formerly Obstetrics)	Communications	Communication with patient
103229	Maternity (formerly Obstetrics)	Clinical Treatment	Injury sustained during treatment or operation
103296	Maternity (formerly Obstetrics)	Clinical Treatment	Delay or failure in treatment for infection
103322	Maternity (formerly Obstetrics)	Clinical Treatment	Mismanagement of labour
103414	Maternity (formerly Obstetrics)	Communications	Conflicting information
103516	Maternity (formerly Obstetrics)	Clinical Treatment	Post-treatment complications
103778	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in treatment
103790	Maternity (formerly Obstetrics)	Clinical Treatment	Failure to follow up on observations / recognise deteriorating patient
104156	Maternity (formerly Obstetrics)	Appointments	Appointment - availability (inc urgent)
104668	Maternity (formerly Obstetrics)	Clinical Treatment	Failure to recognise/respond to abnormal fetal heart
104668	Maternity (formerly Obstetrics)	Clinical Treatment	Failure to recognise/respond to abnormal fetal heart
104680	Maternity (formerly Obstetrics)	Clinical Treatment	Inadequate pain management
104687	Maternity (formerly Obstetrics)	Clinical Treatment	Incorrect procedure
104744	Maternity (formerly Obstetrics)	Patient Care	Care needs not adequately met
104760	Maternity (formerly Obstetrics)	Consent	Failure to obtain appropriate consent
104928	Maternity (formerly Obstetrics)	Communications	Conflicting information
105381	Maternity (formerly Obstetrics)	Clinical Treatment	Dispute over diagnosis
105538	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives
105628	Maternity (formerly Obstetrics)	Clinical Treatment	Mismanagement of labour
106068	Maternity (formerly Obstetrics)	Communications	Communication with patient
106226	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in induction of labour
106516	Maternity (formerly Obstetrics)	Clinical Treatment	Injury sustained during treatment or operation
107175	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in treatment

Neonatal: No complaints or PALS received in Q2.

9.3. Friends and Family Feedback

Response rate by month and recommended rate by month



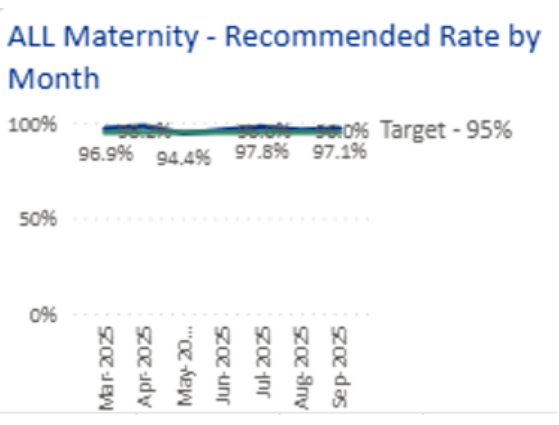


Table below demonstrates Q2 data.

Area		Responses	V. Good		Good		Neither		Poor		V. Poor		Positive Themes	Negative themes
WRH	Delivery suite	400	334	84%	51	13%	12	3%	3	1%	0	0%	Well Informed, Positive staff attitude, Personalised Care, Well Supported	Staff Attitudes, information
	Meadow	224	224	100%	0	0%	0	0%	0	0%	0	0%	Safe & Empowered, Positive Birth Experience, Professional, Caring, Relaxed	Nil
	Antenatal Ward	306	183	60%	117	38%	6	2%	0	0%	0	0%	Polite, Friendly, Kind, Knowledgable	Information, Communication during stay, Delays, Waiting times, Scanning
	Postnatal Ward	254	157	62%	76	30%	15	6%	3	1%	3	1%	Helpful, friendly, knowledgeable, reassuring, Feeding support	Access to care, Delays for reviews, Staff Attitudes, communication, support
Outpatients	WRH	84	57	68%	7	8%	5	6%	3	4%	12	14%	Professional, Efficient, Friendly, Informed	Unhelpful, Wait Times, Errors, Communication
	ALX	100	74	74%	5	5%	10	10%	6	6%	5	5%	Helpful, Friendly, Efficient, Welcoming	Wait Times, Uncomfortable,
	KTC	76	61	80%	12	16%	0	0%	0	0%	3	4%	Informed, Supportive, Knowledgable, Friendly,	Very warm environment
	POWCH	8	3	38%	5	63%	0	0%	0	0%	0	0%	Kind, Communication, Informed	Not looking back at records, Staff attitude
Community		24	18	75%	6	25%	0	0%	0	0%	0	0%	Helpful, Kind	Nil

9.4. FTSU Submission summary Quarterly

Directorate	Number of submissions	Themes
Maternity	7	Band 2 role (JD, support from Band 3's), Attitudes and behaviours towards an individual
Neonatal	0	

9.5. Patient Experience Meeting

The MNVP and the Maternity and Neonatal governance team meet bi-monthly. This meeting agenda's features the CQC Action Plan themed with the groups Action log. These actions are derived from WAHT feedback (Complaints, PALS, Badger Friends and family quarterly data, Birth debriefs) and MNVP feedback (monthly face to face feedback, monthly walk the patch feedback, community events, digital feedback, Parent Panel and 15 steps).

Key areas of local focus include

- Health Visitor access to badger – team is waiting for a project plan from system C.
- Badgernet Data syncing problems with 6 machines – IT is working on a solution
- Debrief Service and screening tool – Service under review and new screening tool being developed to ensure appropriate referrals
- Communication issues were the most discussed theme
- Induction of Labour delays spiked in July and improved in August
- Staff Attitude and Behaviour Monitoring – continues to be monitored on P/N Ward

See Appendix v – Patient Experience Meeting Notes

9.6. CQC Maternity Survey 2024 and Action Plan

The survey is designed to capture the experiences of women and birthing people who have recently used NHS maternity services. Those who accessed services from the 1-29 February each year are invited to respond. It provides insight into the quality of care across antenatal, labour, birth and postnatal stages. This informs the CQC of targeted assessments of NHS trusts and supports regulatory decisions and performance monitoring. Following receipt of the survey results an action plan is co-produced with the MNVP.

Key areas of local focus include

- Postnatal ward – drug rounds and access to pain relief
- BRAINS implementation
- Further development of website
- Debrief Service

See Appendix vi – CQC Maternity Survey Action plan

10. Safety Champion escalations

The Safety Champions meet monthly with the MNVP membership (as per year 7 CNST requirement).

17th July 2025 Summary

Safety Champion feedback

- **Staffing and Breaks** – ongoing staffing issues highlighted, Unit coordinators and senior team members are sighted and monitoring the issue. Questioned SitRep and actual vs expected staffing. Drop-in session with DOM dedicated to breaks held and data collected via audit to DDOM for reporting.
- **Triage and Environment** – Delays in reviews experienced; this was escalated. As a result, a dedicated Resident doctor has been assigned. Noted no air conditioning during hot weather spells – escalated to estates – additional fan placed in area.
- **Antenatal ward staffing** – two midwives present (one newly qualified). Midwife in charge stressed and emotional, coordinator informed, and staffing moved to support the ward.
- **Diabetic care** –Staff expressed concerns about the increasing cases of women with gestational diabetes and the challenges this presents. Awaiting arrival of newly appointed Diabetic Lead Midwife and the Perinatal Leadership Team (PLT) will explore service changes and develop and improvement plan to address any identified issues.

27th August 2025 Summary

Safety Champion feedback

- **Postnatal ward staffing and workload** – persistent concerns about staffing levels raised. Confusion noted regarding the supernumerary status of midwife in charge, reluctance among senior midwives to take charge, and a tendency for junior staff take charge for development. Morale affected by redeployment from this area.
- **Breaks** – PLT team are auditing if staff are being offered breaks, taking breaks or choosing not to take them and the implications of this practice.
- **Scan Service Availability** – Challenges in meeting demand for USS following admission for RFM –challenge to perform scan within recommended timing. The PLT have implemented daily huddles to find scan slots, sometimes relying on waiting list initiatives, radiology staff, or midwives working extra shifts. A review of demand and capacity is underway.
- **CQC Maternity Survey Action plan** – Update provided to champions

18th September 2025 Summary

Safety Champion Feedback

- **Antenatal Inpatient Scan Allocation and booking** – Ongoing problems with scan capacity for antenatal inpatients. Only three slots per day are available via X-ray. High DNA rate for antenatal scans. Confusion and inefficiency due to multiple booking systems (PAS, ICE, CRIS) and not all community midwives can request scans via ICE. This leads to double-booking and overbooking. A new band 3 administrator role is being created to coordinate scans, daily scan huddles are

held, and improvements are being traced at directorate and divisional meetings. PLT took suggestions to bi-weekly radiology meeting.

- **Safety Action 8** – Training compliance action plan for rotational medical staff will be submitted in Q2 CNST report
- **Risk register – DAU collapsed patient** – this has prompted examination of manual handling procedures in the area. Ferinject administration is currently being delivered on delivery suite to mitigate any risks not being able to safety and correctly transfer from the area in the event of an emergency.
- **Safety Action 3 QI project** – Presentation to members given regarding the QI project to ensure admissions between 34+0 and 35+6 are all BAPM pathway admission compliant.
- **Cold temperature approaching** – Seasons now changing and close observation needs to be given to window solutions applied in the spring to improve room temperatures. A member of the PLT also discussed that Riverbank are experiencing the same issues with insufficient window insulation.
- **Documentation surrounding personalised care** – The importance of formal capacity assessments and robust documentation in complex cases were discussed. Regional work on personalised care plans is ongoing.

Action plan Summary

- Triage emergency buzzer system – Staff unable to identify from workstation where buzzer is located – DAF process commenced
- Neonatal Unit exit buzzer – Word exit has been covered to reduce confusion and fingerprint access implementation.
- Covid screens, room 4 temperature and broken lights – DAF intervention required and in progress, escalation to estates

See Appendix vii – Safety Champions Notes

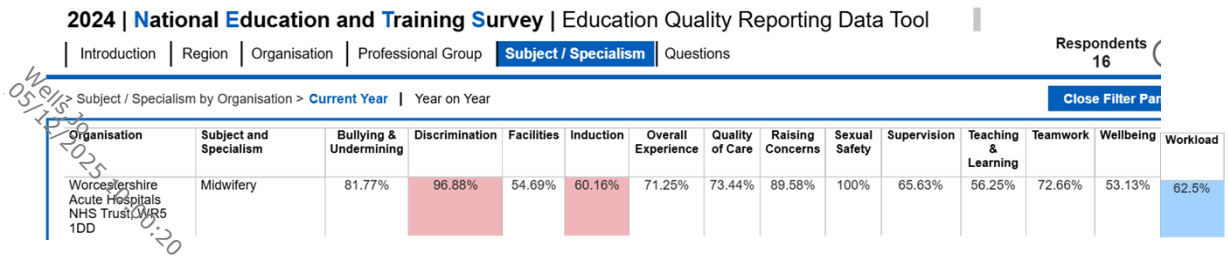
11. Receiving feedback from staff

11.1. NETS Survey

The NHS National Education and Training Survey (NETS) has been running annually since 2019 and is the only national survey that collects feedback from all healthcare students and trainees across England (@43,000). The survey asks about key areas of the learning environment including Introduction, clinical supervision, facilities, learning opportunities, teamwork, equality, diversity and inclusion and sexual safety and forms part of the NHS England's Education Quality framework. The 2024 results can be found by clicking the link Microsoft Power BI

See Appendix viii – NHSE WT&E Action Plan and GMC Action Plan

11.1.2. Midwifery



2024 | National Education and Training Survey | Education Quality Reporting Data Tool

Introduction | Region | Organisation | Professional Group | Subject / Specialism | Questions

Respondents 16

Subject / Specialism by Organisation > Current Year | Year on Year

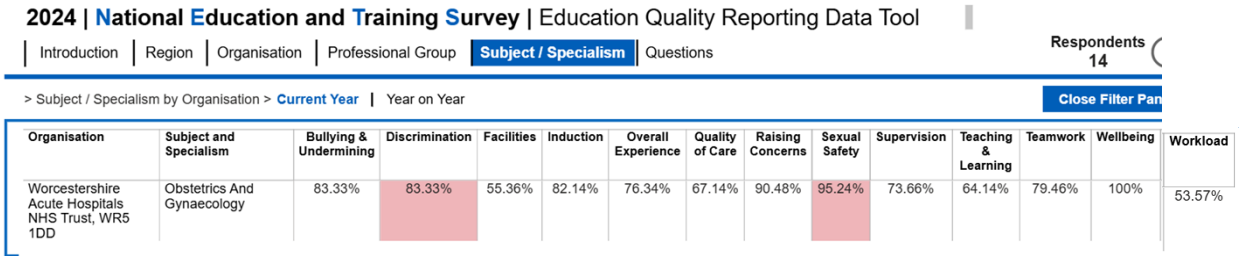
Close Filter Pa

Organisation	Subject and Specialism	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workload
Worcestershire Acute Hospitals NHS Trust,WR5 1DD	Midwifery	81.77%	96.88%	54.69%	60.16%	71.25%	73.44%	89.58%	100%	65.63%	56.25%	72.66%	53.13%	62.5%

This result is an improvement in the previous results from 2022 and 2023. The service has been on the NHSE WT&E Intensive Support Framework since 2022; the level of support has now been reduced to Level 1 as significant improvements have been noted. A paper will be shared at People & Culture Committee in October.

11.1.3. Medical

NETS Survey 2024



2024 | National Education and Training Survey | Education Quality Reporting Data Tool

Introduction | Region | Organisation | Professional Group | **Subject / Specialism** | Questions

Respondents 14

> Subject / Specialism by Organisation > **Current Year** | Year on Year

Close Filter Pan

Organisation	Subject and Specialism	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workload
Worcestershire Acute Hospitals NHS Trust, WR5 1DD	Obstetrics And Gynaecology	83.33%	83.33%	55.36%	82.14%	76.34%	67.14%	90.48%	95.24%	73.66%	64.14%	79.46%	100%	53.57%

GMC Survey 2025

Challenges in local teaching, induction, study leave, and workload within our medical unit have prompted changes such as scheduling adjustments, virtual attendance, enhanced induction materials, streamlined study leave processes, and additional staffing to support trainees, with ongoing monitoring and audits planned to assess improvements over the coming months.

Worcestershire Royal Hospital - RWP50	Overall Satisfaction	N less than 3	67.00	Within IQR	72.50	Within IQR	46.67	Q1 but not below
	Clinical Supervision	N less than 3	86.00	Within IQR	90.00	Within IQR	78.75	Q1 but not below
	Clinical Supervision out of hours	N less than 3	87.50	Within IQR	89.24	Within IQR	91.67	Within IQR
	Reporting Systems	N less than 3		N less than 3	83.33	Q4 but not above		N less than 3
	Workload	N less than 3	37.50	Within IQR	41.67	Within IQR	23.61	Below
	Teamwork	N less than 3	75.00	Within IQR	72.22	Within IQR	66.67	Q1 but not below
	Handover	N less than 3	70.00	Within IQR	84.38	Above	79.17	Within IQR
	Supportive Environment	N less than 3	57.00	Q1 but not below	76.67	Within IQR	65.00	Within IQR
	Induction	N less than 3	70.00	Within IQR	82.50	Within IQR	60.00	Below
	Adequate Experience	N less than 3	75.00	Within IQR	81.25	Within IQR	58.33	Q1 but not below
	Educational Governance	N less than 3	61.67	Within IQR	66.67	Within IQR	52.78	Q1 but not below

11.2. Staff SCORE Survey

As part of NHS England's three-year delivery plan, all Trusts providing maternity and neonatal services were mandated to participate in the *Perinatal Culture and Leadership Programme* (PCLP).

The plan is structured around four key themes:

1. Listening to and working with women and families with compassion
2. Growing, retaining, and supporting our workforce
3. Developing and sustaining a culture of safety, learning, and support
4. Embedding standards and structures that enable safer, more personalised, and equitable care

The PCLP was designed to support senior leaders in perinatal services—including senior midwifery, obstetric, neonatal, and operational leads (collectively referred to as the 'perinatal leadership team')—in fostering a culture of safety, compassionate and relational leadership, openness, and collaborative teamwork.

