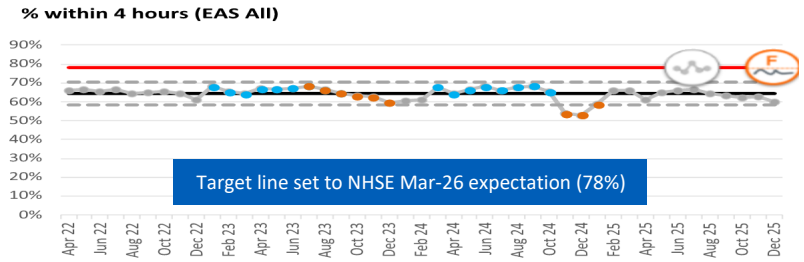
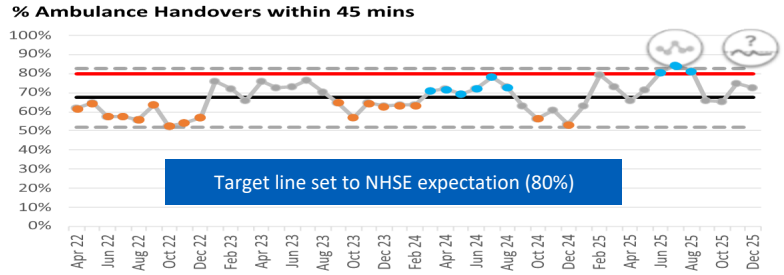
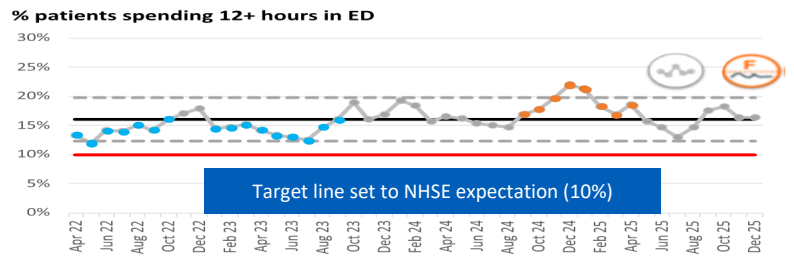
OUR OPERATIONAL PERFORMANCE – URGENT & EMERGENCY CARE

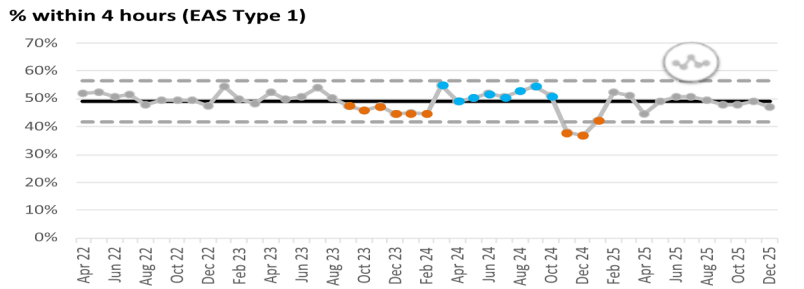
We are driving this measure because

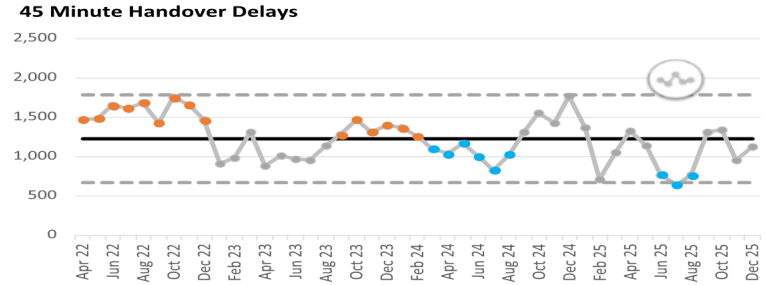
The national Emergency Access Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at any Emergency Department. In addition, the effective and timely handover of patients arriving by ambulance enables patients waiting in the community to access care in a timelier manner and is an indicator of system flow.

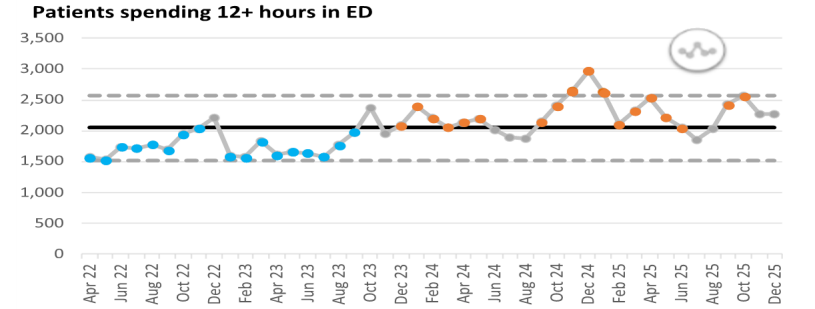












Understanding the performance

- There is no change in statistical significance across the metrics in this report.
- 13,727 patients attended our type 1 sites in December (at an average of 442 per day) which is a 2.0% increase compared to December 2024.
- December was the 10th month in a row where WRH had more than 8,000 attendances.
- The percentage of ambulance handover breaches under 45 minutes was 73%; 80% is the NHSE baseline expected performance for this measure.
- The percentage of patients spending more than 12 hours in our emergency departments is showing normal variation even though the number of patients breaching is a concern.

Actions (SMART)

- ED Consultant Vacancies will be filled by 31st Jan 2026.
- Acute Medicine focus on Ward Round and Consultant cover until 7pm being explored – job plans are being reviewed to support this later ward cover. ECIST support in place.
- ED model has moved to two nurse co-ordinators. Designed to improve oversight, decision-making, and responsiveness across the department, particularly during busy periods.
- Daily Operational support to progress chaser – split between waiting room and minors to impact on the NANR/Paediatric performance
- Paediatric winter planning commenced, learning from ast year, in advance of 2026/27
- Radiology KPI's agreed, and actively being monitored
- Specialty review planning meeting diarised for 23rd Jan – cross divisional action planning session to discuss IPS/GIRFT Standards
- Extending the AMA service on both sites. This will mean at WRH taking over another 6 trolly spaces for AMA.
- Acute Consultants have now left the GIM rota, with consultant cover on AMU/AMA until 7pm being included on rota.
- GP relocated from Kidderminster MIU to AGH stream, with enhanced focus and improvement in NANR
- 45 MInute Ambulance Handover SOP reviewed, updated and cascaded – tabled for TMB discussion on 22/1/26
- Review of ED Clinica Oversight. PDSA underway for new model which provides greater leadership presence and coverage in ED.
- CDC feasility study work completed by Division. Now awaiting final decision to proceed at AGH as part of Constitutional Standards
- SAU looking to adop AMA approach – both Divisions working together to scope and submit proposal
- Urgent Care are reviewing fit to sit/GP activity and specialty input and compliance with SOP's to support improvements in NANR

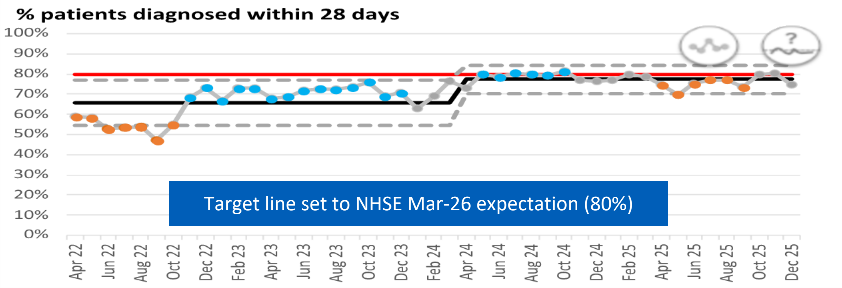
Risks

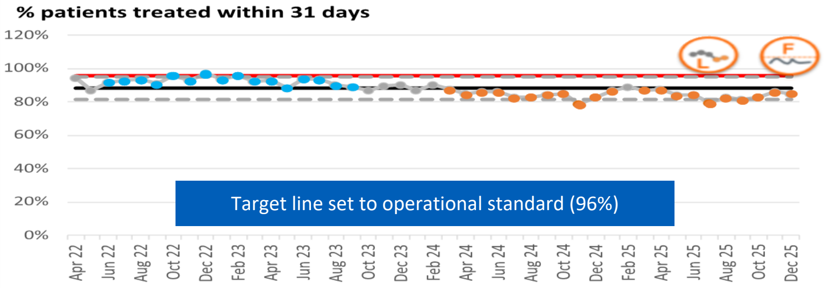
- Critical Incident – impact on day to day business and transformational work
- CDC approval to proceed stalled, impacting on AGH EAS delivery plans
- Visibility of system wide assumptions to reduce 4% activity - outstanding
- Patient delays in waiting room and public behaviour (attending ED as opposed to accessing alternatives)
- Continued growth in attendances, which is above expected levels.
- Engaged approach to delivery of escalation actions, which could be challenging. New approach and time to embed may prove hard to accommodate.
- Inconsistency in offer of alternative pathways for ED/SPOA to access
- Hospital flow and late discharges – transport capacity
- Navigator streaming options external to organisation in development and consistency of use by WMAS
- Long delays for Ambulance Patients resulting in increased risk of harm and deteriorating patient (GRAT process in place for assessment)
- Acute Oncology capacity
- WMAS uptake of call before you convey and redirection before ED
- Financial risk associated with managing safety in overcrowded department
- Organisational challenges regarding increased reporting/assurance and resource
- System wide closure of beds resulting in increased length of stay for pathway patients
- Potential closure of PDU reducing bed base

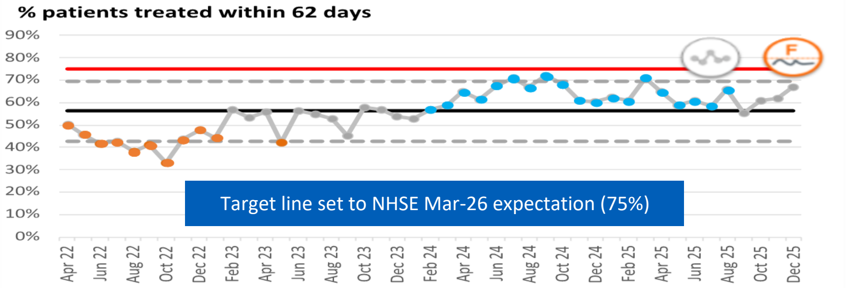
OUR OPERATIONAL PERFORMANCE - CANCER

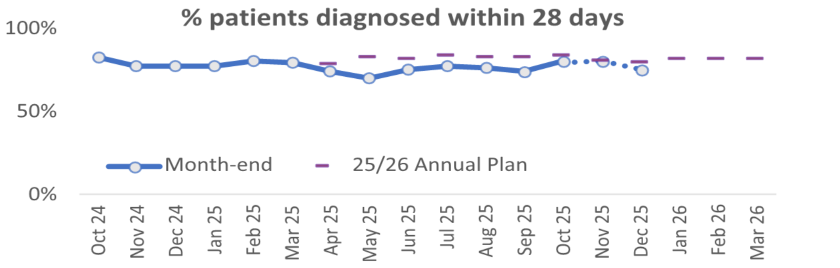
We are driving this measure because

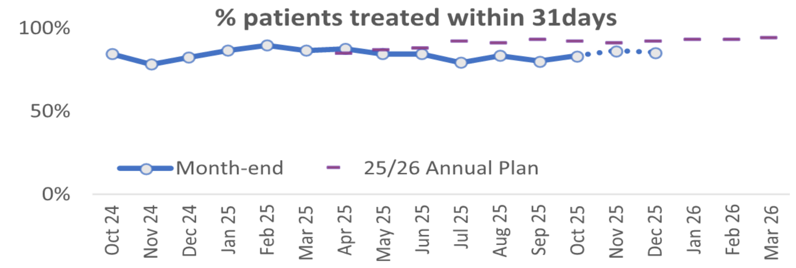
Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime.

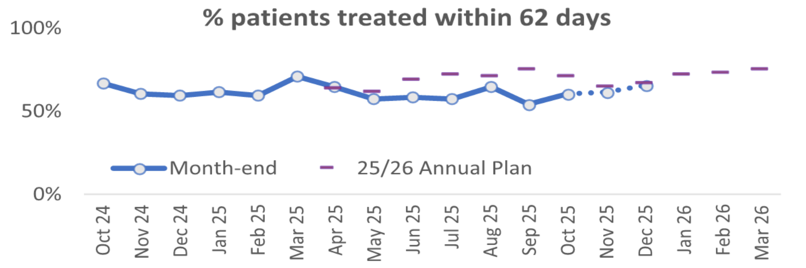












Understanding the performance (provisional)

- We received 2,418 cancer referrals in December; this is a reduction from November which is normal season variation and still 5% more than Dec-24.
- 28-day performance is at 75% and below our annual plan target.
- The 31-day performance (85%) is below our annual plan target. 4 specialties achieved the 96% operational standard but were all low volume contributions.
- The 62-day performance (66%) is just below our annual plan target of 67%.
- Skin and Urology are the specialties that are contributing 66% of patients to the backlog of patients waiting over 62 days.

Actions (SMART)

- Breast – further impacted by sustained high levels of demand, sickness absence within the breast cancer nursing team and loss of locum Consultant Radiologist. Additional WLI clinics being run in January with plans for the same in February, alongside consideration of a full outsourced model to clear the backlog. New low risk / breast pain pathway now fully signed off with implementation in February 2026, and additional external monies secured to extend locum Consultant Radiologist arrangements to ensure continuation of one-stop clinics as per best practice timed pathways (BPTP).
- Gynaecology – capacity and demand modelling being undertaken given implementation of new PMB pathway whilst showing benefits has not offset the volume of increases in demand for other sub-specialties. Weekend WLI's underway to support more timely diagnostics and SMS pilot for benign results due to commence.
- Head & Neck – SOP for the commencement of a STT (US) pathway agreed internally, with meeting being arranged to agree this with ICB and primary care colleagues. Directorate developing a plan to reduce delays in follow up outpatient delays and TCI dates.
- Lung – Continued micro-management of the PTL amid ongoing workforce shortfall challenges. Respiratory-wide capacity and demand review underway with support from NHSE IST team, following which a WMCA facilitated deep dive / process mapping session with all relevant internal and external stakeholders is being scheduled for 17th April 2026.
- Skin – Teledermatology pilot extended to include a second PCN from 12th January 2026, with full rollout dependent upon RPA solution with NHSE scheduled to witness test our solution on 20th January 2026. This project aims to reduce demand on OPA capacity and allow more timely access to those who do need to be seen. Re-introduction of one-stop / see and treat clinics to include Max Fax provision being aimed for early 2026, and outsourcing of Max Fax MOP's backlog commenced in December 2025 with expectation of completion by March 2026, following successful cancer recoveries bid.
- Urology – further impacted by sustained increased demand resulting in deterioration of first seen waiting times, staff sickness absence and loss of activity over the bank holiday period. WMCA funded locum started on 5th January 2026 with further resources approved for 2 x consultants / doctors with locum consultant commenced 12th January and recruitment into further been sought. Additionally, an LATP mobile unit is scheduled to come on-line in February. These additional resources will support capacity for USC OPA, LATP and post MDT OPA, as well as provide additional support increase theatre list capacity.
- Oncology – Partial success with bids with funding awarded from WMCA, though due to a combination of prioritisation of funds exercise and recruitment delays will now be funded via 2026/27 allocation.
- Development of a business case to extend operating capacity to support delivery of the 31 day and 62 cancer standards for both Urology and Colorectal.

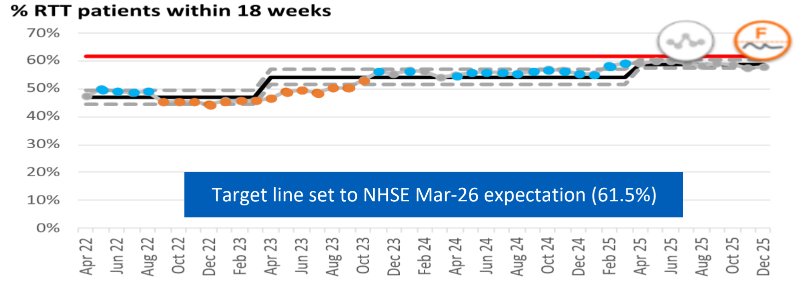
Risks

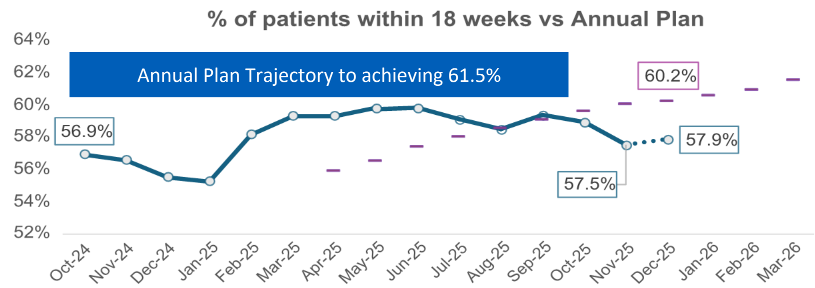
- Impact to achieving delivery of 31 and 62 days resulting from insufficient Oncology and radiotherapy capacity.
- Failure to reach annual plan target for FDS due to the fragility of Breast and Urology services (amid increased demand).
- Ongoing financial impacts associated with the use of high-cost diagnostic outsourcing solutions in histology and radiology.
- Risk to delivery of FDS, 31- and 62-day targets due to service model fragility particularly for Skin (which also relates to fragile Max Fax service)
- Delays in pathology turnaround times impacting on all tumour site pathways.
- Delays in imaging, particularly MRI, impacting on all tumour site pathways.

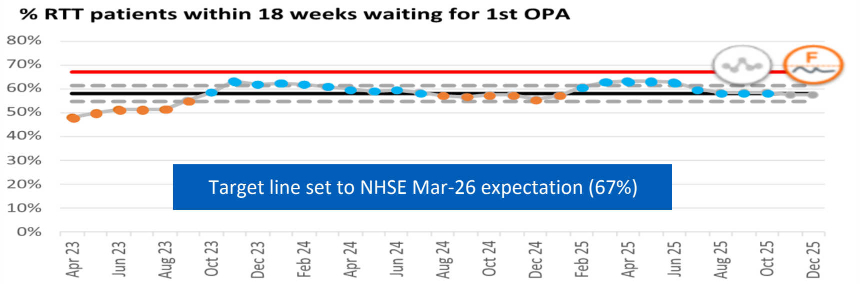
OUR OPERATIONAL PERFORMANCE – REFERRAL TO TREATMENT

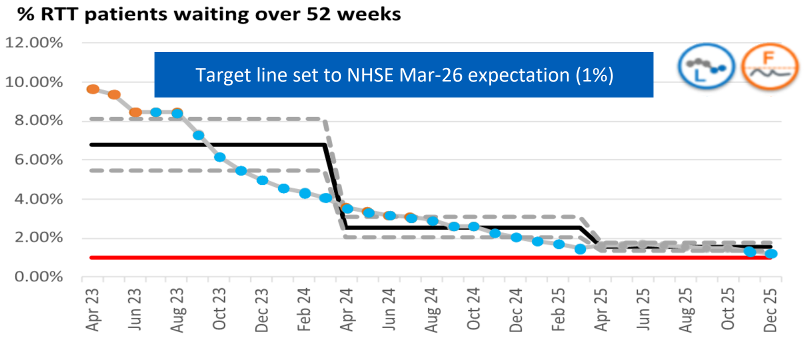
We are driving this measure because

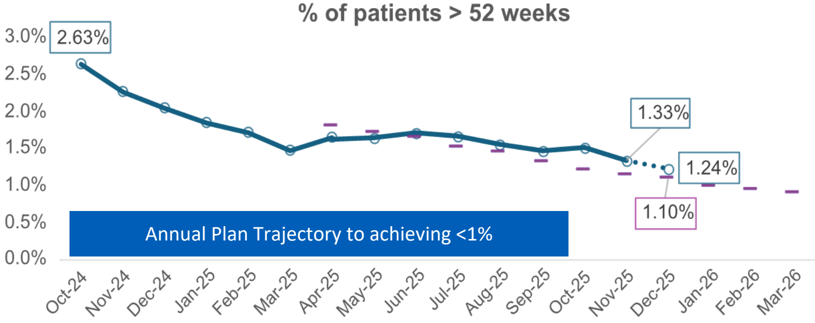
It is a key priority to ensure that patients can access the elective treatment they need in as timely a manner as possible and to continue to recover to the 18-week Referral to Treatment standard as set out in the NHS constitution.