Following the completion of the SCORE culture survey and NHS Staff survey, an action plan *(Appendix ix*) was developed to address the following: burnout & workload management, decision making and growth, retention and job certainty and work – life balance. The surveys demonstrated five cultural strengths – professionalism and purpose, safety culture, engagement, line management and teamwork.

12. In-utero and ex–utero activity

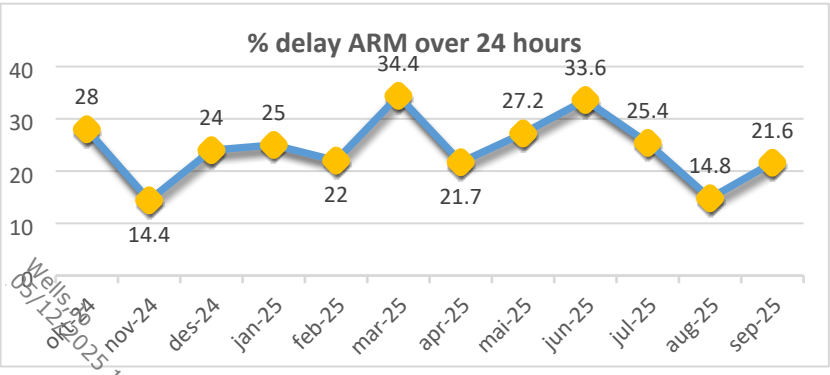
The table below summaries the in-utero and ex-utero transfers as per network pathway:

Type of Transfer	July- Sept 2025		Comments
	In	Out	
IUT Transfers for clinical reasons as per network pathway	1	2	1 in from Hereford as per pathway 2 out as per <27-week pathway – BWH & New Cross
IUT Transfers for non-clinical reasons	0	0	
IUT Transfers outside of the network	1	2	1 in from Burton 1 out to Bristol & 1 out to Gloucester
Ex-utero Transfers for clinical reasons as per network pathway	1	5	1 in requiring level 2 care 5 out for clinical reasons
Ex-utero Transfers for non-clinical reasons	10	3	10 in – 7 in as repatriations, 3 in to assist with Network capacity 3 out - repatriations
Ex-Utero Transfers out of network	0	2	2 repatriated out to be closer to home – St Helier & Burton
Delays in transfer in/out	1	0	1 delay in from BWH due to capacity, accepted 4 days later
IUT or Ex-utero Exceptions	5		2 IUT transfers out of Network, 2 IUT unable to transfer as no cots/beds and 1 ExUT- <27 week born outside NICU

13. Delays in care

13.1. Induction of labour

Delay in induction of labour is captured on our Perinatal Dashboard. The % of women waiting over 24 hours (awaiting ARM) on the IOL pathway are as follows:



Induction of labour pathway remains a focus as delays in care is a red flag - a QI project continues to reduce delays in this pathway. Despite the last quarter being some of our busiest months for some time,

and in September 2025, we had our busiest month since January 2019 (with 454 babies being born), there was an overall sustained position in delays in transfer for ARM.

14. Claims scorecard review in conjunction with incidents and complaints

The Q1 claims and learning review is contained within the appendices. Highlights are:

- a stable term admission rate to NNU compared to Q4
- PPH continues as a theme but a notable reduction in PPH has been seen in Q1 - ObsUK continues to run – benchmarking to follow
- We have had only 1 complaint relating to delay in induction of labour again in Q1 which is positive compared to previous quarters.
- Delay in assessment and review appears to be an emerging theme but this is predominantly related to delays in triage review in accordance with BSOTS – this is on the risk register and plans are in place to ensure sufficient medical staff to support the obstetric reviews.

The draft Q2 claims and learning review is also in the appendix – this has been completed using the newly released NHSR scorecards which were published in late September 2025.

See Appendix x – Claims Scorecard Quarterly Report

15. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust

15.1. CQC visit

The maternity service was rated as good overall. The safe domain remains at 'requires improvement. All actions are monitored via the COSMOS platform and are discussed at ISAG.

15.1.2. CQC Rait Tool

Below is a summary of 'Must' and 'Should' Do's by Level of Assurance from the Regulatory Activity Tool (RAIT) produced from the published report 29.11.23. There have been no changes since the previous report.

The outstanding '*must do'* that has not yet been achieved is safeguarding training being above 90% - all others have been achieved with an assurance level of 7. Current rates for the quarter have varied between 86 – 88%.

See Appendix xi – Maternity RAIT Tool

No of Must Do's by LOA		No of Should Do's by LOA	
7	3	7	3
6		6	
5	1	5	
4		4	
3		3	
2		2	
1		1	

15.2. Coroner Regulation 28 made directly to Trust

No regulation 28 regarding maternity or neonatal care was made to the Trust in this month.

15.3. MSSP Report

Formal confirmation of our exit from the MSSP was received in June 2024. A sustainability plan has been agreed and shared at Trust Board. Progress with the plan is monitored by the ICB and a quarterly update will be provided via this report.

Focus continues on the following actions:

- PDR compliance rates – rates have improved as per trajectory.
- Increasing Consultant led theatre lists – recruitment of the maternal medicine consultant post will improve the consultant led lists
- Enact findings of administrative review – a formal management of change process is currently underway to enact the proposed changes
- Review GTT service efficiencies – this service is under review as part of a wider review of antenatal outpatient services.
- Exploration of service improvements at AGH – this will require capital funding to make improvements to the environment

There are no further updates for this month.

16. Evidence of NHSR CNST 10 – Maternity Incentive Scheme (MIS)

Year 7 MIS scheme was launched on 2nd April 25. The following table presents a quarterly overall summary of current position. A detailed CNST MIS paper is also produced (and referred to in the table below) containing the mandatory documents that trust board are required to review and formal document that they have been received, reviewed and discussed during QGC meetings quarterly.

Safety Action & Current status		Actions	Evidence for Trust board prescribed in CNST year 7
1	PMRT	• Quarterly reporting in place	See appendix i See CNST Q2 report
2	MSDS	• Submission and criteria on track for July 25	Awaiting confirmation
3	ATAIN/ TCU	• Quarterly reporting in place • QI project commenced and registered • QI project presented to Safety Champions in Septembers Meeting • QI project to be presented to LMNS Nov 12th	See CNST Q2 report
4	Clinical Workforce	• Medical and Midwife Safe Staffing reports in place • NCCR implementation plan BAPM Medical and nursing staffing plans continue • Risk register entry number 5991 (Neonatal Medical) • Risk register entry number 6031 (Neonatal nursing) • Audits for Obstetric Medical staff completed • Consultant attendance monitored • Clinical Supervision of Locum and Temporary • Compensatory rest monitoring	See BAPM Action plan embedded in bespoke CNST Q1 and obtained trust sign off BAPM Action Plan embedded into CNST Q2 report to reflect Neonatal staffing noncompliance
5	Midwifery Workforce	• Monthly Safe staffing report in place. • Item 7 within report • BR+ tabletop due Jan and July • BR+ Audit currently underway	See Midwifery Safe Staffing Reports and Birthrate + update in

			bespoke CNST Q1 and Q2 report, trust sign off achieved
6	Saving Babies Lives	• Quarterly reports in place • NHS Futures Implementation Toolkit continues • Validation with LMNS quarterly • PLGF testing workstream continues	LMNS validation 24th Sept 2025 – 97% compliant
7	MNVP	• Strategic lead for MNVP (appointed) • MNVP included in Terms of reference as members for, Guidelines, Patient experience, Safety champions, Maternity Governance meetings • CQC action plan 2024 (Picker Survey) agreed at Safety Champions 20.3.24 (update presented July 25) Maternity Governance on 21.3.25, • Plan to submit safety concern – added to risk register entry number 5961	See MNVP safety concern in bespoke CNST Q1 report for trust sign off
8	MDT Training	• CNST compliance across all training progressing. • Item 6 within this report • Areas of Medical staff attending PROMPT and Fetal surveillance Study day concerning – CD aware and actions in place.	Action Plan created for rotational medical staff added to CNST Q2 for trust sign off
9	Safety Champions/ Perinatal Safety	• Reporting process in place. • Roles embedded and SC meetings working well. • Perinatal Surveillance guideline to be updated in line with yr 7 – and the new Perinatal Quality Oversight Model • PLT present at every Safety Champions meeting embedded, PLT/ Quad now attends bi-monthly, MNVP invited to attend at every meeting • Summary of Perinatal Culture SCORE and staff survey results collated into an action plan (see appendix) • Quarterly reporting of Claims Score Card	See Q4 and Q1 Claims score card reports in the bespoke CNST Q1 report for trust sig
10	NHSR EN Scheme	• Reporting process in place – externally validated. • See monthly table within the report	See MNSI /EN reports in the bespoke CNST Q1 and Q2 report for trust sign off

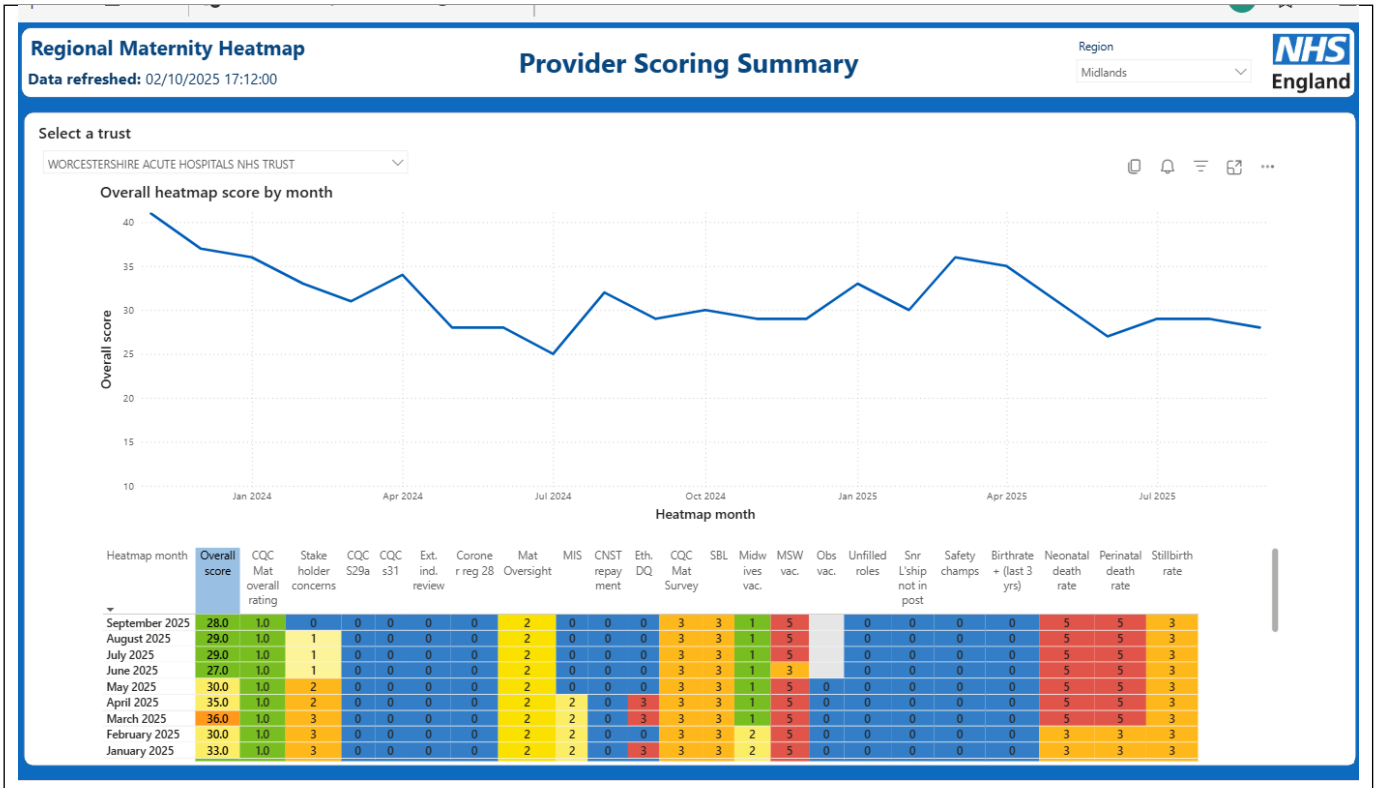
17. Dashboards and Heatmaps

17.1. Regional Heatmap

The Regional Perinatal Heat map was introduced in October 2023 and tracks 22 quality and safety indicators. This will read the signs of trusts that require additional early intervention and support. It scores systems and providers to ensure the right level of support is in place to enable focussed quality improvement to address key challenges.

The heat map score is used to determine which systems and trusts are encouraged to take up the offer of regional involvement in system-led insight visits to maternity services and additional regional improvement support. It aligns to the themes of the maternity and neonatal single delivery plan and perinatal quality surveillance model.

The Trust position for September is as follows:



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
September 2025	28.0	1.0	0	0	0	0	0	2	0	0	0	3	3	1	5		0	0	0	0	5	5	3
August 2025	29.0	1.0	1	0	0	0	0	2	0	0	0	3	3	1	5		0	0	0	0	5	5	3
July 2025	29.0	1.0	1	0	0	0	0	2	0	0	0	3	3	1	5		0	0	0	0	5	5	3
June 2025	27.0	1.0	1	0	0	0	0	2	0	0	0	3	3	1	3		0	0	0	0	5	5	3
May 2025	30.0	1.0	2	0	0	0	0	2	0	0	0	3	3	1	5	0	0	0	0	0	5	5	3
April 2025	35.0	1.0	2	0	0	0	0	2	2	0	3	3	3	1	5	0	0	0	0	0	5	5	3
March 2025	36.0	1.0	3	0	0	0	0	2	2	0	3	3	3	1	5	0	0	0	0	0	5	5	3
February 2025	30.0	1.0	3	0	0	0	0	2	2	0	0	3	3	2	5	0	0	0	0	0	3	3	3
January 2025	33.0	1.0	3	0	0	0	0	2	2	0	3	3	3	2	5	0	0	0	0	0	3	3	3

The score has decreased in month as a stakeholder concern has been removed. It is expected that as vacancies fill and compliance with element 4 of saving babies lives increases the score will drop further.

17.2 Regional Perinatal Dashboard

The perinatal dashboard provides information at system-level and currently this is not available at provider level. Once this data is available at provider level escalations from this dashboard will be included with the report.

17.3 Maternity Outcome Signal System (MOSS)

The Maternity Outcomes Signal System (MOSS) is a new NHS signalling tool designed to spot early signs of risk in maternity care, for instance unexpected trends in stillbirths, brain injury rates or neonatal deaths. It uses near real-time data to flag concerns and is designed to work alongside existing tools such as MBRRACE-UK. The system is due to launch across NHS Trusts from November 2025, with oversight through the National Perinatal Surveillance Group. We await further details.

18. CCOSMOSS

CCOSMOSS is a local acronym for Clinical Negligence Scheme for Trusts (CNST), CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2, Saving Babies Lives (SBL) and Safety Champions. The recommendations/actions (n=505) from all these national documents have been captured within a TEAMs platform to ensure that the directorate can track the progress of actions completed, communicate with leads and demonstrate monthly position/compliance.

As the Single Delivery Plan (NHSE 2022) superseded Ockenden 1 and 2. CNST restarts at 0% every April. The level of compliance against these key documents is presented in the table below.

Q2 July/Aug/ Sept 25-26		Compliant	In progress	Overdue	Not Started	Total	Compliance
C	CNST	15	73	0	0	88	17%↑
C	CQC	22	0	4	0	24	92%↔
O	OCK 1	50	0	0	0	50	100%↑
S	SDP	30	33	1	0	64	47%↔
M	MSAT	157	5	0	0	157	100%↑
O	OCK 2	100	1	0	0	101	99%↑
S	SBL V3	Q1 (25/26) LMNS Validated					97%↑

19. Conclusion

This report provides a monthly update on key maternity and neonatal safety initiatives which will support WAHT to achieve the national ambition. The report provides the evidence outlined within the revised perinatal quality oversight model and following the 4 key themes of the Single Delivery Plan. It will also assist the directorates to collate evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.

Key escalations this quarter

- Triage attendance challenges
- Ultrasound scan capacity particularly in the 3rd trimester
- Staff health and wellbeing
- FFT response rates
- Complaints – attitude and behaviour

Celebrations this quarter

- Compliance with Saving Babies Lives Care Bundle – 97% (validation 24.9.250
- Registrar has been assigned to triage and postnatal ward, and this is helping to reducing delays and improving both staff and service user feedback.
- Continued reduction in low cord gases and APGARS following the formal introduction of physiological CTG implementation in April.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**09/12/2025**
Title of Report:	CNST MIS Year 7 Quarter 2 Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Justine Jeffery – Director of Midwifery Jane Wardlaw – Lead Assurance and Compliance Midwife
Reporting Route:	Quality Governance Committee
Appendices included with this report:	Appendix within this report - Q2 PMRT 25-26 - RCOG Short/ Long-term Locums (6-month Audit) - Q2 WRH Neonatal Workforce Staffing - WMNODN Implementation Plan 08.10.25 - June Midwifery Staff staffing Report - July Midwifery Staff staffing Report - August Midwifery Staff staffing Report - Maternity and Neonatal Safety Champions notes 18th Sept 25 - Q1 Claims Score Card - Staff and Score Survey paper - PCLP People and Culture Action plan
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

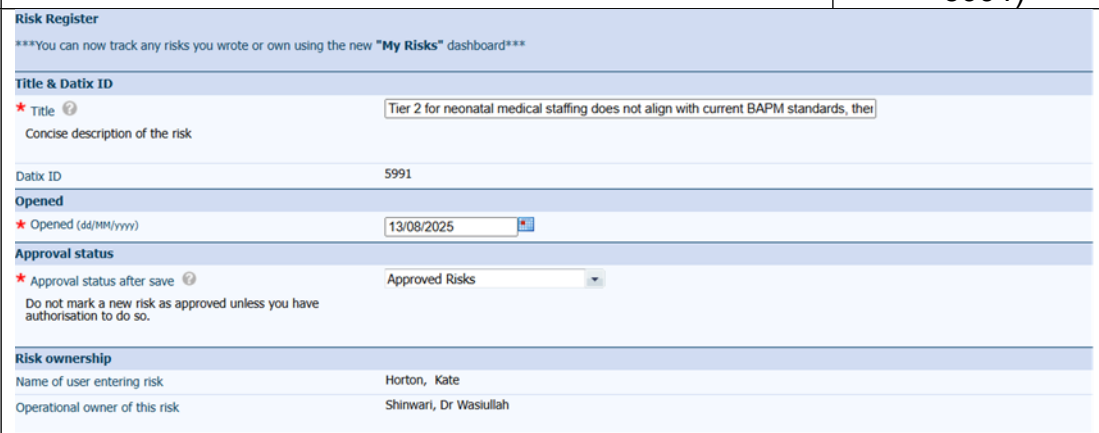
Brief Description of Report Purpose

The NHS Resolution's Maternity Incentive Scheme (MIS) continues to promote safer maternity and perinatal care by encouraging compliance with ten Safety Actions. These actions support the national goal to halve stillbirths, neonatal and maternal deaths, and brain injuries (from 2010 levels) by the end of 2025. The scheme applies to all acute Trusts offering maternity services under the Clinical Negligence Scheme for Trusts (CNST)

This report presents the evidence for review and provides assurance that compliance is met as outlined in the Year 7 scheme.

Recommended Actions required by Board or Committee

Safety Action	Evidence	Required actions and recorded minutes required from QGC.
1	PMRT Q2 25-26	• eligible perinatal deaths and required standards have been met
3	BAPM action plan continues (presented in Q1 CNST report). Risk register entry completed.	

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>4</td><td>Compliant - Compliance of engagement according to the RCOG long term locums (6-month Audit)</td><td>• long-term are compliant with RCOG guidance for both long term and short-term locums.</td></tr>
<tr><td>4</td><td>Compliant – RCOG ‘Roles and Responsibilities’ (3-month Audit) – 80% minimum compliance standard.
<table><tr><td>Month</td><td>Cases</td><td>%</td></tr><tr><td>March</td><td>13 out of 14</td><td>92.8%</td></tr><tr><td>April</td><td>12 out of 12</td><td>100%</td></tr><tr><td>May</td><td>4 out of 4</td><td>100%</td></tr></table></td><td>Committee to acknowledge the review in the minutes that
• there is compliance with Obstetric consultant attendance in person to clinical situations to the labour ward above the minimum standard of 80%</td></tr>
<tr><td>4</td><td>Non-compliant - BAPM with Neonatal Medical staffing standards</td><td>• the Neonatal Medical Staffing standard is not BAPM compliant
• This has been added to the risk register as screenshot below (ID 5991)</td></tr>
<tr><td></td><td colspan="2"> 
</td></tr>
<tr><td>4</td><td>Compliant - BAPM QIS standards Neonatal Nursing staff</td><td>• the Neonatal Nursing QIS standard is BAPM compliant</td></tr>
<tr><td></td><td colspan="2">Q2 Screen shot of nursing data (full data expansion attached) – QIS standard met
<table><tr><th colspan="6">Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY</th></tr><tr><td colspan="6">NB total nurse staffing required to staff declared cots = 48.56, of which 33.99 (70%) should be QIS</td></tr><tr><td></td><td colspan="2">Current position</td><td>Required to meet activity at average 80% occ</td><td>Variance: budget against required</td><td>Variance: in post against required</td></tr><tr><td></td><td>Budget</td><td>In post</td><td></td><td></td><td></td></tr><tr><td>Total nursing staff</td><td>38.77</td><td>34.03</td><td>39.35</td><td>-0.58</td><td>-5.32</td></tr><tr><td>Total reg nurses</td><td>33.15</td><td>30.55</td><td>34.79</td><td>-1.64</td><td>-4.24</td></tr><tr><td>Total QIS</td><td>23.30</td><td>22.20</td><td>24.36</td><td>-1.06</td><td>-2.16</td></tr><tr><td>Total non-QIS</td><td>9.85</td><td>8.35</td><td>10.44</td><td>-0.59</td><td>-2.09</td></tr><tr><td>Total non-reg</td><td>5.62</td><td>3.48</td><td>4.55</td><td>1.07</td><td>-1.07</td></tr><tr><td>Reg nurses as % nursing staff</td><td>85.5%</td><td>89.8%</td><td>88.4%</td><td></td><td></td></tr><tr><td>QIS as % reg nurses</td><td>70.3%</td><td>72.7%</td><td>70.0%</td><td></td><td></td></tr></table></td></tr>
</table>

4	**Non-compliant** - BAPM with Neonatal Nursing staffing standards 	ID	Opened	Title	Manager	Division	Directorate	Rating (current)	Risk level (current)	Review date	Approval status
---	---	---	---	---	---	---	---	---	---
6031	10/10/2025	Non-compliance with nurse staffing standards may lead to suboptimal nurse/baby ratios causing reduction in quality of care		Women and Children	Paediatrics	3	Low	30/01/2026	Risks Awaiting Approval		• the Neonatal Nursing staffing ratio standard non-compliant. • This has been added to the risk register as screenshot below (ID 6031)
5	Midwifery Staffing (Birthrate + tabletop Audit August 25) (June, July, Aug)	• safe staffing reports have been received in line with NICE midwifery staffing guidance • Compliant with Birthrate
8	Trusts are permitted to submit a lower compliance for rotational Medical Staff that commenced work after 1st July. The Action plan below demonstrates current levels of compliance, the dates of courses and the staff numbers required to be booked to achieve over 90% within 6 months of commencement (August – January).	*Committee to acknowledge the review in the minutes that* • an action plan has been submitted and agreed for PROMPT training to reach 90%.

Date	Plan Total number of rotational Anaesthetic doctors trained *Commencing 1st August 2025*	Plan Total number of rotational Obstetric doctors trained *Commencing 1st August 2025*	PROMPT Dates and staff to be booked
Oct 25	14 (63%)	16 (80%)	15th + 20th October (3x Anae 2x Obs booked to attend)
Nov 25	17 (77%)	18 (90%)	13th + 21st November (3x Anae 1x Obs booked to attend)
Dec 25	20 (91%)	19 (95%)	11th December (3x Anae 1x Obs booked to attend)
Jan 26	22 (100%)	20 (100%)	23rd Jan (2x Anae 1x Obs booked to attend)

9	NED Appointed  Wells Jo 05/12/2025 10:00:20	• Sue Sinclair is appointed and visibly is working with the Board Safety Champion

9	Quarterly Perinatal Safety Report	• the Perinatal Safety Report aligns with the Perinatal Quality Oversight Model
9	Trust Claims Score Card Q1 25-26 discussed with Safety Champions	• the claims score card received and discussed with safety champions
9	Safety Champions meeting with Quad (bimonthly) and PLT (Perinatal Leadership Team) every meeting. • July meeting PLT/Quad attended • August meeting PLT • September meeting PLT/Quad attended	• the Safety Champions meet with the Quad Bi-monthly and that a member of the PLT is present in all meetings.
9	PLT (Perinatal Leadership Team) – Maternity and Neonatal culture improvement plan • Presented to People and culture on 7th October 25 • Presented to Safety champions Sept 25 (see attached notes above)	• That a maternity and neonatal culture improvement plan is in place and has been shared with safety champions and the People and Culture board
10	MNSI / EN reports - Q2 - July/Aug/Sept 25 Screen shot below from the Perinatal Safety Report confirming the two cases in the quarter had appropriate information sent to them	• that families have received information on the role of MNSI and NHS resolution's EN Scheme and that the duty of candour was performed.
	4.2. Summary of current MNSI cases and actions	

MNSI reference	Date of case	*DOC completed	Stage of investigation
MI-040822	Mar 25	Yes	Investigation completed – final report received – see recommendations and actions below
MI-043307/ MI-041974 (rejected)	May 25	Yes	MNSI initially could not gain consent from parents therefore initial referral rejected but subsequently re-referred as consent gained; draft report received in October 2025.

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

Q2 2025/2026 – Perinatal Mortality Report

This report presents the reviews undertaken for Q2 2025/2026 and any immediate actions identified. Some aspects of the MIS Year 7 safety action 1 have been included in the report for an understanding of ongoing compliance with the scheme throughout the Year 7 reporting period.

Terminations of pregnancy where the baby has been born >22+0 weeks' gestation have been excluded as these are not counted by MBRRACE in their official figures (though a notification is completed) and the PMRT review process is not supported by MBRRACE.

Late fetal losses are pregnancy losses where the baby has been born between 22+0 and 23+6 weeks' gestation, either born with no signs of life at birth, or who have been born alive and have subsequently died. Some of our babies are born alive but on the edge of viability, and resuscitation and ongoing care of these babies, with the parents' consent, is undertaken. However, these babies do not always thrive and survive and sadly die at a later time. Because they are not born at 24+0 weeks' gestation or older, they fall into the late fetal losses category in terms of being counted, though they are also by definition neonatal deaths. They have been captured here under the late fetal losses tab because of the gestation of their birth. MBRRACE supports the use of the PMRT tool for these losses but they are not counted in our official perinatal mortality figures.

Late fetal losses born between 22+0 and 23+6 weeks gestation

MBRRACE Case ID	*Gestation at death (weeks)*	*Level of investigation*	*SA1a – reported in 7 days*	*SA1b - Parents aware of review*	*SA1c – review started within 2 months*	*SA1c - External reviewer*	*Grading of care*	*Actions identified*
99385 Gater	22+4	PMRT	Y	Y	Y	Y	B/A	- Sharing learning about auscultation when clinical picture changes to support decision making for clinicians and psychological wellbeing for mother - 5 doses of paracetamol given in 24 hours – learning shared with staff at time of incident
99404/1 99404/2	22+6	PMRT	Y	Y	Y	-	TBC	- Some initial concern identified regarding appointments in Premature Prevention Clinic - ? should have had further scan - Being reviewed in November 2025 meeting so external Consultant can attend as per ODN externality process

Stillbirths are babies that are born at or after 24+0 weeks' gestational age showing no signs of life, irrespective of when the death occurred.

MBRRACE Case ID	*Gestation at death (weeks)*	*Level of investigation*	*SA1a – reported in 7 days*	*SA1b - Parents aware of review*	*SA1c – review started within 2 months*	*SA1c - External reviewer*	*Grading of care*	*Actions identified*

99575	26	PMRT	Y	Y	Y	Y	A/A	-	Good case to share with staff regarding professional curiosity and safeguarding, including assessing social vulnerabilities. Digital poverty support to be shared.

Neonatal deaths refer to a live born baby who died before 28 completed days after birth. These babies are counted by place of birth and not place of death. There are 2 cases where the Trust provided care but the babies were born and died elsewhere; these have been identified below. The responsibility for completion of the PMRT tool lies with the Trust where the baby has died though we review our care provided and allocate a care grading.

Neonatal deaths > 24 weeks where the baby died at WAHT:

None

Neonatal deaths > 24 weeks where the baby was born at WAHT and has died elsewhere:

MBRRACE Case ID	***Gestation at birth (weeks)***	***Age at death (days)***	***Level of investigation***	***SA1a – reported in 7 days***	***SA1b - Parents aware of review***	***SA1c – review started within 2 months***	***SA1c - External reviewer***	***Grading of care***	***Actions identified***
99946	25+1	7	PMRT	Responsibility of reporting Trust to complete				TBC	- No concerns on initial review - Being reviewed in November 2025 meeting so external Consultant can attend as per ODN externality process

Neonatal deaths where the pregnancy was booked at WAHT but the woman was transferred antenatally and the baby was born and died elsewhere:

(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

MBRRACE Case ID	***Gestation at birth (weeks)***	***Age at death (days)***	***Level of investigation***	***SA1a – reported in 7 days***	***SA1b - Parents aware of review***	***SA1c – review started within 2 months***	***SA1c - External reviewer***	***Grading of care***	***Actions identified***
99327	25+5	4	PMRT	Responsibility of reporting Trust to complete				B/A	- To review management and treatment of GBS in MSU sample – was subsequently treated but some delay – did not affect outcome
99352	32+2	0	PMRT	Responsibility of reporting Trust to complete				TBC	- Awaiting allocation by tertiary Trust – initial data provided
99421	24+1	4	PMRT	Responsibility of reporting Trust to complete				TBC	- Awaiting allocation by tertiary Trust – initial data provided

99892	36+0	- (SB)	PMRT	Responsibility of reporting Trust to complete	TBC	- Awaiting allocation by tertiary Trust – initial data provided
100080	27+0	1	PMRT	Responsibility of reporting Trust to complete	TBC	- Awaiting allocation by tertiary Trust – initial data provided
99940	22+4	0	PMRT	Responsibility of reporting Trust to complete	TBC	- Awaiting allocation by tertiary Trust – initial data provided

Neonatal deaths where the community midwifery was provided by WAHT but the woman was booked and the baby was born and died elsewhere:

(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

None

Worcestershire Acute Hospitals NHS Trust

Minutes for Quality Governance Committee

Thursday 30th October2025 at 10.00 am
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director (Chair)	✓
Required Attendees	Hayley Flavell	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	✓
	Chris Bryne	Healthwatch	✓
	Emma King	Director of Estates and Facilities	
Attending			
	Samantha Bucknall	EA to Chief Nursing Officer (minutes)	✓
Guest			

	Mike Cornes	Deputy Divisional Director of SCSD	
	Helen Harris	Associate Director of Nursing and Quality ICB	✓
	Tracy Pearson	Deputy Chief Operating Officer	✓