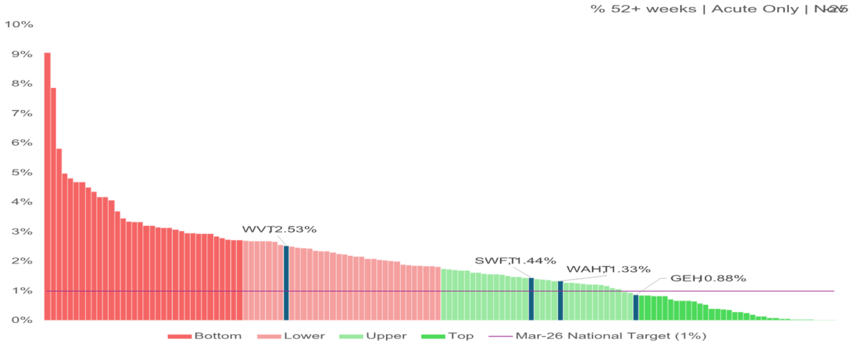












Understanding the performance (provisional)

- At the end of Dec-25, 57.9% of patients, of a waiting list of 57,484, were waiting less than 18 weeks for their first definitive treatment. This continues the recent trend of significant improvement, but the year end target is not yet achievable without further change.
- For those patients waiting for their first appointment, the proportion waiting less than 18 weeks no longer shows continuous improvement and the target is not achievable without significant change.
- The number of patients waiting over 52 weeks has decreased from 769 at the end of November to 712 and is 1.24% of the total waiting list.
- 3 specialties with 52-week waiters at month end (ENT, T&O and OMFS) contribute 87% of patients to the Trust overall position.
- In November's NHSE RTT publication, WAHT benchmark in the upper quartile of performance with 1.33% of the waiting list over 52 weeks.

Actions (SMART)

- Weekly oversight, monitoring and support from ICB and NHSE
- Weekly DCOO oversight and monitoring of our longest wait patients
- Gastroenterology insourcing solution commenced 25th Oct to address 65-week breaches and support achievement of end of year 52-week target. 9-week programme to see ~800 patients waiting for their first appointment.
- ENT and OMFS insourcing plans approved to support recovery of 52-week breaches in line with annual plan. Commenced end of November.
- T&O working with foundation group and IS for mutual aid for foot and ankle and hand surgery with 50 patients under review with IS to support treatment. Commencing work in treatment room 2 in Kidderminster as part of right procedure right place which aims to protect theatre resource for theatre only procedures with smaller cases now been managed through an upgraded treatment room.
- Divisional oversight and micro-management of patients on admitted pathways requiring surgical treatments which exceed 52 weeks
- Services working up additional plans as part of an elective sprint bid for Q4 to improve performance in overall waiting list size and delivery of 18 week wait performance in line with plan

Risks

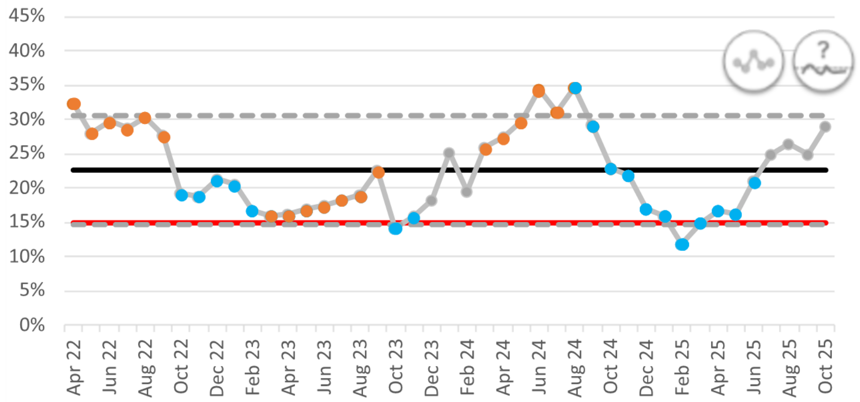
- Risk to elimination of 65+ week waiters due to late onward referral to external diagnostic services with limited capacity i.e. manometry, HIDA scans, impacts gastro and general surgery pathways
- Risk to delivery of eliminating all waits over 52 weeks by Mar 2026 particularly for ENT, T&O, OMFS and gastroenterology services, without in year process change/ services transformation
- Financial impacts of ongoing use of insourcing and outsourcing solutions particularly
- Delivery of 52 weeks target for OMFS due to fragility of service resulting from medium to long term absence of Consultants.
- Impact from further Resident Doctor Industrial Action
- Impact of severe weather impacted on patient attendance to appointments. Circa 200 patients requiring reschedule, risk to delivery of 52 weeks

OUR OPERATIONAL PERFORMANCE – DIAGNOSTICS

We are driving this measure because

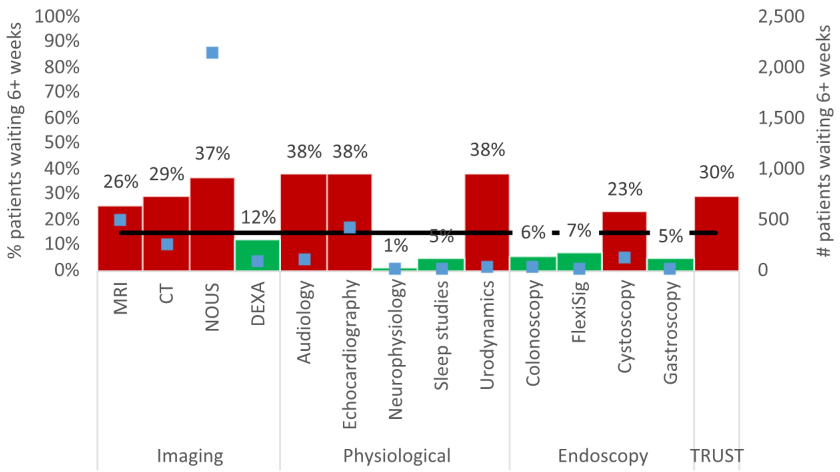
Early diagnosis is important to patients and central to improving outcomes, for example early diagnosis of cancer improves survival rates. Bottlenecks in diagnostic services can significantly lengthen patient waiting times to start treatment.

% patients waiting over 6 weeks

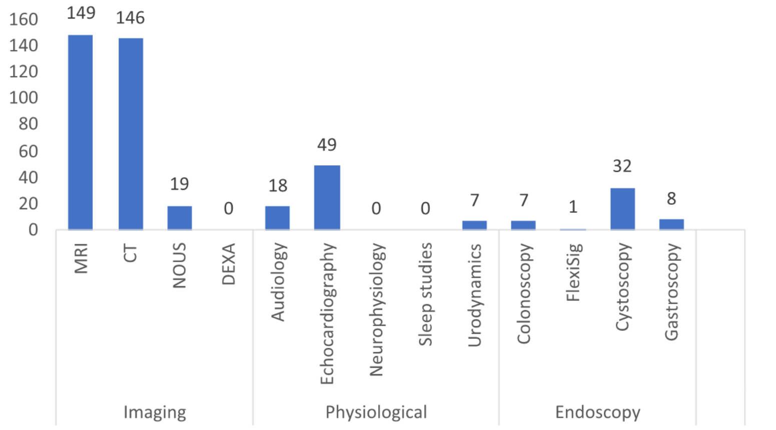


Target line set to NHSE expectation
(no more than 15%)

DM01 - % and # of patients waiting 6+ weeks | Dec25



Patients waiting 13+ weeks for a diagnostic test | Dec25



Understanding the performance

- 3,705 (29.6%) patients were waiting over 6 weeks at the end of Dec-25. This means that performance remains within our normal variation range.
- The target is achievable, although not consistently.
- 7 modalities are above the 15% threshold. They account for 96% of all patients breaching 6 weeks at the end of December.
- NOUS still has the most patients over 6 weeks followed by MRI, CT, Echocardiography and Audiology.
- MRI have reduced their month-end 6+ week breaches by 63% from a peak of 1,447 in Jul-25, to 529 in December.
- MRI and CT account for 71% of the 436 patients reported as breaching 13 weeks at the end of the month.

Actions (SMART)

- **MRI –** Insufficient capacity to meet demand with a marked increase in responding to urgent and cancer demand. Service have been successful with a bid for external funding to increase capacity with use of a mobile. This will support improved access for patients on routine and cancer pathways. Mobile was delayed but was operational from mid-Nov
- **NOUS –** service is delivering planned activity however demand is higher than expected. Additional WLIs sought to support position. Alternative options been explored to improve overall 6-week performance
- **Urodynamincs** – service utilising additional WLIs to support and recover position.
- **Audiology** action plan continues to support overall recovery, though recent spike in audiology referrals is evident in October which is under investigation. Immediate actions taken to provide additional activity.
- **Echocardiography –** Recovery plan is continuing to support the reduction in overall waiting list. Actions include increased capacity from conversion of facilities and continued recruitment to vacancies of physiologist and is delivering in line with plan.
- **Cystoscopy** – Continued use of waiting list initiatives to reduce backlog

Risks

- Risk to delivery of DM01 performance resulting from carve out of capacity to support cancer pathways e.g. urology prostate MRI
- Risk to permanent recruitment to audiology vacancies could impact on delivery.
- Impact from further Resident Doctor Industrial Action

OUR WORKFORCE

Ali Koeltgen

Chief People Officer

Recruitment

This month substantive Funded establishment has increased by a further 2 wte which relate to two Admin roles in Finance. Funded establishment is 410.28 wte higher than M9 last year due to agreed business cases and funding of Ward 15 and Avon 4. We have recruited 61 new staff in M9 but have 5 less starters than leavers which aligns with the direction of the Annual Plan. Corporate has reduced by 6 in line with plan. We have seen more starters than leavers in SCSD and Medicine although Medicine has a 3.21 reduction in FTE due to reductions in hours. Surgery ended up 8 less headcount and Women and Children's 5 less over the month.