Item	Title
QGC/25/1	**Welcome and Apologies for Absence**
	Ms Moore welcomed all present at the meeting. Apologies from Stephen Collman, Rachel Dunne and Chris Douglas.
QGC/25/2	**Declarations of Interest**
QGC/25/3	**Minutes of the last meeting**
	The minutes of the meeting held on 2 October 2025, with a slight amendment to the IPR section, were confirmed as an accurate record and duly 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 further updates were provided
QGC/25/6	**Quality & Safety**
QGC/25/6.1	**Perinatal Services Safety Report**
	Ms. Jeffery presented the Perinatal Safety Report, highlighting the transition to NHS England's new Perinatal Quality Oversight Model and the expanded content of the report. She acknowledged the team's efforts in adapting quickly. Booking by 10 weeks remains below the 85% target but has improved from Quarter 1 to Quarter 2. Staffing and clinic space challenges have been addressed, and a shift to one-stop appointments is expected to drive further progress. Ms. Flavell asked about accreditation progress and safety champion feedback. Ms. Jeffery confirmed targets are on track and feedback from both executive and non-executive champions is included. Triage concerns raised during a September walkaround will be reflected in the October update. Two MNSI reports are ongoing, with one action plan approved. Key learning includes CTG monitoring and timely cooling during therapeutic hypothermia. Training is on trajectory, though mandatory training remains challenging. Role-specific training is strong. NET survey results show outlier status in several areas. The service remains understands for Workforce, Training and Education support, recently reduced to level one, with an updated action plan. New surveillance tools include the national perinatal dashboard (awaiting provider-level data) and MOSS, an early signal system. Initial feedback from pilot sites

	indicates teething issues, with normal tertiary activity being flagged unnecessarily. Ms. Jeffery will provide updates following webinars in November. **ACTION: Ms. Jeffery proposed a revised reporting schedule to reduce duplication and improve efficiency. The Safe Staffing Report would continue monthly, while two other reports would be rotated across each quarter. Ms. Flavell and Ms. Walton to review and discuss implementation.**
QGC/25/6.2	**Perinatal Incident Report**
	Ms. Jeffery highlighted two serious cases: an antenatal stillbirth following reduced foetal movements and a neonatal death after transfer at 25 weeks. Both meet PMRT criteria and will be reviewed in the quarterly report. Several moderate harm incidents were noted, including two hematomas, a bladder injury, and a drug error now under PSII investigation. A complex case involving bilateral hip fractures was managed with strong MDT support; the patient had undiagnosed osteopenia exacerbated by pregnancy. Ms. Flavell asked about CTG monitoring, noting its recurrence in recent incidents. Ms. Jeffery confirmed targeted work is underway, including support from a foetal monitoring lead, use of physiological CTG, and integration of learning into mandatory training, which has high attendance. Ms. Jeffery also noted potential changes under the new oversight model, where moderate harm incidents may be summarised as themes within the Safety Report, helping reduce reporting volume. Ms. Harris queried the haematoma and episiotomy case on page 44, asking whether consultant involvement should have been required. Ms. Jeffery clarified that the decision was subjective and based on the resident's competence, which was deemed appropriate at the time.
QGC/25/6.3	**Maternity Safe Staffing Report**
	Ms. Jeffery reported continued difficulty filling MCA vacancies, with turnover matching recruitment. The BirthRate+ three-year audit identified a need for just over six additional WTE staff, including 0.58 of a midwife. Investment planning is underway. Exit interviews revealed some Band 3 staff left due to redeployment following a skill mix review, while some Band 2s left after finding limited clinical contact in their roles, despite clear expectations at interview. Ms. Flavell queried funding for ACP and midwife roles. Ms. Jeffery confirmed partial CNST funding is available from last year's 10/10 achievement, with a further "invest to save" request planned. Discussion clarified that the new CPS role, functioning at registrar level, will support triage without replacing junior doctors. Ms. Flavell noted this could help address current challenges and acknowledged the two-year lead-in for ACP development.
QGC/25/6.4	**CNST Report Q3**
	Ms. Jeffery reported that the Trust is on track to achieve 10 out of 10 for CNST compliance this year. A minor vulnerability remains in training figures, with a small number of anaesthetists and doctors whose attendance is essential to maintaining the 90% threshold. All are booked and committed, and the target is expected to be met barring any unplanned absences. She noted that. The Quarter 2 PMRT report is embedded within the Safety Action Report. Of the cases reviewed so far, all have been graded A or B, indicating learning only. While there were areas for improvement, none of the issues would have

	changed the outcomes for the babies involved. Learning has been shared with the service and is reflected in the report. Ms. Jeffery confirmed compliance with Safety Action 4, including short- and long-term locum cover, appropriate induction, and 80% obstetric attendance at required events. However, the Trust remains non-compliant with BAPM neonatal medical standards and neonatal nurse staffing, both of which are recorded on the risk register and will be shared with the ODM as part of the technical guidance. Midwifery staffing is supported by monthly Safe Staffing Reports, which have been reviewed and discussed. The committee acknowledged submission and agreement of the action plan to achieve 90% compliance in PUMP training, addressing challenges posed by frequent changes in resident doctors. Additional documentation includes the Trust claim scorecards in the appendices, minutes from safety champion meetings, and records of QUAD meetings—all of which require formal acknowledgement. The report also confirms compliance with MNSI referral processes, with timely notifications, completed documentation, and additional notifications as required. Ms. Flavell sought clarification that, despite non-compliance with BAPM neonatal standards, the Trust remains compliant with CNST technical guidance due to the presence of an action plan, its discussion at committee, and its sharing with the ODN. Ms. Jeffery confirmed this. Ms. Flavell also asked whether a dedicated CNST session is required from a QGC perspective and whether it has been scheduled. Ms. Jeffery advised that the ideal timing for a dedicated CNST session would be January, to coincide with the Quarter 3 report and a round-up from Jane. She noted that the CNST reporting period ends on 30 November, and QGC falls around Christmas and New Year. Dates will be reviewed outside the meeting. **ACTION: Ms. Jeffery and Ms. Flavell to review and confirm with Ms. Moore whether a dedicated CNST session should be held in December or early January, ensuring alignment with the Quarter 3 report and CNST reporting period (ending 30 November).** **A short meeting will be arranged if needed, ensuring quorum.**
QGC/25/6.5	**Nurse Safe Staffing Report**
	Ms. Flavell introduced the paper and confirmed it would be taken as read. She noted that the document includes escalations from the Nursing Workforce Advisory Group (NWAG), which inform the current report. The paper outlines that fill rates and care hours per patient per day remain in line with national guidance. The biannual staffing review has been completed, with findings to be presented to this committee and the Trust Board in due course. The Trust is currently compliant with agency cap requirements. A structured programme is underway to reduce agency usage across the organisation. Ms. Flavell emphasised that this will be done in a measured way, avoiding any knee-jerk decisions that could require reversal. This approach has been agreed through NWAG. She also noted that, while standard bank rates are not under review, there is ongoing consideration of enhanced bank arrangements. Categories labelled PA and NTL are also under review, with plans to remove them safely to ensure parity with bank staffing across the organisation. Ms. Flavell drew attention to temporary escalation areas, which currently require approximately 84 whole-time equivalent staff per month. These areas include the PDU which is under consideration for closure but faces ongoing challenges, and funded posts within the Emergency Departments.
QGC/25/6.6	**UEC Harm Review/ Assurance Dashboard**

	Ms. Flavell presented a revised, more focused report triangulating complaints, risk, and feedback, noting nearly 13,000 attendances in the month. Red-rated areas requiring intervention have been identified, with actions underway. Audits are being reviewed to ensure they drive improvement, including the waiting room audit. Feedback from ECIST following visits to Worcester and Redditch is included, with support offered to address corridor care and escalation spaces. ECIST noted good governance but highlighted the need for further work across pre-hospital, discharge, and internal processes. Mr. Murphy raised concerns about staff behaviour complaints. Ms. Moore queried an agency nurse incident, which Ms. Flavell confirmed is under investigation. Ms. Moore suggested a review of agency staffing, citing both financial and quality concerns. She also noted that care and comfort rounds should be embedded as part of staff roles, rather than requiring additional resource. Ms. Lynch suggested exploring greater use of volunteers to support basic care tasks, freeing up nurses for clinical duties. Ms. Flavell confirmed that volunteers are already present in Emergency Departments and agreed to include further detail in the report.
QGC/25/6.7	**Patient Safety Incident Investigation Report**
	Ms. Flavell provided an interim update from the Patient Safety Incident Report Group, covering incidents from September and October. A full quarterly report is forthcoming from the Head of Patient Safety. She highlighted a red-rated incident involving the death of a patient in ED Resus, reviewed at the PSII meeting and subject to coroner investigation. The patient's sister has been involved throughout, received the report, and is expected to meet with the division, Ms. Flavell, and Ms. Walton. Ms. Smart raised concerns about alarm fatigue, referencing a safety walkaround where constant alarm noise made prioritisation difficult. Ms. Flavell acknowledged the issue and stressed the importance of appropriate alarm settings. Ms. Moore called for a review of staff allocation decisions on the day of the incident, suggesting this may be more critical than training gaps. She also questioned the reliability of monitoring equipment. Ms. Walton confirmed all monitors have been checked and latching functions are inactive, explaining that latching causes alarms to persist until manually silenced. Ms. Harris recommended sharing the learning with the Foundation Group, given its broader relevance, and asked about concerns regarding the coroner's outcome. Ms. Flavell agreed, noting the value of system-wide learning and confirmed preparations are in place ahead of the March inquest. Ms. Moore requested that, as part of the staffing paper and agency review, consideration be given to whether current staffing levels are sufficient but skill mix may be lacking. She suggested exploring whether staff are adequately trained for the roles they are expected to perform, with an initial focus on Emergency Department settings. Ms. Moore raised concerns about repeated wrong-side eye procedures, questioning whether there may be a systemic issue in ophthalmic. Mr. Walton confirmed the division is reviewing the matter, noting complexities in distinguishing left and right due to overlapping conditions. Measures such as differentiated paperwork are being considered to improve clarity. Ms. Sinclair queried whether safety protocols like LOCSSIP/NatSSIPs are in place outside theatre settings. Mr. Walton confirmed they are, clarifying that incidents involved incorrect eye selection or marking prior to treatment, rather than errors during the procedure itself.

	ACTION: Include an assessment of staff skill mix and training needs, particularly within ED, as part of the upcoming staffing and agency workforce review.
QGC/25/6.8	**Medicine Management**
	Ms. Flavell provided an update on recent incidents involving medicines preparation and administration, noting a concerning trend despite long-standing practices. An initial audit has been conducted to establish a baseline, with a focus on how drugs are prepared and administered, rather than storage or temperature controls. She emphasised the need to understand the gap between expected and actual practice. Incidents have occurred across different areas, including maternity, and involve both a student midwife and a newly qualified staff member. Compassionate support is being provided, and system-based investigations are underway. The Trust is also engaging with the University of Worcester to review training content and has reviewed internal training policies. Ms. Moore noted that the current audit does not assess whether patients receive the correct medication and asked when live data would be available. Ms. Brown confirmed that the electronic system will go live on 24 November at the Alexandra Hospital, followed shortly by Worcester, enabling real-time audit of medication administration.
QGC/25/7	**Performance Reports**
QGC/25/7.1	**Patient Safety Alerts Q1**
	Ms. Flavell confirmed that the Trust is up to date with all safety actions reported, noting that the first item listed in the report has now been closed following verification with the Head of Patient Safety.
QGC/25/7.2	**Integrated Performance Report**
	Ms. Pearson reported that August saw improvements in 62-day cancer treatment performance, bucking the regional trend. However, a dip is expected in September due to efforts to clear a backlog of 62-day patients, particularly in breast and skin pathways. While this may impact reported performance, it reflects a proactive approach to recovery and prioritising timely treatment. Recovery is anticipated by January, with efforts underway to accelerate progress following higher-than-expected patient treatment volumes in September. Ms. Smart raised concerns about theatre throughput at Worcester, noting fewer cases per list compared to past practice. She asked how performance compares with model hospitals and what actions are being taken to improve theatre utilisation. Ms. Pearson responded that utilisation at both Alexandra and Worcester sites is consistently reaching 85%, placing the Trust among the better performers nationally. However, she acknowledged that the number of cases per list remains an area for further focus. Ms. Moore queried whether 85% utilisation reflects actual productivity, noting it may only indicate that sessions were used, not how well they were used. Ms. Pearson confirmed that the Trust tracks a variety of metrics including session use, early starts, late finishes, dropped sessions, recycled sessions, and conversions between elective and emergency cases. Ms. Moore noted that not all metrics are visible to the committee and suggested performance may be worse than reported. **ACTION: Provide a detailed theatre performance report within six months, covering:** • **Dropped sessions** • **Recycled sessions**

	• **Sessions not completed** • **Late starts and early finishes** • **Planned theatre hours vs. actual hours spent operating on patients**
QGC/25/7.3	**GIRFT Q2**
	Ms. Walton presented an update on the national GIRFT programme, which aims to ensure patients receive the best care first time. The report outlines current activity, including theatre utilisation metrics such as late starts and early finishes, with supporting data available in the paper. She noted ongoing efforts to better integrate GIRFT into divisional workstreams, as it currently operates somewhat separately. Strengthening oversight and embedding GIRFT into operational practice remains a priority. Ms. Walton also highlighted a recent neurology visit that received excellent feedback, commending the team's performance and emphasising the importance of recognising areas of success alongside those requiring improvement.
QGC/25/8	**Governance & Risk**
QGC/25/8.1	**Improving Safety Action Group Escalations**
	Ms. Flavell provided an update from the Improving Safety Action Group (ISAG), which tracks improvement work arising from the Patient Safety Incident Review Group (PSIRG). She noted this was her first meeting and presented the escalation report. A Regulation 28 notice relating to fragile services was discussed, with plans to address this through divisional processes. Progress will be monitored via ISAG until embedded, after which oversight will transfer to routine financial performance executive meetings. Sepsis management was a key focus. Training modules are now available on ESR, and compliance is being tracked weekly via the CNO production board. Ms. Brown confirmed that sepsis data will begin to flow from November. Sepsis has also been integrated into the DREAMS meeting. Ms. Flavell highlighted the upcoming rollout of Martha's Rule, led by one of Ms. Walton's deputies, and noted efforts to avoid siloed working. The group also reviewed the longstanding CQC action plan, with some actions dating back over a decade. The health and care safety team, alongside divisions, has been asked to assess which actions are now part of business as usual and how to progress under the new single assessment framework.
QGC/25/8.2	**Clinical audit & Effectiveness**
	Ms. Walton highlighted that the next major focus area will be the management of key documents across the organisation. The aim is to ensure all documents remain in date and are proactively updated as they approach expiry. This work will be supported by a structured plan developed by Elaine, the lead for this initiative, and will link with actions from audit and the Research & Innovation team.
QGC/25/8.3	**Risks (15 or above) Report**
	Ms. Brown presented the quarterly report on risks rated 15 and above, monitored by the Quality Governance Committee. The current profile includes one risk rated 26, one at 16, and two at 15. Several of these relate to ED overcrowding and specialty referrals and have been discussed in earlier agenda items. She noted that deep dives are scheduled every two months via the Executive Risk Management Committee, with outcomes reflected in the report. Ongoing work

	includes improving training and linking mitigations to business continuity measures, as requested by committee members. Future reports will include an appendix listing all risks rated 15 and above to support triangulation and broader visibility across the Trust. Ms. Moore requested clarification on the timeline for cath lab developments following the Trust Board meeting scheduled for 12 November. Ms. Walton advised that, based on information from the Director of Operations for Medicine, the work is scheduled to commence in January. This is expected to help mitigate associated risks, and final dates will be confirmed Mr. Byrne queried the reference to HALO inconsistencies in the ED overcrowding report, seeking clarification on the nature of the issue. Ms. Brown explained that HALO refers to the Hospital Ambulance Liaison Officer role, and Ms. Walton confirmed that the position has been inconsistently filled across sites by partner organisations. Ms. Walton noted that the impact is more pronounced in processing delays, particularly from the West Midlands side—rather than in direct handovers. These delays occur when ambulance crews complete their hospital transactions and "pin off," which can be affected by the absence of a HALO on site
QGC/25/9	**AOB**
	No AOB
QGC/25/9	**Next Meeting Date 27th November 2025**
QGC/25/10	**Reflections on the meeting**
	The Chair thanked all presenters and attendees for their contributions. No further items were raised, and the meeting was concluded.
QGC/25.10.1	**Meeting closed at 11.15**

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 13 November 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	**Electronic Patient Record (EPR) Programme Benefits Realisation**
Rating rationale	The programme started in 2022 following a 2-year pandemic related delay. A considerable amount of work had been undertaken to implement the programme, which had multiple workstreams and phases. The next, important, phase (electronic prescribing and medicines administration) would launch in November, with a further phase planned for 2027. Expenditure to date was just under £3m over budget. The Committee was assured regarding the reasons for this and the associated governance arrangements but agreed that there should be a clearer mechanism for Board oversight. A number of significant quality benefits had been achieved including improved staff feedback. Validated financial benefits to date were savings of over £2.3m since go-live. Additional £346k savings per annum were calculated (to be validated). Further work was needed to translate improvements into cash savings, which were linked with the workforce plan. Operational and clinical processes required standardisation, and optimal use of the system was needed to ensure full benefits realisation (including productivity) through transformation.
Outcome	The Committee welcomed the transparency and openness of the report and commended the achievements to date in challenging circumstances **Action**: Consider a mechanism to keep the Board more regularly apprised of major programme implementation, including any projected overspends.
Item/Topic	**Financial Governance**
Rating rationale	• Losses and special payments These included bad debts, lost patient property and expired pharmacy stock. It was proposed that 41 items (value £24.2k) be written off following attempts of debt recovery. Items included former staff member overpayments, private patients and overseas visitors. • Non-compliance with SFIs The main breaches were invoices received with no purchase order and confirmation orders raised after invoice received. All breaches were logged and followed up by the Finance Department, which assured appropriate documentation was put in place. Where appropriate a matter may be escalated to the Chief Finance or Chief Operating Officer. Guidance had been updated and regular budget holder training was now provided. Repeat offenders may have system access removed. • Tender Waivers The new procurement system and associated engagement with staff was reducing the number of waivers, with a clear decrease in volume and value compared to the same period last year. • Managing Medicines Waste The year to date % losses were above target due to a small number of particular issues affecting high-cost drugs. An action plan was in place aligned to common themes or therapeutic groups, with new actions added as needed. Many actions were low cost.
Outcome	The Committee was assured by new and developing processes and systems to improve financial governance across the Trust. The Committee agreed the proposal to write off £24.2k bad debt. The Committee welcomed the attention paid to the reduction of medicines waste.