Vacancy Rate

Our vacancy rate is broadly unchanged at 6.64% (511.68 wte vacancies) which is above the Trust revised target of 6.5%.

Non Clinical vacancies - We have 122.02 wte Admin and Estates vacancies (10.13%), 7.32 wte Managers vacancies (2.54%), and 2.06 wte other infrastructure support (0.78%).

Monthly Bank and Agency Spend

Temporary staffing spend remains a considerable challenge. There has been a 13.49 wte reduction in agency worked in December which has translated into a 1.24% reduction in agency spend. Operational pressures and a period of being in Critical Incident required additional surge capacity will have had an impact. We are 24.11 wte ahead of plan for Agency worked. Medicine are outliers with 5.07% of gross cost. However, all clinical divisions have seen a reduction this month. We are quartile 4 (worst) on Model Hospital (August 2025 rates). There is an increased focus on bank usage/spend as our M9 usage means that we are 58.53 wte adrift of our 25/26 plan for bank.

Annual Staff Turnover

Our annual staff turnover has reduced to 7.65% which continues to comfortably meet our target of 11.5% and is an improving trajectory compared to rates of 9.93% last year. We benchmark well against other Trusts remaining at Quartile 1 (best) on Model Hospital (September 2025 rates). Estates and Facilities are outliers although reduced to 11.25%. All Divisions meet the target this month.

Sickness Absence

Monthly sickness absence has increased by 0.32% from last month to 5.93%. This is 0.03% worse than the same month last year in line with seasonal variation including an increase in cough/cold and flu. The % of absence attributed to stress has reduced to 28% of total sickness. Women and Children are outliers with 39% of all absence attributed to stress followed by Corporate with 38.8%. The highest sickness levels are in Estates and Facilities (reduced to 8.75% overall with 3.42% long term sickness. This group are nationally historically higher than other staff groups, but we remain in Quartile 4 on Model Hospital in September 2025 for this group.

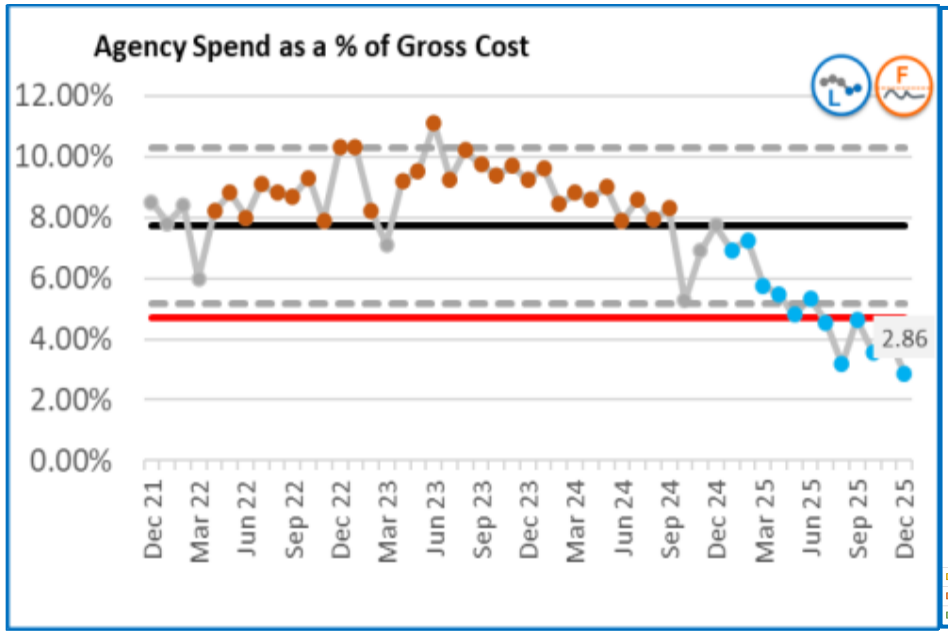
Job Planning

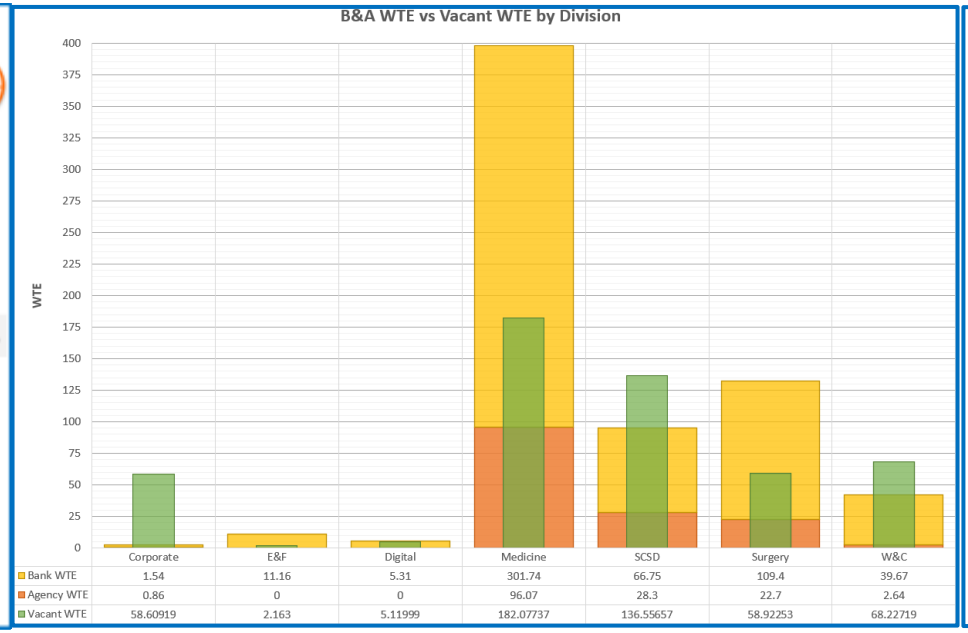
Consultant Job Planning has increased to 69% against target of 95%. Women and Children's now meet target with 93% for Consultants and 100% for SAS doctors. All other divisions require significant improvement with 56% Medicine, 63% Surgery and 75% SCSD.

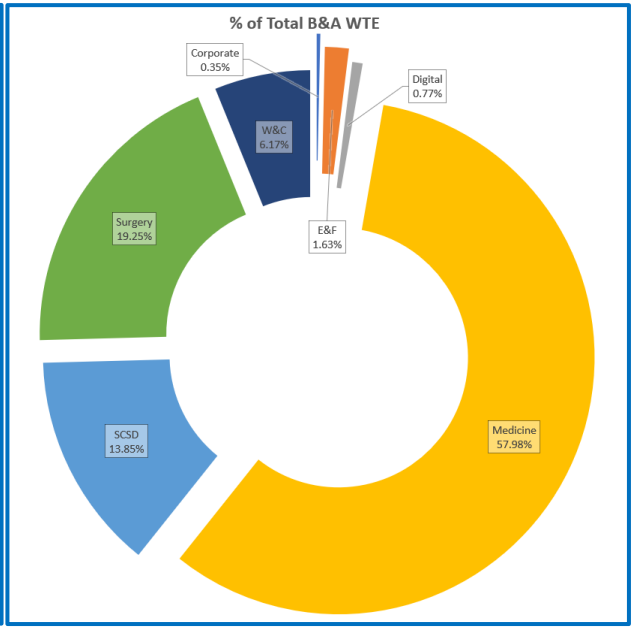
OUR WORKFORCE PERFORMANCE – REDUCTION OF AGENCY SPEND

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.







Understanding the performance

There has been a reduction in Agency spend in December to 2.86% compared to 4.10% in November. This remains significantly better than last year when agency costs were 7.73%. Work needs to continue to focus on reducing bank usage which has increased to 10.39% of gross cost.

The Trust have been identified by NHSE of being at risk of delivering bank and agency spend targets for 25/26 and therefore will receive additional support from the NHSE regional team.

'Programmed Activity' (enhanced bank rates) within Nursing & Midwifery have ceased with effect from 8/12/25.

Actions

Senior Nursing and Midwifery colleagues have developed a bank and agency reduction plan up to 1/4/26 which includes the following initiatives:

- Reducing shift visibility for agencies
- Plans for 'switching off' cascade to agency per ward/department
- Plans for cessation of usage of HCA agency (NHSE mandate) to be completed by 31/1/26.

The Trust are participating in the Midlands Price Cap Compliance group across all staff group, with the focus during the current quarter being on medical temporary staffing rates.

Band 2/3 agency removal work ongoing with an enhanced focus on Clinical Support Worker recruitment.

Continuing to identify long standing agency workers to migrate to trust or NHSP to support trust cost reduction targets.

Risks

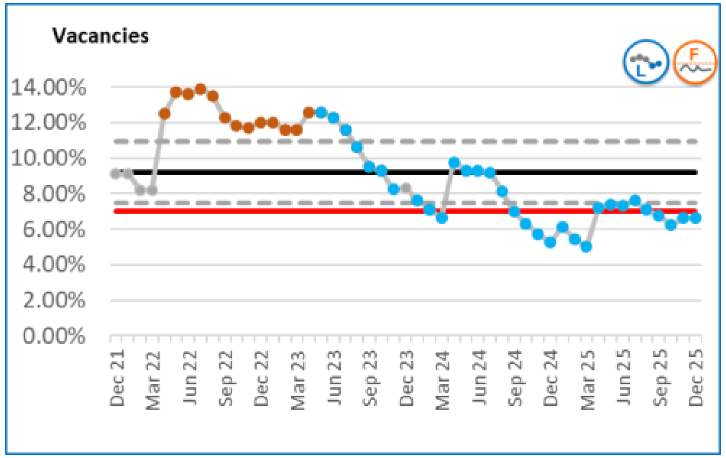
Retrospective agency bookings leading to inaccurate reporting on agency usage and spend.

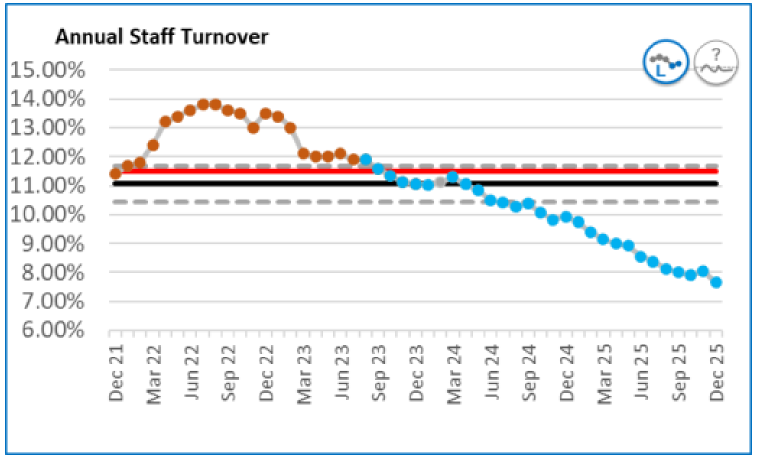
Ongoing risk to financial performance and compliance with the annual plan to reduce temporary staff by 40%.

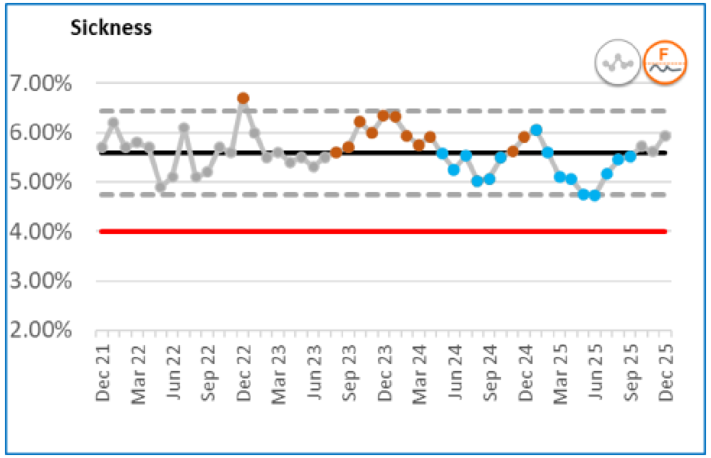
OUR WORKFORCE PERFORMANCE – VACANCIES, TURNOVER AND SICKNESS

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.







Understanding the performance

- **Trust-wide Vacancies** Staff in Post has remained broadly unchanged at 7189.87 wte this month. An increase in establishment at budget setting, and a further 2 wte increase this month, has impacted our vacancy rate which has increased marginally to 6.64%, against a target of 6.5%. Women and Children's have the highest clinical vacancy rate at 8.26% directly related to the increase in establishment earlier in the year.
- **Starters and Leavers** - We have 5 less starters than leavers this month . We have processed 61 new starters in month (headcount) and 66 leavers.
- **Annual Staff Turnover** continues to comfortably meets our 11.5% target with a further reduction to 7.65% which is 2.28% better than the same period last year and better than pre-pandemic levels.
- **Monthly sickness absence** has increased by 0.32% to 5.93% which is 0.03% worse than last year. There has been increased sickness absence in all clinical divisions except Women and Children's. Estates and Facilities are outliers with 8.75%. Digital meet the 4% Group target. This KPI continuously fails to reach the target and is showing common cause variation.

Actions (SMART)

- We have a **Sickness and Health and Wellbeing strategy**.
- **Continued Support** is being offered to staff through Occupational Health, Staff Support, Employee Assistance Programme (EAP) and Wellbeing interventions.
- **Targeted intervention meetings** implemented with managers in areas of highest sickness absence levels, with support from the HR Advisory team. Identifying hotspot areas and getting back to basics to ensure processes are in place to manage absence effectively within a timely manner as well as providing drop in sessions for managers.
- **Trigger reports** have been discussed at divisional meetings to drive compliance with policy and ensure sickness is appropriately addressed

Risks

Performance to Plan Our 2025/26 workforce plan includes challenging bank, agency and infrastructure workforce reductions. At present we are 24.11 wte better than plan for Agency but above plan by 58.53 wte for bank. Medicine, Surgery, Estates and Facilities and Digital continue to use more wte than their establishment.

Healthcare Support Workers Vacancy rate has increased to 11.21% (131.59 wte vacancies) from 11.09%.

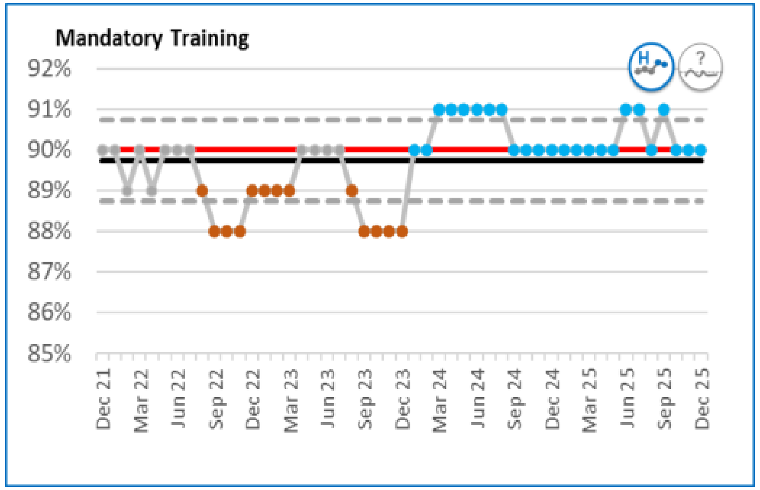
Sickness for Estates and Facilities continues to be very high despite a reduction to 8.75%. The primary reason for sickness in this Division is Other Musculoskeletal problems, Stress and Anxiety and Genitourinary and Gynae problems. This staff group has historically higher sickness across the NHS and we are now in Quartile 4 on Model Hospital (September 2025 data). HCA sickness is also high at 8.17% (Quartile 3 on Model Hospital).

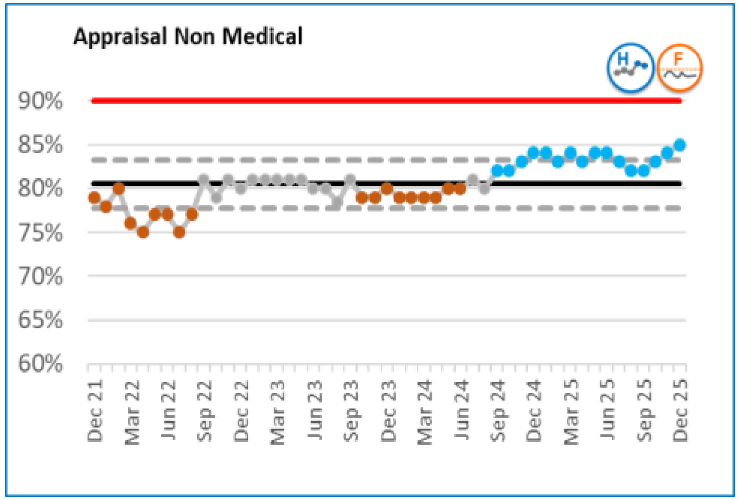
Absence due to stress remains higher than pre-pandemic levels. Women and Children's and Corporate are significant outliers with 39.22% and 38.80% respectively.

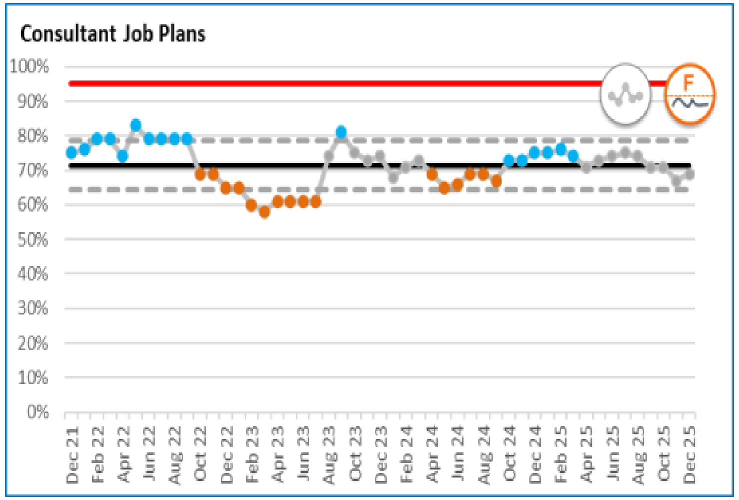
OUR WORKFORCE COMPLIANCE – MANDATORY TRAINING, APPRAISAL & JOB PLANNING

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.







Understanding the performance

Overall Mandatory Training has remained at 90% and continues to meet target. This is against a Model Hospital average of 91.6% (revised 2024/25 rates). We are Quartile 2 (good) on Model Hospital. Women and Children's Division are outliers at 87% (unchanged). Digital and Medicine have remained at 89%. All other divisions meet the target of 90%.

Appraisal Rate has improved by 1% to 85% against a target of 90% with improvements in all divisions except digital and Surgery. Compliance is 1% higher than last year. Corporate are outliers at 66%, followed by Digital at 75%. Estates and Facilities and Surgery meet target. Medical appraisal rates are good at 96%.

Consultant Job Planning has improved to 69% against target of 95%. Women and Children's are closest to target with 93% for Consultants and 100% for their SAS Doctors. Medicine and Surgery are significant outliers at 56% and 63% (both improved). This KPI failed to reach the target and is showing common cause variation.