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: 13 November 2025
Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	**Counter Fraud, Bribery and Corruption Progress Report**
Rating rationale	Proactive activities were progressing according to plan. An assessment of the Trust's position against the checklist of requirements for the prevention of fraud would be presented at the next meeting alongside an action plan. 13 incidents had been reported so far in 2025/26; three were in the investigation phase and all others were closed.
Outcome	The Committee was assured regarding progress against the plan.
Item/Topic	**Internal Audit Progress Report**
Rating rationale	Good progress was being made on the annual plan with two reports complete – both rated significant assurance – and three reports in draft. Planning for 2026/26 had commenced with both executive and non-executive engagement; the final plan would be presented for approval in March. The management action tracker continued to show good progress in responses to audit recommendations.
Outcome	The Committee was assured by progress and management actions.
Item/Topic	**Internal Audit: Fit and Proper Person Test**
Rating rationale	The report was rated 'significant assurance' based on a robust policy, compliant processes and good record management. Two low risk recommendations were made, one of which was complete. The other required an adjustment to the policy, which would be undertaken as part of a fully policy update, planned for January 2026.
Outcome	The Committee welcomed the positive report.
Item/Topic	**Internal Audit: Procurement and contract management**
Rating rationale	The report was rated 'significant assurance' with two medium and five low risk recommendations, all of which had appropriate plans in place.
Outcome	The Committee welcomed the positive report and the management response to the recommendations.

To Note: Items received for information or approval	
Item/Topic	**Board Assurance Framework (BAF)**
Summary	An update was provided on the development of a refreshed BAF on a new template, aligned to the new Trust objectives, with a greater focus on actions and assurances.
Outcome	The Committee welcomed the developments.

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
Colab, Kidderminster Treatment Centre
Tuesday 7th October 2025 at 10:00

Present		
Chair	Karen Martin (KM)	Non-Executive Director
Members	Ali Koeltgen (AK)	Chief People Officer
	Stephen Collman (SC)	Managing Director
	Jules Walton (JW)	Chief Medical Officer
	Justine Jeffery (JJ)	Director of Midwifery
	Neil Cook (NC)	Chief Finance Officer
	Sue Sinclair (SSi)	Non-Executive Director
	Colin Horwath (CH)	Non-Executive Director
Attendees	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Rachael Hayter (RH)	Director of AHPs
	Liz Faulkner (LF)	Deputy Chief People Officer
	Richard Haynes (RHa)	Director of Communications & Engagement
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Libby Marshall (LM)	Apprenticeship & Widening Participation Lead
	Rebecca Fox & Sinead Tullett	Deputy Director of Midwifery & Directorate Manager - Maternity
	Sarah Troth (ST)	Advanced Clinical Practitioner- Lead for 'Out of hours hospital at night, practitioning team
Apologies	Chris Douglas	Chief Operating Officer
	Kate Haddigan	Chair of Women's Network
	Simon Murphy	Vice Chair
	Rich Luckman	Assistant Director of People & Culture
	Julie Moore	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 5th August 2025 were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly.	
	Staff Story – Fatigue Management	
	A staff survey conducted several years ago highlighted areas for improvement, but progress on the strategy has been slow. The initial plan was to pilot a nutritional coach and Z beds for unpaid rest breaks in two wards (one at WRH and one at ALX). The initial proposal was difficult to gain approval due to being deemed as a clinical trial, but wording in the proposal has since	

	been revised as a wellbeing project. Implementation began two weeks ago; a Z bed chair is now available for staff, and a nutritional coach will be accessible via an app next week. ST shared that data collection was initially planned to be via activity watches, however due to team changes this had to be changed to manual collection. Questions were raised regarding compliance and quality of the data over an extended period due to the length of the questionnaire. Overall progress has been limited; there have been delays with the e-learning however information is available on the wellbeing hub. ST did not feel the culture had improved, with staff still sleeping in costa entrance at WRH, and signs displayed which request light switches not to be turned off. There is an opportunity to combine this work with the Resident Doctor 10-point plan and make improvements for multiple staff groups. **ACTION - JW meet with HF and AK on next steps.**	
	Staff Network Updates: Women's Network	
	Since launching in February, the Network has had considerable engagement from staff, and elections will commence soon for a Vice Chair. Staff stories are shared via the intranet and a Q&A panel meeting on imposter syndrome was well received. Further events are planned on women's health, career development and mindfulness following feedback from Network members. The Network would benefit from involvement by male allies, and the Committee was asked to encourage colleagues to join.	
	Chief People Officer Report	
	The 2025 Flu campaign has started, and with a change in the distribution of Covid vaccines, only individuals who meet specific criteria will be offered a jab from their GP. Whilst all bookable slots for staff flu vaccines have been filled, Flu Champions will start visiting areas soon to offer vaccinations. Walk-ins are still available. SC noted that evidence indicates staff sickness rates can be directly influenced by the timely administration of flu vaccinations prior to winter. Setting a vaccine target was also recommended. There was feedback that some staff feel that vaccines do not work on new strains, and RH confirmed that there will be communications on this shortly to clarify. Racism is being experienced by some colleagues in the Trust and AK informed that the Trust will be signing the Anti-Racism charter. Following the publication of national profiles, there has been variation across Trusts in the uplift from band 2 to 3 of Healthcare Support Workers. WAHT has now reached agreement with Unions on the offer, however, there remains activity via the Trust's Rumour Mill, both from existing band 3s, and band 2s who are out of scope. It was noted that this could have an impact on the Staff Survey in some areas.	
	HR Casework	
	Formal casework has increased each year and is projected to reach approximately 200 cases by the end of the year. This has also affected the number of tribunals; there were previously approximately two cases at any given time, and there are now seven cases listed and three additional cases with ACAS for conciliation. While the cases are not directly related, recurring themes such as racism and constructive dismissal have been identified. The first case is scheduled for tribunal in November, with the next not scheduled until 2027. The impact on staff has been noted, and the team is working diligently to provide necessary support. Following some themes regarding reasonable adjustments, the HR team have been working the DAWN Network to develop a Reasonable Adjustments toolkit to support staff and managers. There has also been feedback from staff on panels or appeal panels and some cases where staff have been reinstated on appeal. Panels were previously composed of a Chair and supported by 1 HR person. Following feedback that the Chair felt isolated in decision making, it has been agreed via JNCC the composition will now be 2 individuals, plus 1 HR person. Due to a sharp rise in suspensions the previous year, a review of the process and documentation was undertaken with new guidance being issued. There have been some instances of inappropriate use of social media or staff accessing data inappropriately (their own or other colleagues'). It was felt that strong and clear messaging was needed to remind staff of the reasons why this is inappropriate, and the consequences of doing	

so. It was noted that the rollout of EPR in some areas could correlate with the instances, making it easier and quicker to access records. BE noted that consequences can vary depending on other factors and context, and AK shared that Staffside felt previous messaging warning staff of accessing records inappropriately was too strong.

Given the increase in casework it was suggested that a collaboration with the rest of the Foundation Group might be beneficial in terms of the Capsticks contract. There was discussion regarding the rise in sickness absence, and the policy may be reviewed. Cases regarding sexual safety are reported separately however BE agreed it could be beneficial to consolidate.

AK observed that the trend in more litigious cases is reflective of the national landscape. Individuals pursue formal legal action more rapidly when held accountable, leading to higher costs as disputes escalate. Contracting out to Capsticks provides the Trust with flexibility, although there may be opportunities for improved arrangements as a Foundation Group. ***Agreed for 6 monthly report.***

Widening Access

There has been considerable growth in the apprenticeship programme; the Trust now spends around £1.1m of on apprenticeships, the majority of which are for the existing workforce.

The use of degree apprenticeships in nursing, AHP and Allied Health sectors are growing the workforce. Divisions are beginning to review applications for nursing apprenticeships to confirm that a position will be available upon completion of the apprenticeship. Early careers apprenticeships have reduced in the last year, and changes nationally mean that level 7 apprenticeships will be de-funded from January 2026 with the government aiming to focus on the early careers workforce. Work experience included 178 placements, with more than 500 individuals expressing interest. The program collaborated with 20 schools and members of the local community. The supported internship cohort achieved a 100% transition to employment in its first year. While the second year's outcomes were less successful, targeted improvements are being implemented for the third year. The Trust is working with local Worcestershire colleges on developing T Levels, to bridge A levels and apprenticeships. They require a 45-day placement, encouraging students to consider WAHT as a future employer.

Managers report that having an employee on an apprenticeship involves their absence for study days and potentially at the completion of their programme. As a result, teams typically support only a limited number of apprentices at a time and may require backfill to cover for those participating in study.

LM stated that supported internships are intended for younger individuals with diverse abilities. AK mentioned a discussion with the growth hub chamber of commerce regarding whether certain groups may require additional attention. The retention rate of apprentices was queried and LM advised that this information is available via ESR.

People Strategy – Workforce Transformation

An administrative review will begin next week to examine duplication, inefficiencies, and variations in roles and processes. With the rollout of T PRO and Copilot, the group will assess if current structures are operating effectively. The group will have both Divisional and Staffside representation. Collaboration with digital colleagues will be undertaken to clarify details and expectations related to TPRO. The Working Group will compile recommendations, including identifying initial focus areas and prioritising specific roles for early review. The first six months are intended for rapid implementation in smaller areas; however, the overall process is expected to continue for a longer period.

NHS England is launching a national programme, 'Transforming People Services', to review the operating model for People Services in Trusts over the next 2-3 years and utilise digital improvements.

The committee felt that more detail on the structure of the programme and aspirations would be useful. For oversight and assurance, the group will report to the Operational Assurance Committee.
Agreed for a further report to come to the December meeting.

	Nursing & Midwifery Job Profiles	
	As part of the settlement following industrial action, the government committed to review job profiles. Concerns had been raised regarding the job evaluation process, with staff felt to be working to outdated Job Descriptions and therefore inaccurate banding. A task and finish group has been initiated to evaluate the level of risk across the nursing workforce in bands 4–9. The assessment includes determining how recently job evaluations have been undertaken. The Trust will be required to submit quarterly audit returns. Questions arose about the number of band 7 managers. LF clarified that many advanced nurse practitioners are classified as band 7 due to their expertise, not due to holding managerial positions. The committee recognised the need to compare the Trust with similar organisations and to develop generic job descriptions. It was asked that future reports on this item include next steps.	
	Responsible Officers Report	
	The report is a Summary of activity taken place over the last year. 602 doctors were connected to the Trust, and of this, 467 had completed an appraisal. Some missing individuals are doctors who joined this year but aren't yet due for appraisal, and 44 were late. The number of cases flagged is increasing, with referrals to the GMC. Regarding safeguards and complaints about medical staff, JW informed this is incorporated into the appraisal process as central information sharing has been implemented. Part of the process will involve triangulating complaints, litigation and incidents, and sending this information to individual doctors. The appraiser will be made aware if something needs to be discussed but will not know the detail. SS commended the significant improvement.	
	Midwifery Quality Intervention Review Report	
	There was poor survey feedback in 2020, followed by 2 visits from NHS England over 4 years, resulting in action plans and the Trust being placed on an intensive support framework. Following a visit in spring, NHSE observed considerable improvements and deescalated support. Feedback requiring continued improvement include learner dissatisfaction with the duration of placements, lapses in providing feedback, and the effect of cohort size on the quality of learning. The University had previously increased cohort size without consulting the Trust, however communication has improved, and the Trust has reconfirmed the number of students it can support given the number of births in a year. NHSE will continue to monitor the progress of the action plan and the Trust awaits confirmation of the criteria to exit intensive support.	
	Maternity Culture Improvement Plan	
	As part of attendance at the Perinatal culture and leadership programme course a culture survey was required. There was a 50% response rate, and this was compared with results of the Staff Survey. Some areas of strength were identified such as professionalism, purpose teamwork, line management and sense of psychological safety. Areas for development were also identified for example burnout and workload, leadership visibility and feedback, teamwork and communication, safety culture, decision-making and growth, retention and job certainty, and work-life balance. A variety of actions have been carried out against each area for improvement and are listed in the slidedeck shared. SC felt it was important for staff to feel empowered and encouraged to use the improvement methodology to make improvements. There has previously been poor communication with the Neonatal team, however a bimonthly directorate meeting is now in place to improve communication and encourage the teams to work together to resolve issues. The team is promoting the Hold the Moment maternity appeal and encouraging donations.	
	Job Planning	
	Ongoing efforts are increasing progress, with compliance now at 70%. Directorates will be undertaking the first round of team job planning over the next few months. Most elements of the action plan are on track for completion, however acknowledged the need to ensure the right	

	resources are available to support this. Discussions about job planning within the cultural context are currently ongoing. The next stage will be to review the effectiveness of job plans.	
	Compliance with 10-point Resident Doctor	
	A 10-point plan has been issued from NHSE following conversations with the BMA and Resident Doctors Committee to improve their working lives. A subgroup has been formed and led by the CMO and medical education teams to work on the action plan. Reports will continue as the work progresses. AK noted this level of reporting requires a high level of administration. If Resident Doctors work beyond a specified number of hours or if working conditions are affected by actions or omissions of the Trust, they may submit an Exception Report for up to 2 hours over their allocated time, which will be paid automatically. There is also a fine structure for the organisation if it does not process the reports within a required timeframe.	
	Temporary Staffing Reduction Plan	
	The strategy for this year focused on reducing agency usage, which has been achieved; however, this has resulted in increased bank usage. While using the Trust's own staff for extra hours is preferred, reducing reliance in both areas is ideal. The Trust will be meeting with the national team soon to discuss the progress through Agency Programme Board. The Trust considers reducing bank rates and is working through a Quality Impact Assessment to understand potential impact. The operational risk was acknowledged, along with a need to be cautious agency does not increase. Rules should be consistently applied; if there are no vacancies, agencies should not be used, and payments should align with cluster rates. It was noted that 80% of bank nursing staff are Trust employees taking on extra shifts. This may lead to feelings of being undervalued and some pushback, which could be reflected in staff survey feedback. ***Include cultural impact in the next update.***	
	Governance	
	People & Culture Risk Register Two risks above 15 persist: job planning and bank/agency. Following the previous meeting, there was a request to include the threshold for reducing the risk scores. For bank and agency this is where the Trust achieves the aim outlined in the workforce plan. SC felt the narrative needs to reflect the issues persisting with bank, acknowledging agency moving in the right direction. For job planning, the threshold is to be withing 5% of achieving the national 95% job planning target. SC pushed for further improvement and suggested to make incremental changes as approaching 95%. Two risks, related to retention and vacancy, are being reduced. The vacancy rate has decreased to 7%, and turnover is currently at 8%, which is below the target of 11.5%. Recommendations will be submitted to Executive Risk Management (ERM) for closure of these risks; however, they may be reopened if specialist concerns arise in the future, in which case they will be managed by the professional lead for the relevant area. A minimum turnover target was briefly discussed given the need to reduce headcount. A risk regarding employee casework should be considered at ERM as it is likely to worsen.	
	Any Other Business (AOB)	
	A charity bid supported by EmbRACE has secured a grant of approximately £50,000 to support international students, with implementation planned for 2026. The initiative will be managed through the wellbeing steering group. ***Agreed to bring back to the December meeting to share the impact on staff.*** **Impact of change in SPAs (action log query)** A paper to TMB outlined SPA benefits but raised questions at FRB about tracking the financial impact of increasing paid SPAs from 1.5 to 2. Some divisions are absorbing costs and others are not. The organisation must clarify cost recording, as JW noted highlighting SPA cost increases may be perceived negatively. **ACTION – AK, NC, and JW to determine how best to present the cost of raising SPA.**	
	Date of Next Meeting	
	The date of the next meeting is Tuesday 2nd December, Boardroom Alexandra Hospital.	