Actions (SMART)

Revised Appraisal Form and submission process have been rolled out. Working Group led by divisions has reviewed and made improvements to the system.

NHSE have implemented a national **job plan target of 95%** effective from February 2025 and require compliance to be reported via the Provider Workforce Return on a monthly basis.

A project to **fully roster** medics is being rolled out which will improve transparency and should improve clinic and theatre productivity.

Divisions to focus on Job Planning to improve productivity and transparency. A consistency panel and Job Planning Committee are in place.

Risks

Medical and Dental are outliers for Mandatory Training at 80% (unchanged). All other Staff groups meet the 90% Trust target with the exception of Scientific and Technical (89% unchanged).

Poor Appraisal rates raises concerns that some staff are not meeting regularly with their manager which will impact on Staff Survey scores and morale.

Corporate remain **outliers** for Appraisal with 66% (1% improvement).

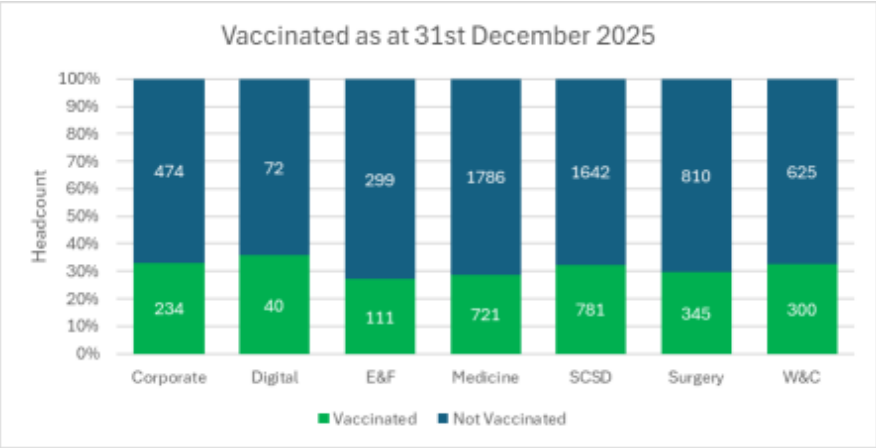
Consultant Job Plans are low although improved by 2% to 69% against the NHSE monitored target of 95%.

OUR WORKFORCE – VACCINATION UPTAKE

We are driving this measure because

Getting flu vaccination is the most effective intervention for reducing harm from flu infection

Local report from RAVS looked up into our current Staff in Post as of 31st December 2025



Vaccination Uptake by Division as at 31st December 2025	Vaccinated	Total All Staff	%vaccinated
365 Corporate	234	708	33%
365 Digital	40	112	36%
365 Estates & Facilities	111	410	27%
365 Medicine	721	2507	29%
365 Specialised Clinical Services Division	781	2423	32%
365 Surgery	345	1155	30%
365 Women & Children	300	925	32%
Grand Total	2532	**8240**	31%

10 highest and lowest Clinical Directorates as of 31st December 2025

365 Neurophysiology Service	67%
365 Palliative Care Service	63%
365 Surgery Daycase Service	59%
365 ITU ACCPs & Medics	57%
365 Paediatric Service	56%
365 Dermatology Services	50%
365 MADEL Funding	50%
365 Rheumatology	50%
365 Infectious Diseases	49%
365 Renal Service	46%
365 A&E WRH	21%
365 Ophthalmology	21%
365 Trauma & Orthopaedics	21%
365 Haematology Services	21%
365 Geriatric Medicine	20%
365 Urology	20%
365 Acute Medicine & AMU (AGH)	18%
365 Neurology Service	18%
365 A&E KTC	17%
365 General Internal Medicine Service	9%

Understanding the performance

When a member of staff receives a flu vaccination, data is collected on Record a Vaccination Service (RAVS) which feeds through to the NHS Federated Data Platform (FDP) which is used nationally to monitor vaccination rates.

However, there are limitations with the FDP as it can only report at Trust Level and only includes clinical staff. For Divisional and Directorate splits and for our ImmForm National reporting, we have to look up a national report from RAVS into our Staff in Post on ESR which gives us a percentage of 31% (3% improvement).

The national FAQ guidance states: “FDP denominators include all staff employed by a Trust regardless of job role or employment status (substantive / non-substantive). The FDP report defaults to show uptake for active staff in frontline roles. There may be differences in FHCW population/denominator figures between Immform and FDP”.

Actions (SMART)

We have raised concerns with the FDP that we believe their figures are inflated as they appear to include patients and external contractors/agency staff.

In the meantime, we will use our own RAVS report looked up into current SIP in ESR (31%). This is necessary in order to breakdown our uptake into Divisional and Departmental level for FPE packs.

The Top 10 and Bottom 10 Departments/Directorates are shown above.

Risks

As the flu vaccination is not mandatory the risk is that we will have frontline healthcare workers who are not vaccinated who may then spread flu to their patients and/or cost the Trust in sickness absence if they catch flu.

There is an identified risk that the national report from FDP is inflated to include people who are not employees of this Trust. This is remedied in our own internal reports from RAVS looked up into our actual Staff in Post from our Payroll.

A&E at Worcester, Minor Injuries at Kidderminster and AMU at Redditch are amongst the 10 lowest vaccination rates.

OUR FINANCIAL PERFORMANCE

Katie Osmond

Interim Chief Finance Officer

Financial Plan 2025/26
A balanced plan was submitted for 2025/26, this included Non-Recurrent System Deficit Support funding of £47.3m and £53m of Cost Improvement (CPIP).

Income & Expenditure Performance – At the end of Month 9 we report a **year to date (YTD) adverse £9.7m position against plan** driven primarily by the material planned increase in CPIP requirement and intended reductions in capacity. One-off hits in month and a reduction in our ability to support the position non recurrently have contributed to the deterioration since M7. **The underlying run rate shows improvement remains below expectations.**

- **Income is £9.9m favourable YTD** – favourable variances include: £3.9m on pass through drugs and devices; £1.9m deferred income release supporting CPIP non recurrently; £1m recognition of work in progress; £1m ICB support; £1.3m additional income to offset costs of industrial action in M8 and M9; and some smaller items. These are offsetting small adverse variances.
- **Employee expenses are £17.1m adverse YTD** – adverse variances include: £11.5m CPIP under delivery; additional resources supporting flow £2.9m; £1.3m in year impact of regrading Health Care Support Workers (HCSW) Band 2 to Band 3; £1.2m costs of Industrial action; £0.9m of workforce costs in Estates and Facilities (E&F) (cover for vacancies and sickness); £1.0m increased investment in Stroke and Frailty; £0.9m of backdated job plans; and £1m of WLI. The remainder is driven by additional cover for sickness, specialling and maternity leave and erosion of vacancy factor through additional recruitment with no temporary staffing offset. This is partially offset by £3.7m of balance sheet release and £0.8m of Dermatology vacancies.
- **Operating expenses excluding Employee Expenses are £2.9m adverse YTD** – adverse variances include: £2.9m of pass-through drugs and devices (£1m difference to income due to nature of H&W ICB contract); £1.1m of tariff drugs driven by activity; £3.1m CPIP under delivery; £0.8m Dermatology Insourcing; £0.8m costs of surgical activity; £0.4m additional costs of Radiology Reporting (increase in 1hr turnaround); and increased costs of other activity across multiple Divisions. This is partially offset by favourable variances including: £4.8m of gross balance sheet release (noting inclusion as CPIP); £1.8m of utilities underspend; and smaller items.

Delivery of a balanced financial plan – revised Divisional Control Totals for income and expenditure were set from month 8 (November) to increase traction back to the plan by year end and as part of developing an overall Financial Recovery Plan. This resulted in a target surplus of £0.2m for month 9, assuming all mitigations were delivered. The actual deficit of £2m in month 9 is £2.2m worse highlighting insufficient progress on financial recovery. **Immediate corrective action is required and actions have been strengthened,** overseen through Financial Recovery Board. **Our current assessment is that there is significant risk to achievement of the break-even plan.**

Capital – The YTD capital spend at Month 9 is £9.75m, the majority of which is spend on the ALX Fire Scheme (£3.4m), IFRIC 12/PFI Lifecycle replacements (£1.7m) additional digital schemes including laptops purchased in year (£753k) and the CHEC Lease (£1.4m) leading to a variance against budget YTD of £1093k. Efforts are focused on delivering the programme by year end.

Cash – The Trust cash position at the end of Month 9 was £4.478m (cash in bank). The Trust has received the notified deficit support of £3.942m in December totalling £35.475m to date. **There remains a significant risk to cash over the final quarter of the year, given financial performance.**

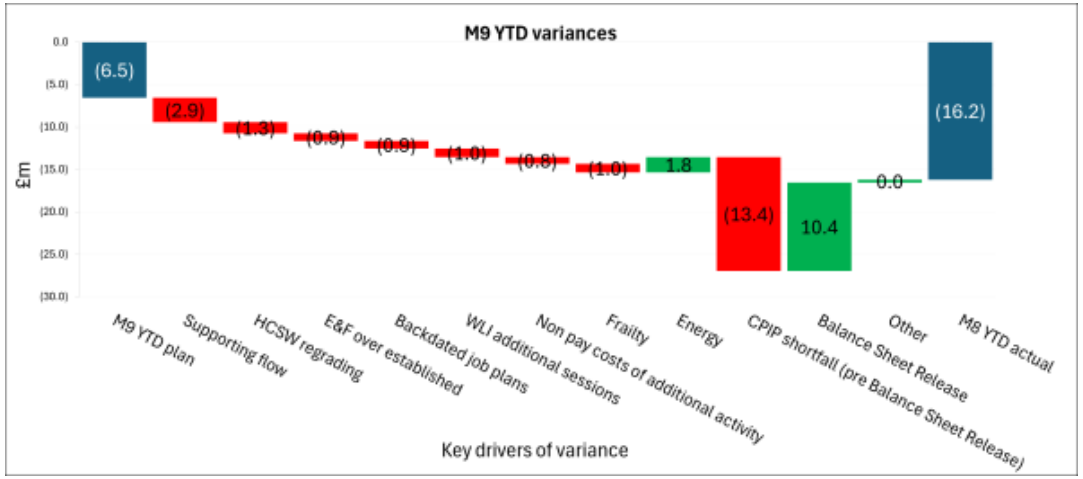
Clinical Coding – December is at 100% on the 7th working day(due to Christmas). Total of FCE's for December was 15,465 compared to 15,266 in November.

BEST USE OF RESOURCES – INCOME & EXPENDITURE

We are driving this measure because

The Income and Expenditure plan reflects the Trust's operational plan, and the resources available to the Trust to achieve its objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

Statement of comprehensive income	Year to Date Plan £'000	Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Operating income from patient care activities	559,828	565,595	5,766
Other operating income	26,501	30,609	4,108
Employee expenses	(361,209)	(378,354)	(17,145)
Operating expenses excluding employee expenses	(213,482)	(216,377)	(2,894)
OPERATING SURPLUS / (DEFICIT)	**11,638**	**1,473**	**(10,165)**
FINANCE COSTS			
Finance income	1,105	1,622	517
Finance expense	(7,988)	(7,810)	178
PDC dividends payable/refundable	(3,784)	(3,783)	1
NET FINANCE COSTS	**(10,667)**	**(9,971)**	**696**
Other gains/(losses) including disposal of assets	0	(170)	(170)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**971**	**(8,668)**	**(9,640)**
Remove capital donations/grants/peppercorn lease I&E impact	136	(167)	(303)
Remove PFI revenue costs on an IFRS 16 basis	28,015	30,500	2,485
Add back PFI revenue costs on a UK GAAP basis	(35,660)	(37,887)	(2,227)
Adjusted financial performance surplus/(deficit)	**(6,538)**	**(16,222)**	**(9,685)**



Understanding the performance

At the end of Month 9 we report a year to date (YTD) adverse £9.7m position against plan. Adverse variances primarily driven by under-delivery against recurrent CPIP (£9.3m), resources supporting flow and activity (£5.9m) and HCSW regrading (£1.m). This position has been supported by a non-recurrent benefit of £9.8m balance sheet release, utility benefit (£1.5m) and a system contribution to CPIP (£1m).

- **Income is £9.9m favourable YTD** – favourable variances include £3.9m pass through Drugs & Devices and £1.9m deferred income release supporting CPIP non recurrently, £1m work in progress, £1m ICB support, £1.3m income for industrial action and £0.3m over delivery of CPIP (excluding £1m WIP declared as CPIP), £0.2m E&T tariff, £0.3m donated assets and £0.3m Injury cost recovery scheme and are offsetting small adverse variances.
- **Employee expenses are £17.1m adverse YTD** – adverse variances include £11.5m CPIP under delivery, additional resources supporting flow £2.9m, £1.3m impact of regrading HCSW from Band 2 to 3, £1.2m costs of Industrial action, £0.9m of costs in E&F driven by cover for vacancies and sickness, £1.0m increased investment in Stroke and Frailty, £0.9m backdated job plans, £1m of WLI, the remainder is additional cover for sickness, specialling and maternity leave and erosion of vacancy factor through recruitment with no temporary staff offset. Partially offset by £3.7m of balance sheet release and £0.8m of Dermatology vacancies.
- **Operating expenses excluding Employee Expenses are £2.9m adverse YTD** – adverse variances include £2.9m of pass-through Drugs and Devices (£1m difference to income due to fixed nature of income contract with H&W ICB), £1.1m of tariff drugs driven by activity, £3.1m CPIP under delivery, £0.8m Dermatology Insourcing and £0.8m of non pay costs of activity in Theatres and Surgery, £0.4m additional non pay costs of Radiology Reporting relating to increase in 1hr turnaround, remainder due to increased non pay costs of other activity across multiple Divisions. Partially offset by favourable variances including £4.8m of gross balance sheet release (noting inclusion as CPIP), £1.8m of utilities underspend, £0.4m Equans settlement and £0.5m DCR slippage.

Actions (SMART)

The Trust commenced a Financial Recovery Plan comprising several workstreams. Executive led Weekly Divisional Recovery Board meetings are embedded progressing delivery of actions.
CPIP review meetings take place fortnightly assisting with monitoring and measuring performance to improve development of existing plans as well as delivery against fully developed plans.

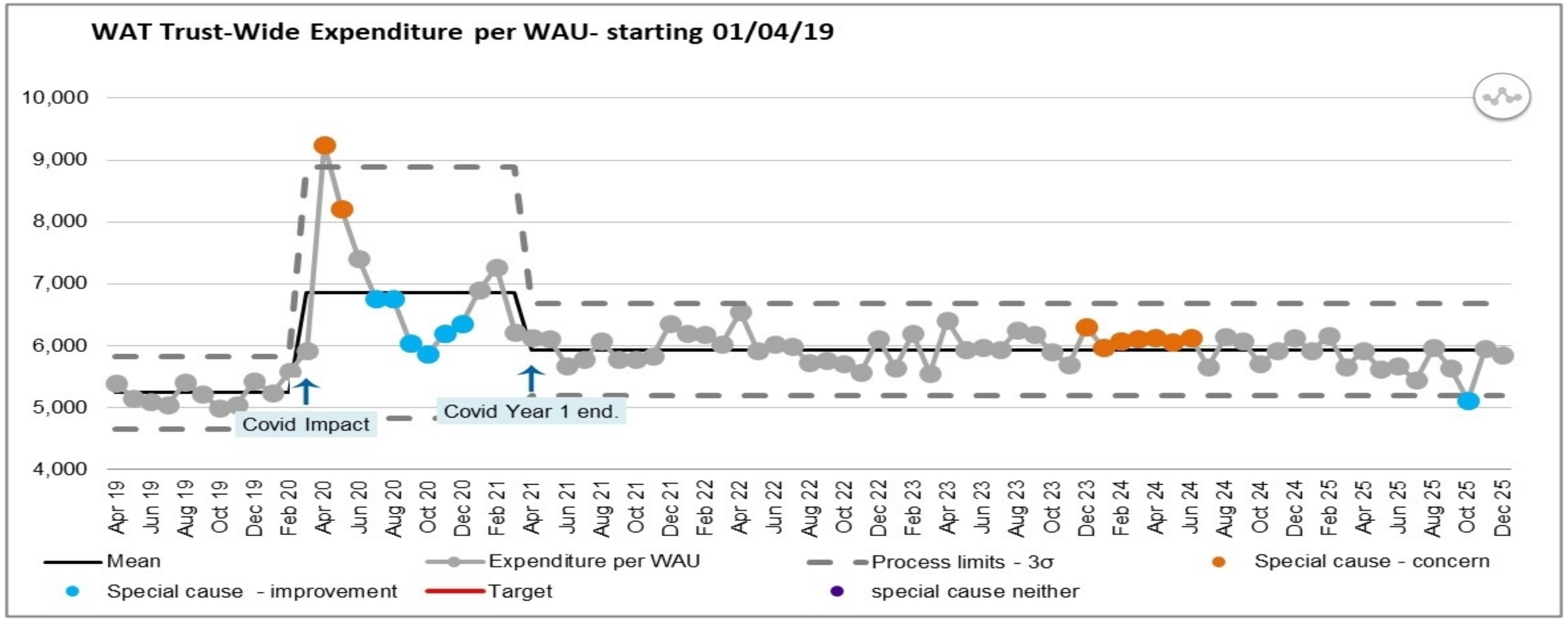
Risks

If recovery plans fail to deliver, and deficit support funding is with held or if they do not deliver in cash – the Trust will face cash flow issues.

BEST USE OF RESOURCES – ADJUSTED EXPENDITURE PRODUCTIVITY TREND

We are driving this measure because

This SPC measures expenditure against activity, allowing us to follow productivity changes. Tracking is currently available at Trust wide level only. Weighted Activity Unit (WAU) has been developed within the Foundation Group using Inpatient/Outpatient/ED/Critical Care activity, adjusted to be weighted equally. There is no adjustment for working day variations.
Previous years Expenditure is adjusted up for inflation to make them comparable with the current year. As the WAU relies on coded activity, recent months can still move until coding is complete.



YTD Movement compared to 2024/25

Exp per WAU	-5.2%
Expenditure	-0.2%
WAU	5.3%

Monthly Movement

	Nov - Dec	**Adjusted for Working Days**
Exp per WAU	-1.7%	2.2%
Expenditure	-2.4%	-2.4%
WAU	-0.6%	-4.5%

Costing Team Update

- Costing teams across the Foundation Group are looking at updating the Cost per WAU measurement to use more up to date weighting to bring it in line with the NHS England's Implied productivity methodology.

Understanding the performance

For December, our **Cost per WAU is 1.7% lower than November. This is driven by increase in Emergency discharges offsetting most elective reduction due to the holiday period and a 2.4% reduction in expenditure. When working days are factored in for Elective it has increased by 2.2%. YTD versus 2024/25 our Spend per weighted activity is 5.2% lower** indicating we are more productive than the same period of 2024/25 after expenditure is adjusted for inflation.

Actions (SMART)

The Costing team continue to support Divisions in identifying opportunities to improve productivity.

Risks

If the Trust cannot reduce expenditure whilst also increasing activity levels, then achievement of financial and performance targets are at risk.

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

We are driving this measure because

If the Trust fails to identify recurrent Cost and Productivity Improvement Plans (CPIP) and put in place sufficient resources and governance arrangements to drive delivery, then it will not achieve financial sustainability.

YTD CPIP achieved
vs plan target (£53.016m) month

YTD CPIP achieved
vs plan target (£53.016m) cumulative

Schemes identified (forecast) vs target (£53.016m)

Understanding the performance

M9 delivered actuals of £2.259m against a plan of £6.448m, an under delivery of £4.189m. M9 actuals comprised £1.370m recurrent and £0.889m non-recurrent. YTD actuals are £24.277m against a £33.005m plan, an under delivery of £8.728m. YTD there are £14.974m of recurrent actuals and £9.303m of non-recurrent actuals.