Escalation and Assurance Report

Report from: PFI Exit Committee
Date of meeting: 01 December 2025
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**General Update**
Summary	The Committee received an update on the following topics and was assured by progress to date in each area. • Liaison with the National Infrastructure and Service Transformation Authority (NISTA) had now been formalised. This would provide a source of both support and independent assurance to the PFI exit project. • Options to resource the management of the project were being considered; a detailed proposal would be presented to the Committee at its next meeting in March. • The plan to commission a Condition and Compliance Survey was progressing well. It was intended that the Compliance survey would be completed first to help inform the scope of the Condition Survey. The former was expected to start in early 2026; the latter would require legal documentation which was in development ahead of Board approval by the end of March. It was noted that extraordinary meetings of both the Committee and the Board may be required for this purpose. • Plans and options regarding the Managed Equipment Service were developing; a clear position would be presented later in 2026/27.

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 COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**09/12/2025**
Title of Report:	Freedom to Speak Up Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☒ **Discussion**
Report Approval Route:	Other
If Other, provide details:	
Lead Chief Officer/Director:	**Director of People and Culture**
Author:	Melanie Stinton FTSU Guardian
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

- The themes arising from the concerns raised through freedom to speak up
- The learning the Trust has taken from recent concerns

The actions that are being taken to further improve our culture of openness

2. Recommendation(s)

The Board are asked to receive the report as part of our ongoing commitment to creating a transparent and psychologically safe culture.

3. Report

Role of the Guardian

The role of the guardian is to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement. This is done by ensuring that workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and issues raised are used as opportunities for learning and improvement.

Role of the Champions

The role of the champion is to support any member of staff who wishes to raise a concern, take their full details and forward to the Guardian for action.

We currently have 38 appointed FTSU champions spread across all three sites and departments who can be the first point of contact for staff who wish to raise or discuss a potential concern. We are constantly actively recruiting and have 5 new ones being trained later this month.

A recent scoping of the Champions has identified though that within the surgical, urgent care, medical and estates and facilities we have very few champions and a push to recruit to these areas is now required. All champions complete the National Guardians office training, and we have worked in collaboration with the health and care trust to develop bespoke training for all existing champions and any new recruits. We have started to grow a further group of champions with more being recently trained in conjunction with the Health and Care Trust, this programme will remain on-going all year. A page dedicated to the champions is now available on the FTSU section on the source, this enables staff to locate one on their site and there are plans to list all champions on the mentoring platform as that evolves.

Good news

The portal continues to grow, and the Trust is now host for two neighbouring Trusts who are using the portal, the Guardian has also been approached by another Trust in the foundation group to adopt the portal and that's on-going. We have added protected characteristics, so the Guardian is now able to provide this data, and we have added a feedback survey which is automatically sent when cases are closed to enable us to continuously improve on the service. The Guardian has also recently done a deep cleanse of the portal and changes are sat with IT to make it more concise with data collection. A QR code has also recently been developed, and this will be launched across the Trust to give staff even more access to the portal particularly those groups that don't or can't access the source. This will be prominent at the newly designed Trust Induction where champions will man the stalls at lunchtime and hand out

business cards containing the code. The Guardian is also developing a video to be shown to all staff at this as well.
The Listen Up module of the training launched on March 1st and for leaders and managers in the Trust This will be followed by the last module of Follow Up for senior leaders in the Trust in the New Year.

Cases

Data on FTSU concerns to date on November 24th 2025

Month	Cases raised	Open	Closed	Anonymous
November 2024	11	0	11	2
December 2024	1	0	1	0
January 2025	12	0	12	5
February 2025	6	1	5	1
March 2025	13	0	13	5
April 2025	8	2	6	2
May 2025	3	0	3	0
June 2025	11	2	9	4
July 2025	18	5	13	3
August 2025	13	2	11	3
September2025	6	4	2	1
October 2025	14	8	6	5
November	8	7	1	2
Total:	124	31	93	33

From November 2024 to date there were 124 cases, there have now been 578 cases since the advent of the portal in October 2020. The breakdown of anonymous cases over the last 4 years is as follows:

	Cases	Anonymous percentage
April 18-19	36	5%
April 19-20	44	0%
April 20-21	63	20%
April 21- 22	103	28%
April 22-23	123	46%
April 23 –24	102	45%
April 24- 25	134	27%
April 25-date	80	25%

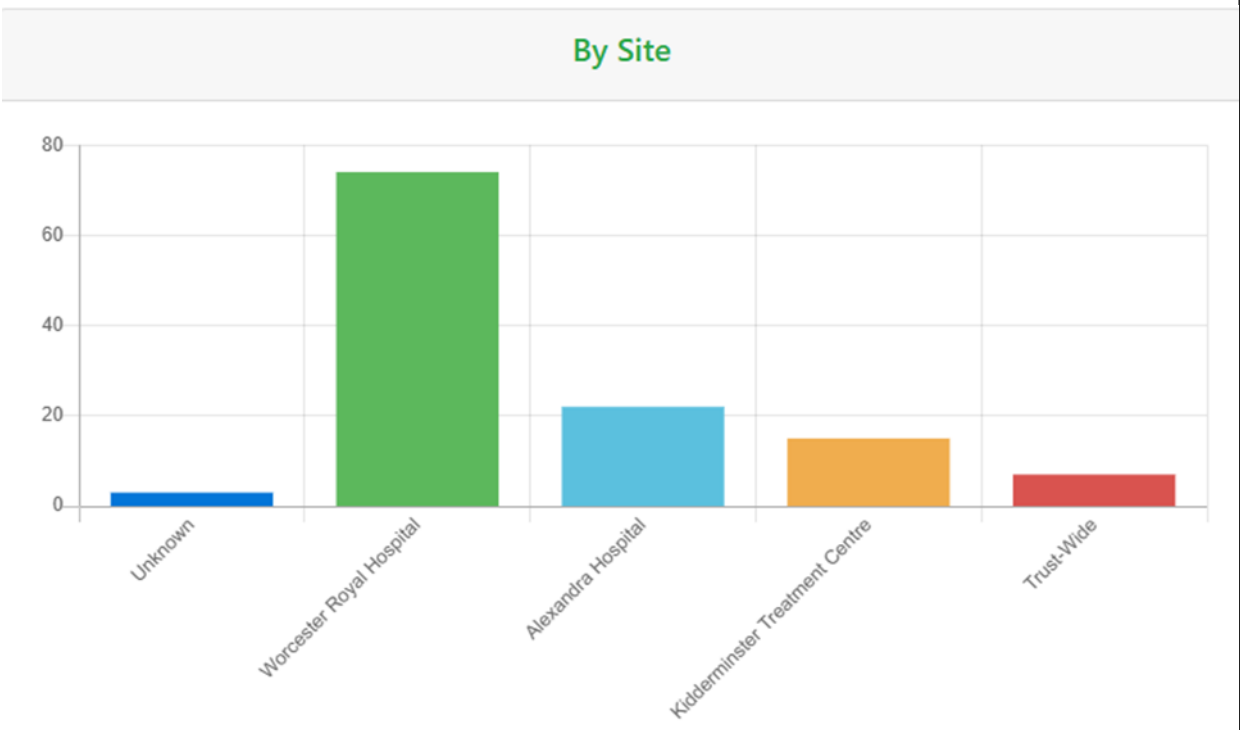
There has been an increase of cases being reported, for the first time though we have seen a decrease in anonymous cases raised, this has continued into this year and this is positive as it means staff are becoming more confident in raising concerns.

From the table below it can be seen that attitudes and behaviours is the most common theme of the concerns raised. There has been a sharp increase in cases reported since in the last calendar year and it appears that since mandatory training has launched that this has impacted on the number of cases.

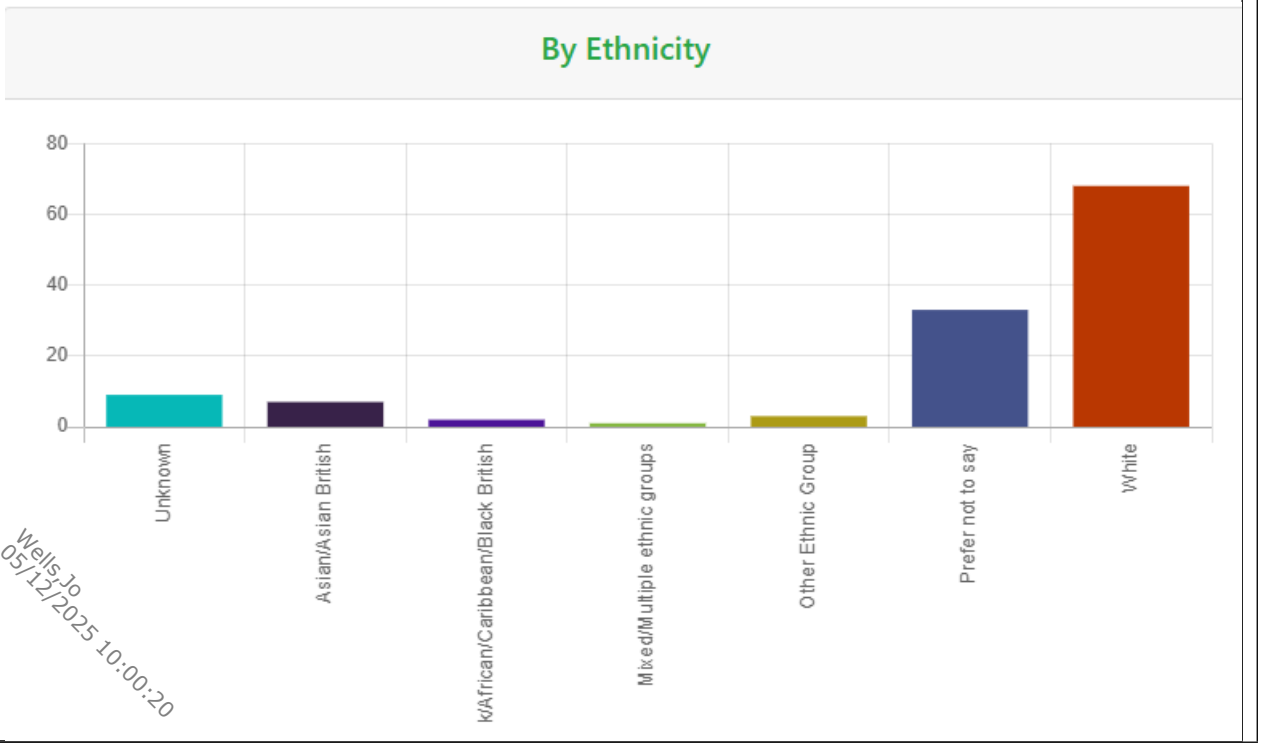
Theme	Number
Bullying and harassment	38
Staff Levels	3
Fraud	2
Attitudes and behaviours	90
Policy and Procedures	32
Quality and Safety	11

Worker safety and well-being	41
Other	8

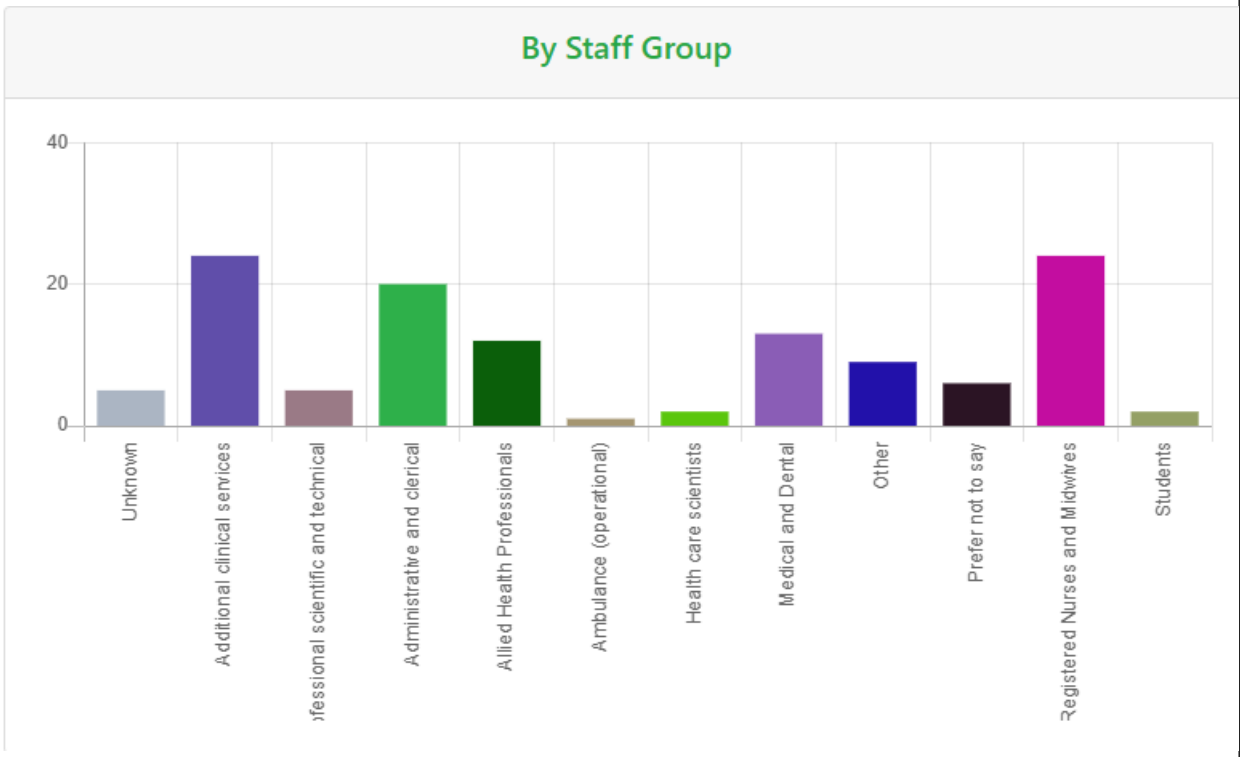
The following graph details the number of concerns raised by site:



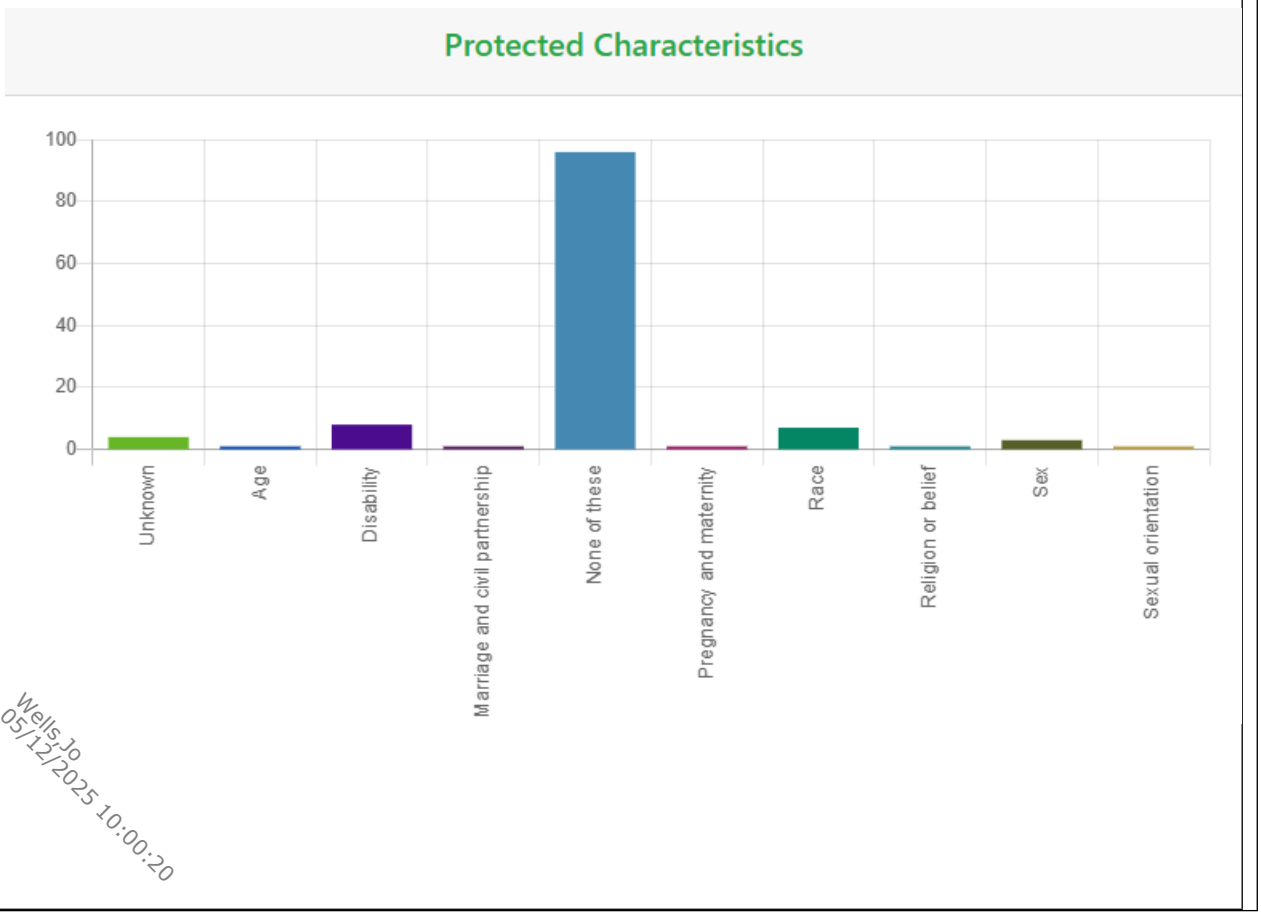
The following graph details the number of concerns raised by ethnicity:



The following graph details the number of concerns raised by each staff group:



The following graph provides a breakdown by protected characteristic:



Headlines from the data:

- The distribution across the three sites is proportionate to the sizes, this is aided by regular walkabouts by Guardian and NED.
- The main themes continue to remain predominantly attitudes and behaviour and bullying and harassment.
- The option to highlight a protected characteristic now allows us insight into if we are seeing an increase of concerns raised in any of these areas
- There has been a slight increase in concerns with people with disabilities which follows the National trend, this is often around reasonable adjustments and neuro diversities despite the launch of the neuro diversity toolkit. There has also seen an increase in reporting racism, and this includes by patients as well as staff on staff. The Guardian continues to work with the staff networks to support in these areas
- Anonymous reporting despite cases going up has dropped which demonstrates a confidence in the process

Learning

The learning that the Trust has taken from the concerns raised through freedom to speak up in the period November 2024 to November 2025 are as follows:

Themes	Points of learning	Changes as a result
90 concerns re attitudes and behaviour	Treatment of staff with neuro-diversity and reasonable adjustments Team relationships/dynamics 2 formal grievances	Signposting and working in collaboration with DAWN network, formal processes in place OD intervention
38 concerns re bullying and harassment	2 cases proceeded to formal dignity at work	Changes to practice, awareness of behaviours and how to tackle them, working with ICB to develop active bystander training
41 concerns re safety and well-being	Fraud prevention Staffing levels in a department	Quality visits undertaken to monitor
32 concerns re policy and procedure	On-call policy Band 2-3 uplift JD Band 2's	Consultation process reviewed, communication to staff around process

Learning from the concerns is currently shared at various forums. It is shared at a local level when the concerns are raised with themes discussed at the 4ward Steering group.

Work on how we share learning across the organisation continues to develop. The Guardian now shares with HR business partners sharing at Divisional Management and directorate meetings and to patient experience fundamentals of care via the Governance Teams in divisions. The Guardian has now put measures in place to provide more accurate drilled down data for divisions to enable triangulation and learning plus promote accountability in Divisions.

Training

Speak Up module

Org L3	Sum of Headcount	Sum of Competency Completed	Sum of % Completed
365 Corporate	695	659	94.82%
365 Digital	112	105	93.75%
365 Estates & Facilities	409	391	95.60%
365 Medicine	2502	2388	95.44%
365 Specialised Clinical Services Division	2415	2346	97.14%
365 Surgery	1147	1087	94.77%
365 Women & Children	934	885	94.75%
Grand Total	**8214**	**7861**	**95.70%**

The above figures show the training completion in the first month from 1st June 2024 to October 1st 2025 , compliance is now above 95%.

Listen Up module

Org L3	Sum of Headcount	Sum of Competency Completed	Sum of % Completed
365 Corporate	195	163	83.59%
365 Digital	49	33	67.35%
365 Estates & Facilities	22	19	86.36%
365 Medicine	565	455	80.53%
365 Specialised Clinical Services Division	585	486	83.08%
365 Surgery	274	210	76.64%
365 Women & Children	213	151	70.89%
Grand Total	**1903**	**1517**	**79.72%**

Listen Up training was launched on March 1st to leaders and managers in the Trust, compliance is as above, a greater push is needed for the relevant staff to complete this although small figures still to complete need to encourage particularly in digital and estates and facilities.
The final module 'Follow Up' will now be scoped, this will be for senior leaders in the Trust

Conclusion

Since the launch of the portal reported, cases have continued to increase. The additional data capture now enables a deeper dive into issues and hotspots and this will develop further in coming months.
Continued representation at the staff network meetings, on Trust induction and raised profile through marketing has aided this.
The guardian continues to work on the harder to reach staff with the help and support of the staff networks and increased visibility with the aid of the champions.
The introduction of mandatory FTSU speak up training on June 1st 2024 has increased awareness of the Speak Up agenda, Listen Up module has now launched which hopefully will assist in staff's confidence for concerns to be dealt with and this will now be followed by Follow Up.

Anonymous concerns have decreased, and staff are becoming more likely to raise them now with a name to them although may still choose anonymity at the point of escalation.
The champion pool is increasing but there are still divisions that we need to target to recruit as they are lacking representation.

4. Executive Director Opinion[1]

The Freedom to Speak Up Report shows positive progress in building a culture of openness, with more staff raising concerns and fewer doing so anonymously - indicating growing trust in the process. The expansion of FTSU Champions, improved data collection, and high training compliance are clear strengths that we recognise.

However, a significant concern is that much of the FTSU work remains very closely linked to attitudes, behaviours and conflict in the workplace. This risks 'blurring' the line at times between the guardian role and HR & OD support and advice. It is essential to maintain a clear separation between these functions to protect the independence of the Speak Up Guardian role and ensure staff confidence in impartial handling of concerns. This is something we will work to review over coming months, particularly as we further develop our early resolution tools and processes.

5. Please tick box for the Trust's 2023/24 Objectives the report relates to:

☒ ***Best services for local people***

☒ ***Best experience of care and outcomes for our patients***

☐ ***Best use of resources***

☒ ***Best people***

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

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**09/12/2025**
Title of Report:	Board Assurance Framework
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Company Secretary
Reporting Route:	n/a
Appendices included with this report:	Board Assurance Framework
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

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

The attached Board Assurance Framework (BAF) comprises:

- A headline summary of all risks
- The current Trust and relevant ICB objectives to which the BAF risks are aligned.
- A separate summary of each BAF risk.

Recommended Actions required by Board or Committee

The Board is asked to review the BAF, noting in particular the progress of actions to address gaps in control and identifying any areas where more information is required at Board or Committee level.

Executive Director Opinion[1]

The BAF risks have been reviewed by each of the executive directors to which they are aligned.

[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.

Board Assurance Framework Headlines December 2025

No	Risk	Primary Pillar/Priority	Secondary Pillar/Priority	Relevant ICS Corporate Objective	Linked Trust Risks (extreme)	Linked BAF Risks (interdependencies)	Entry Risk Score (LxC)	Current Risk Score (LxC)	Lead Chief Officer	Oversight
BAF01	Financial delivery	Effectiveness: Financial	n/a	2a, 2b	5916, 5915	BAF03, 05.	4x4=16	4x4=16	CFO	Financial Recovery Board
BAF02	Health & wellbeing	People: Experience	People: Workforce transformation	n/a	5162	BAF03, 04	4x4=16	4x4=16	CPO	People & Culture Committee
BAF03	Workforce transformation	People: Workforce transformation	n/a	n/a	5162, 5931, 5871, 4654, 4940	BAF01, 02, 04	4x4=16	4x4=16	CPO	People & Culture Committee
BAF04	People Culture	People: Experience	People: Leadership; People: Development	n/a	n/a	BAF02, 03	5x3=15	4x3=12	CPO	People & Culture Committee
BAF05	Urgent & emergency care	Collaboration	Patients: Safe, high quality care	1a, 4b, 4c	4816, 4964, 3908, 5329, 4875	BAF06	5x4=20	5x4=20	COO	Board
BAF06	Digital strategy	Excellence	n/a	3d	4773, 5568, 4084, 5498,	BAF01, 05, 07	4x4=16	3x4=12	CDIO	Digital Programme Board
BAF07	Cyber security	Excellence	n/a	3d	3603	BAF05, 06	4x5=20	4x5=20	CDIO	Digital Programme Board
BAF08	Fire Safety	Effectiveness: Buildings and Infrastructure	n/a	n/a	5511, 4115	BAF01	4x5=20	3x5=15	MD/CEO	Health & Safety Committee

Objectives

ICS Corporate Objectives and Priorities relevant to Trust

	1 Quality and outcomes
1ai	Quality and performance of maternity and neonatal care
1b	Quality and performance of urgent care services
1d	Quality and performance of elective, cancer and diagnostic care
1g	Delivery of patient centred, safe, high quality care
	2 Finance
2a	Deliver the 2025/26 system financial plan
2b	Develop a medium-term financial plan
	3 System development
3a	Deliver the Building a Sustainable Future priority programme on Neighbourhood Health
3b	Deliver the Building a Sustainable Future priority programme on sustainable elective services
3c	Deliver the Building a Sustainable Future priority programme on thresholds and decommisioning
3d	Deliver the Building a Sustainable Future priority programme on system enablers
3e	Deliver the Building a Sustainable Future priority programme on Herefordshire Place plan
	4 Prevention and health inequalities
4a	Embed and maximise work to reduce health inequalities actoss all ICB programmes of work
4b	Drive the shift from treatment to prevention through delivery of key prevention programmes, including implementation of the PHM framework
4c	Drive the shift in acute to community through implementation of actions outlined in response to the Best Value Care in the Right Setting and Point Prevalence reports

Trust Strategic Priorities

Board Assurance Framework Risk Summary	
Risk Reference	BAF01
Strategic objectives and priorities	Effectiveness: Financial

Date	**October 2025**
Risk Headline	Financial delivery
Risk owner	Chief Finance Officer

Risk	Cause	Impact
Risk of failure to deliver the Trust's agreed financial plan.	The 2025/26 financial plan is to achieve financial balance, which is dependent on delivery of a challenging cost and productivity improvement plan (CPIP).	Regulatory intervention. Impact on ability to achieve wider strategic priorities.

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=16	4x4=16	↔	1x4=4	TBA

Current Controls and Mitigations	
1. Financial Recovery Board oversight	2. People and Culture Committee oversight
3. Enhanced financial controls	4. Enhanced vacancy controls
5. Enhanced controls of temporary staff usage	6. New weekly Executive Financial Recovery meeting
7. New Operational & Assurance Committee	8. New Agency Reduction Programme Board
9. Strengthened forecasting	10. Adoption of national financial controls and toolkits

Gaps in Control	Related Actions	Lead	Due Date	Progress
High usage of temporary staff	Reduce agency and bank staff usage	CPO	March 26	Year to date plan not achieved but individual staff groups are performing well.
Fully developed CPIPs to meet target.	Develop and deliver CPIP mitigation plan	CFO	March 26	Plans are still developing in some instances including plans for 2026/27 but progress is very unlikely to deliver the plan for 2025/26 therefore recovery actions are required.
Sustained operational pressures inhibiting delivery	Implement new Recovery Framework	CFO	Nov 25	Recovery workstreams established with executive SROs; enhanced, regular executive oversight in place.
System capacity constraints including reduced community beds	Work with ICB and system partners to manage the system capacity risk.	COO	Nov 25	Engagement is progressing positively.

Key Performance/Assurance Indicators	Date Reported	Performance
Income and Expenditure	October 2025	Year to date break-even position
CPIP performance	October 2025	Year to date under-delivery by £2.632m

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHS Oversight Framework Segmentation (1-5)	Sept 25	Segment 4	n/a	n/a
Internal Audit: payroll	2024/25	Significant assurance	n/a	n/a
Internal Audit: Accounts receivable/payable	2024/25	Significant assurance	n/a	n/a
Internal Audit: expenses	2024/25	Significant assurance	n/a	n/a
Internal Audit: bank and agency staffing	2024/25	Moderate assurance	n/a	n/a
External Audit Value for Money assessment	2024/25	2 significant weaknesses 2 improvement recommendations	4 significant weaknesses 6 improvement recommendations	↑
Internal Audit: financial ledger and reporting	Jan 26	TBC	TBC	TBC
Internal Audit: pay expenditure	Jan 26	TBC	TBC	TBC
Internal Audit: procurement	Nov 25	TBC	n/a	n/a
Provider Capability Assessment Rating	Jan 26	TBC	n/a	n/a

Summary Update:
At month 6, a year-to-date break-even position was reported but the position was supported by non-recurrent benefits as there was under-delivery of CPIP and use of additional resources to support operational flow.

Recovery and mitigation plans are being developed including requirement for system mitigation of capacity reduction programme with strengthened executive oversight.

Board Assurance Framework Risk Summary	
Risk Reference	BAF02
Strategic objectives and priorities	People: Experience, Workforce Transformation

Date	October 2025
Risk Headline	Staff wellbeing
Risk owner	Chief People Officer

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

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

Current Controls and Mitigations	
1. Occupational health service	2. Health and wellbeing communications and resource signposting
3. Clinical psychologist support	4. Health @ Work service
5. Menopause Support Group	6. Oversight by Health and Wellbeing Steering Group
7. Employee Assistance Programme	8. Annual flu vaccination programme
9. Targeted intervention meetings with managers in sickness hotspots	10. Sickness management support by HR advisory team

Gaps in Control	Related Actions	Lead	Due Date	Progress
Impact of cost of living pressures	Launch digital financial support package	CPO	March 26	Now implemented successfully
Increased demand for occupational health support above capacity	Increase mental health expertise within occupational health service	CPO	March 26	Recruitment in progress
Up to date policy and process for workplace adjustments	Review reasonable adjustment support for disabled colleagues	CPO	March 26	A Task and Finish Group has been established to implement this work.
Strategy for reducing sickness	Develop a Sickness Absence Strategy	CPO	March 26	Work is in progress

Key Performance/Assurance Indicators	Date Reported	Performance
Monthly Sickness rate	October 2025	Monthly position deteriorated to 5.45% against target of 4.0%
Flu vaccination rate	October 2025	Current performance under target c25% (Nov 2025)

Independent Assurance	Date	Rating/Outcome
Staff Survey 2024 results: 'we are safe and healthy'	March 25	Score of 6.09: Improvement compared to 2024 and equal to average result for peer group
Internal Audit: Absence management	Mar 26	Planned

Summary Update
Actions are progressing well but sickness rates have deteriorated and stress related sickness remains above pre-pandemic level.

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

Date	November 2025
Risk Headline	Workforce transformation
Risk owner	Chief People Officer

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

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 25	4x4=16	4x4=16	↑	2x4=8	Significant – seek

Current Controls and Mitigations	
1. Agency Programme Board	2. Job planning consistency panel
3. Vacancy controls	4. Agency controls
5. Quality Impact Assessments for workforce transformation programmes	6.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continued reliance on temporary staff due to additional capacity	Implement improvement plan with support from NHSE	CPO	March 26	Agency programme board monitoring progress
Continued reliance on bank staffing	Implement bank reduction plan	CPO	March 26	Communicated reduction in programmed activity from Dec 25
Vacancy numbers above target	Recruitment to establishment	CPO	March 26	Recruitment has increased
High sickness levels	See BAF02	CPO	March 26	
Consultant job plans not all in place	Complete roll-out of medical e-roster	CMO	March 26	Job planning consistency panel established; job planning committee planned.
Capacity to manage full breadth of workforce transformation and people processes	Scope potential for increased use of AI for people processes	CPO	March 26	Initial assessment of 'HR Assist' in progress
Effective, efficient, sustainable admin and clerical workforce structures	Admin and clerical workforce review	CPO	March 26	Commenced October 25, initial programme recommendations due Dec 25.

Key Performance/Assurance Indicators	Date Reported	Performance
Monthly agency spend	October 25	3.17% of gross staff costs
Reduce reliance on bank staff	December 25	52.40 WTE adrift of 2025/26 plan
Vacancy rate	October 25	Reduced to 7.10% against target of 6.5% - improvement on last year.
Annual staff turnover	October 25	Improved to 8.13% against target of 11.5% - improvement on last year.
Monthly sickness absence	October 25	Increased to 5.45% - worse than the same month last year
Consultant job planning	October 25	Dropped by 1% to 74% against target of 95%

Independent Assurance	Date	Rating/Outcome
NHSE: agency reduction oversight	Oct 25	NHSE regional team supportive intervention

Staff survey 2024: “there are enough staff”	Mar 24	Above average score and an improvement on 2023
Internal Audit: Bank and Agency Staffing	24/25	Moderate assurance
Internal Audit: Pay expenditure	Mar 26	Planned
Internal Audit: Absence management	Mar 26	Planned
Internal Audit: Agency provision	Mar 26	Planned

Summary Update
Good progress on actions and some KPIs but more progress needed on temporary staffing reduction and medical E-Roster roll-out.

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

Date	November 2025
Risk Headline	People Culture
Risk owner	Chief People Officer

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

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
5x3=15	Feb 24	5x3=15	4x3=12	↑	2x3=6	TBA
	June 25	4x3=12				

Current Controls and Mitigations	
1. FTSU Guardian and Champions	2. Refreshed Trust values based on staff engagement
3. Staff Networks	4. Sexual safety charter and toolkit
5. Cultural Ambassadors	6. National Mandatory Training MOU
7. Mandatory Training Oversight Group	8. Refreshed appraisal documentation and system
9. People Strategy based on staff engagement	10.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Effective policies and processes for conflict resolution	Develop respectful resolution policy, framework, toolkit and manager training	CPO	Mar 26	Good progress reported Aug 25
Incidents of racism	Implement Anti-Racism Charter	CPO	Oct 26	Signed November 25, 12-month programme now in progress
Low staff engagement	Increase communication of staff survey actions	CPO	Nov 25	Communication and engagement plan in progress
Effective staff training	Refresh induction and mandatory training programmes	CPO	Mar 26	Good progress reported Oct 25, new induction launch planned for Jan 26
	Embed NHS Elect online training and development	CPO	Mar 26	Training available now for all staff

Key Performance/Assurance Indicators	Date Reported	Performance
Mandatory training rates	Oct 25	Meeting target of 90% but some divisions are outliers.
Appraisal rates (non-medical)	Oct 25	Dropped to 82% against target of 90% but improved compared to last year.
Appraisal rates (medical)	Oct 25	Meeting target at 94%

Independent Assurance	Date	Rating/Outcome
Staff Survey 2024: Response rate/engagement score	Mar 25	46%/slightly below average but better than last year
Staff Survey 2024: We are always learning	Mar 25	Slightly below average but better than last year
Staff Survey 2024: We are compassionate & inclusive	Mar 25	Above average and better than last year

Summary Update
Good progress on actions, which are increasing the number of controls in place. KPIs overall are good.

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

Date	**November 2025**
Risk Headline	Urgent & Emergency Care
Risk owner	Chief Operating Officer

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

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

Current Controls and Mitigations	
1. Oversight of improvements by UEC Transformation Board	2. Standard Operating Procedures for key UEC pathways and use of Temporary Escalation Spaces to improve flow and maintain patient safety and experience.
3. UEC navigators	4. Continual monitoring of and response to daily UEC and patient flow dashboards
5. Stress-tested winter plan	6. Call Before Convey
7. PMO support for multiple deliverables	8. Ambulance pitstop
9. NHSE ECIST/GIRFT support	10. Operational Assurance Committee oversees progress of improvement plans

Gaps in Control	Related Actions	Lead	Due Date	Progress
High attendance numbers at ED	Primary/secondary care interface programme	CCSO	Mar 26	In progress
Long waits in ED due to high attendance numbers	Implement UEC improvement plan	COO	Mar 26	Introduction of navigators and dashboards have contributed to improvements; e.g. in triage times and length of stay in ED
Poor patient flow due to high 'front door' demand	Implement Flow and Discharge workstream	COO	Mar 26	Current focus on integrated discharge team processes
Por patient flow due to late discharges.	Implement Streaming Pathways improvement plan	COO	Mar 26	In progress by Streaming Action Group
Insufficient substantive consultant cover to meet UEC demand	Review ED consultant rota	COO	Dec 25	In progress
	Recruit substantive ED consultants	CMO	Nov 25	3 substantive consultants appointed

Key Performance/Assurance Indicators	Date Reported	Performance	Change
ED 4-hour standard (78%)	Nov 25	63%; on trajectory to achieve March target	
ED 12-hour standard	Nov 25	17.4%	
Ambulance handovers <45 mins (80%)	Nov 25	65.8%	

Independent Assurance	Date	Rating/Outcome	Previous rating	Change
NHSE UEC Support	Sept 25	Tier 2	Tier 1	↑
NHS Oversight Framework Segmentation	Sept 25	Segment 4	n/a	n/a
Internal Audit: Performance & Accountability Framework	2024/25	Significant assurance	n/a	n/a
Care Quality Commission: UEC at WRH	Apr 24	Requires Improvement	Inadequate (2020)	↑

Internal Audit: Patient transfers/handovers (joint review with partner trust)	Mar 25	TBC	n/a	n/a
Provider Capability Assessment Rating	Jan 26	TBC	n/a	n/a

Summary Update
Good progress is being made on the various workstreams and actions. However, sustained high monthly ED attendances have continued to challenge performance on national targets.

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

Date	November 2025
Risk Headline	Digital Strategy
Risk owner	Chief Digital and Information Officer

Risk	Cause	Impact
Risk of delay in delivery of full benefits of digital strategy	• Scale, number and complexity of individual projects • Workforce change/transition requirements • Competing digital priorities • Over-subscription of digital initiatives against baseline resources	• Planned service/ quality benefits not achieved • Planned financial savings not achieved • Opportunities for productivity improvements not realised • Maximum digital maturity not achieved.

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	February 2024	4x4=16	3x4=12	↔	1x4=4	TBC
	May 2025	3x4=12				

Current Controls and Mitigations	
1. Digital governance framework	2. Annual business planning cycle
3. Programme and project governance	4. Monitoring and oversight through Trust governance structure
5. Regular review of digital resource plans	6.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Change management	Embed Optimisation process and ringfenced team	CDIO	Sept 2025	In place, and currently embedding
Staff training (and availability for training)	Request EPR training as annual essential to role	CDIO	December 2025	Form being reviewed
Delay due to extraneous factors	Deliver Electronic Patient Record Programme	CDIO	Mar 2026	Good progress (reported to Audit Committee Nov 25)
Prioritisation of digital programmes and projects can affect delivery of EPR Programme	Deliver annual IT Business Plan	CDIO	Mar 2026	

Key Assurance Indicators	Date Reported	Performance	Change
In development			

Independent Assurance	Date	Rating/Outcome	Previous Rating	Change
Digital Maturity Assessment Score	Sept 26	TBC		

Summary Update
Good progress is being made on the digital programme.

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

Date	November 2025
Risk Headline	Cyber security
Risk owner	Chief Digital and Information Officer

Risk	Cause	Impact
Risk of a successful cyber attack on the Trust's systems.	• Increasingly frequent and sophisticated attacks on internal and external digital systems containing critical Trust data. • Oversubscription to digital systems against baseline support levels and resources. • High number of users with access to Trust's digital systems • Increasing reliance on digital systems • Reliance on third party suppliers.	• Data security breaches • Loss or corruption of data • Lost or delayed access to patient care records • Business interruption • High cost of rectification

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

Current Controls and Mitigations	
1. Perimeter level cyber security mechanisms	2. Risk-based approach to cyber and infrastructure funding
3. Testing exercises (e.g. phishing)	4. Contract monitoring (oversight by Digital Strategy Group)
5. Business Continuity plans	6. Capital planning programme
7. Mandatory information governance training	8. Security Operations Centre
9. Cyber Health Dashboard	10.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continual development to meet changing risk environment	Implement cyber security action plan	CTO	March 2026	Monitored through IT Security Forum
Staff understanding and awareness of cyber risks	Maintain mandatory training compliance at 90%	DPO	March 2026	Monitored through IGSG
Uncertainty of funding	Actively seek funding from national and local pots	CDO	March 2026	Ongoing
Ability to keep pace with continually changing cyber security threat.	Chief Information Officers weekly briefing, and inclusion in network groups	CDO	March 2026	Ongoing
Gaps in compliance with CAF (see below)	Implement low priority recommendations	CDO	Dec 25	In progress

Key Assurance Indicators	Date Reported	Performance	Change
In development			

Independent Assurance	Date	Rating/Outcome	Previous Rating	Change
Internal Audit: Cyber Assessment Framework (CAF) – aligned Data Security & Protection Toolkit (DSPT)	June 25	Risk: Low Confidence Level: High	n/a	n/a
Digital Maturity Assessment Score	Sept 26	TBC		
Emergency Planning, Resilience & Response (EPRR) Core Standards compliance	2024/25	Substantial assurance	Partial compliance (2023/24)	↑

Summary Update
Independent assurance demonstrates strong and improved cyber security controls. However, the external threat is such that the risk remains high and is unlikely to significantly reduce.

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

Date	November 2025
Risk Headline	Fire Safety
Risk owner	Managing Director

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

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x5=20	January 2025	4x5=20	3x5=15	↑	2x3=6	TBA
	February 2025	3x5=15				

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

Gaps in Control	Related Actions	Lead	Due Date	Progress
Full implementation of Schedule of Works -Enforcement Notice 1503	Implement Fire Remedial Works Project	DoE	~~Aug 25~~ Feb 26	Complete and added to controls and mitigations as appropriate. Due date extended by Fire Service
Full implementation of Schedule of Works -Enforcement Notice 1508	Implement Fire Remedial Works Project	DoE	~~Aug 25~~ Feb 26	Partially complete and added to controls and mitigations as appropriate. Due date extended by Fire Service
Funding source to complete all fire remedial works necessary	Agree implementation/ mitigation plan	MD	Feb 26	Options assessed and costed. Additional mitigations are being identified.

Key Assurance Indicators	Date Reported	Performance	Change
In development			

Independent Assurance	Date	Rating/Outcome	Previous Rating	Change
Fire Authority Enforcement Notice 1503	Feb 25	Enforcement	n/a	n/a
Fire Authority Enforcement Notice 1508	Feb 25	Enforcement	n/a	n/a
Internal Audit: Fire Safety	Mar 26	TBC	n/a	n/a

Summary Update
Good progress has been made on the implementation of the fire safety remedial works to the satisfaction of the Fire Authority, which has extended the Enforcement Notice due dates. However, the high cost of the options to fully address the safety issues are such that they are unlikely to be approved at a national level. Additional mitigation options are being assessed and a wider risk assessment will be developed.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**09/12/2025**
Title of Report:	Trust Seal 2025-26
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Company Secretary
Reporting Route:	n/a
Appendices included with this report:	n/a
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Company Secretary is custodian of the Trust Seal. The Seal is attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has been approved in accordance with the Trust's Standing Orders and Standing Financial Instructions in accordance with the Scheme of Delegated Authority.

The Trust Seal has been used on the following documents to date in 2025/26.

No.	Description of document	Date of Sealing
264	JCT Contract Documents KHTC C Block Link RAAC (Currie & Brown)	29/05/2025
265	JCT Contract Documents AHR Fire Improvement Works (Currie & Brown)	29/05/2025
266	JCT Contract Documents AHR CT Replacement (Currie & Brown)	29/05/2025
267	JCT Contract Documents KHTC Xray Room Replacement (Currie & Brown)	29/05/2025

Recommended Actions required by Board or Committee

To receive the report for information.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025-2026

Report to:	**Public Board**
Date of Meeting:	**09/12/2025**
Title of Report:	Charles Hastings Education Centre – Update on Issues
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Other
If Other, provide details:	Not Applicable
Lead Chief Officer/Director:	**Managing Director**
Author:	Tony Bramley, Non-Executive Director & CHEC Trustee
Documents covered by this report:	Bi-annual update on CHEC

1. Purpose of the report

To provide a summary report on those items discussed by CHEC Trustees that may be of interest to the Trust Board.

2. Recommendation(s)

This item is for information only

3. Chief Officer/Executive Director Opinion[1]

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

☐ ***Focus on Flow***	☒ ***Think/Act as a Lead Provider***
☐ ***Governance***	☒ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

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

Background

Worcestershire Acute Hospitals Trust has a long-standing relationship with the charity that runs The Charles Hastings Education Centre (CHEC) on the Worcester Royal Hospital site and nominates one of CHEC's Trustees & Directors.

CHEC is a significant partner for the Acute Trust in both broadening and enhancing the on-site medical education offer to potential and current staff, and it is important that we jointly work to maximise mutual benefit.

This report provides an update on those matters discussed by CHEC Trustees at their last Board meeting and AGM on 11th November 2025 and which may be of particular interest to the Acute Trust.

Board Update:

- **Clinical Simulation Facility**: The proposal to significantly upgrade and expand the simulation suite at CHEC into a state-of-the-art facility has made strong progress since the last report thanks to substantial charitable funding being attracted from the Dinwoodie Charitable Company, and it is presently hoped to start work on site during December 2025 and for the facility to be open in March 2026. On completion it will be one of only three such *'augmented reality'* clinical simulation facilities in the NHS in England. The Trust is providing the project with significant project management and other practical support.
- **Museum Bequest:** The very substantial bequest which has been gifted specifically for the enhancement of the George Marshall Medical Museum has been ethically invested while plans for its use are developed.
- **Development of a Wellness/Physic Garden:** This joint project between CHEC and the Acute Trust's Charity is still seeking external funding support in order to progress.
- **Car Parking**: The very longstanding problems with CHEC's dedicated parking provision have finally been resolved in August 2025 following action by the Trust's Director of Estates & Facilities.
- **Life Cycle Maintenance Programme**: Of particular concern to CHEC Trustees are the need for the replacement of the space and water heating boilers, the lift, and tackling persistent water leaks from both the plant and elements of the roof.

AGM:

- The Trustees noted that income in 2024/25 was £0.7m (£1.3m 2023/24 due to legacy donation) and that expenditure in the year was £0.6m (£0.6m 2023/24).
- The Balance sheet shows total funds of £3.5m (£3.5m 2023/24) of which £2.9m are classified as 'restricted'.

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