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Actions (SMART)

- The Trust has commenced a Financial Recovery Plan comprising a number of workstreams based on the outcome of the Financial Mitigation Plan workshops held on 11 and 30 September.
- Fortnightly CPIP review meetings continue which focus on cost out CPIP schemes as well as productivity opportunities.
- The Trust has commenced identification of 26/27 CPIP opportunities as part of the Integrated Planning process

Risks

Delivery of the 25/26 target is challenging. Work is continuing to develop existing schemes as well as identifying further cost saving and productivity savings via the workshops referenced above to bridge the gap to target (GTT)

BEST USE OF RESOURCES – CAPITAL

We are driving this measure because

The Capital investment programme to replace existing and invest in new additional assets is key to driving improved clinical and financial sustainability. Given the size of capital programme there is a significant risk that the Trust has insufficient funding to support backlog maintenance requirements and much needed equipment replacement.

Trust Capital Position at M9

Position v Budget

Workstream	Scheme	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Digital	Additional Digitial Schemes	£0	£0	£56,026	£56,026
Digital	CAP2425 Cardiac PACS	£300,000	£300,000	£159,897	-£140,103
Digital	Cyber Improvement PDC	£39,000	£0	£32,500	£32,500
Digital	Digital rev to cap transfer	£0	£0	£974,887	£974,887
Digital	Externally Funded Constitutional Schemes	£1,091,000	£0	£0	£0
Digital	Frontline Digital	£0	£0	-£35,272	-£35,272
Digital	LIMS Pathology	£370,000	£370,000	£355,091	-£14,909
Equipment	Equipment Contingency	£748,696	£0	£0	£0
Equipment	Equipment Schemes	£381,655	£367,351	£378,538	£11,185
Equipment	Externally Funded Constitutional Schemes	£170,000	£30,000	£33,169	£3,169
Other	2526 LSE Fleet vehicles	£345,000	£345,000	£0	£0
Other	2526 LSE WRH Car park	£259,000	£0	£0	£0
Other	Contingency Scheme	£0	£0	£41,689	£41,689
Other	Donated Equipment Schemes	£467,777	£318,868	£321,713	£2,845
Other	IFRIC 12 and other contingency	£3,138,502	£2,206,072	£1,756,607	-£449,464
Other	Lease Modifications	£0	£0	£1,380,459	£1,380,459
Other	P&W Scheme Funded by Charity	£35,422	£3,000	£1,706	-£1,294
P&W	2025/26 P&W Scheme	£0	£0	£223,886	£223,886
P&W	Externally Funded Constitutional Schemes	£0	£0	£629	£629
P&W	P&W Backlog Maintenance	£1,674,372	£738,372	£225,943	-£512,430
Strategic	Acute Service Review	£4,001,855	£79,918	£47,395	-£32,523
Strategic	Cath lab feasibility	£0	£0	£255	£255
Strategic	Children's Estate Development	£0	£0	£10,791	£10,791
Strategic	Externally Funded Constitutional Schemes	£3,099,000	£281,000	£28,712	-£252,288
Strategic	Internally funded Fire Scheme	£2,600,000	£2,600,000	£2,599,999	-£1
Strategic	LINACS WRH Replacement	£3,321,000	£967,000	£14,447	-£952,553
Strategic	National Diagnostics - Cath lab	£0	£0	£93,443	£93,443
Strategic	National Funding Fire Scheme	£3,000,000	£2,993,738	£805,453	-£2,188,285
Strategic	RAAC A Block Link KTC	£296,850	£296,850	£238,935	-£57,915
Total		**£25,339,129**	**£11,897,169**	**£9,746,898**	**-£1,805,273**

Strategic - (£3,379k) Variance
Waiting on updated cashflows for Fire scheme as spend to date is significantly below what was initially expected, assurance provided that the scheme will be fully spent by year end (£3m scheme).

Other/Leases - £974k Variance
Costs for the CHEC building lease re-measurement are offset by the IFRIC 12 spend being lower than expected YTD and by the delayed start of the Fleet vehicle lease.

P&W - (£288k) Variance
VAT Credit on UEC Scheme.

Digital £873k Variance
Laptops and other items purchased in year have been recharged to capital after review, not originally in plan for 25/26.

Equipment - £14k Variance
Constitutional Scheme of Sleep Diagnostics has been actioned ahead of schedule, other procured equipment as per plan.

Understanding the performance

The Year-to-date capital spend at M9 is £9.75m, the majority of which is spend on the ALX Fire scheme (£3.4m) IFRIC 12/PFI lifecycle replacements (£1.7m) additional digital schemes including laptop purchased in year (£753k) and the CHEC Lease (£1.4m)

At M9 capital spend is lower than budget by £1.805m.

Actions (SMART)

The Capital finance team will continue to work with the workstream leads to ensure all approved capital schemes are completed within the Trust CRL.

Risks

There is a significant risk that the Trust has insufficient funding to support backlog maintenance requirements, much needed replacement schemes and a contingency for any unforeseen events.

BEST USE OF RESOURCES – CASH

We are driving this measure because

Daily monitoring of the Trust cash position to ensure there are sufficient funds to cover employee costs and the payment of Trust suppliers as per the BPPC guidance.

Period Beginning	01/04/2025	01/05/2025	01/06/2025	01/07/2025	01/08/2025	01/09/2025	01/10/2025	01/11/2025	01/12/2025	01/01/2026	01/02/2026	01/03/2026
Period Ending	30/04/2025	31/05/2025	30/06/2025	31/07/2025	31/08/2025	30/09/2025	31/10/2025	30/11/2025	31/12/2025	31/01/2026	28/02/2026	31/03/2026
Cash at Beginning of Period	35,262	21,887	21,473	17,674	18,698	15,859	6,161	6,390	4,638	4,478	3,492	2,224
Cash at End of Period	21,887	21,473	17,674	18,698	15,859	6,161	6,390	4,638	4,478	3,492	2,224	2,186

Understanding the performance

The Trust cash balance at the end of month 9, December 2025 was £4.478m (cash in bank), which included £1.9m from Coventry Warwickshire ICB from 2024/25 through arbitration which was not in our forecast The Trust has received the notified deficit support funding (DSF) of £3.942m for December (£35.478m) to the end of December.

A revised cash position has been modelled incorporating the revised recovery plan. The Trust will need to apply for Provider Revenue Support by 6 February 2026 for March 2026 for £15.5m which is based on the revised recovery plan assumptions. See the cash forecast position which assumes the application of £15.5m is approved and all assumptions/mitigations are achieved.

Actions (SMART)

The Trust will need to apply for revenue support funding in February for payment in March. Please note the Trust must request revenue cash support by 6th February for payment in March and Board approval and support will be required. This application will require daily cash flows, supporting CFO narrative, Board and Finance committee papers and CEO and Chair supporting letters with a cash recovery plan and CPIP details.

Risks

The timing of the mitigation schemes may differ to the planned cash forecast or not come to fruition.

Suppliers may put the Trust on stop if payments terms are not adhered too, which in turn will jeopardise supplies and services to the Trust for patient care.

Worcestershire Acute Hospitals NHS Trust

Trust Key Performance Indicators (KPIs) - up to Dec-25 data

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

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

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

Example

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

Quality of care, access and outcomes		Responsible Director	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month Numerator	Latest Month Denominator	Year to Date (v Standard if available)	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Cancer	% of patients told their cancer diagnosis outcome within 28 days (all routes) ***NHSE NOF***	Chief Operating Officer	77.0%	79.9%	78.9%	74.6%	70.0%	75.4%	77.2%	75.9%	74.0%	80.1%	80.4%	-	2,070	2,575	75.9%		76.5%	Nov-25			
	% of patients receiving their first or subsequent treatment for cancer within 31 days of decision to treat / earliest clinically appropriate date (all routes)	Chief Operating Officer	86.6%	89.5%	86.7%	87.4%	84.7%	84.4%	79.6%	83.3%	80.8%	83.3%	85.8%	-	461	537	83.5%		91.7%				
	% of patients receiving their first definitive treatment for cancer within 62 days of referral (all routes) ***NHSE NOF***	Chief Operating Officer	61.6%	59.7%	71.1%	64.5%	57.4%	58.5%	57.3%	65.1%	54.5%	60.2%	61.1%	-	203	333	59.7%		70.2%				
	% of suspected cancer referrals waiting >62 days	Chief Operating Officer	7.2%	5.4%	6.3%	8.6%	10.3%	9.8%	9.8%	11.5%	9.1%	10.4%	9.3%	12.1%									
Urgent and emergency care	% of ambulance handovers within 45 minutes	Chief Operating Officer	63.3%	79.2%	73.1%	65.9%	71.7%	80.8%	84.2%	81.4%	65.8%	65.2%	74.8%	72.7%	1,122	4,106	73.8%						
	% of patients seen within 4 hours (any type) ***NHSE NOF***	Chief Operating Officer	58.7%	66.2%	66.0%	60.9%	65.1%	66.1%	66.5%	64.5%	63.0%	62.4%	62.7%	59.9%	7,344	18,337	63.4%		75.0%	Oct-25			
	% of patients seen within 4 hours (type 1)	Chief Operating Officer	42.2%	52.3%	51.2%	44.5%	49.3%	50.9%	50.8%	49.5%	47.7%	48.0%	49.1%	47.1%	7,261	13,735	48.6%		61.1%				
	% of patients spending more than 12 hours in A&E ***NHSE NOF***	Chief Operating Officer	21.3%	18.3%	16.9%	18.6%	15.9%	14.8%	13.0%	14.8%	17.7%	18.3%	16.4%	16.5%	2,268	13,749	16.2%		9.8%				
Elective care	Referral to Treatment - % of open pathways waiting < 18 weeks ***NHSE NOF***	Chief Operating Officer	55.3%	58.2%	59.3%	59.3%	59.8%	59.9%	59.1%	58.5%	59.3%	58.9%	57.5%	57.9%	33,255	57,484			61.6%				
	Referral to Treatment - % of non-admitted pathways waiting < 18 weeks for their first outpatient appointment	Chief Operating Officer	57.1%	60.8%	63.0%	63.1%	63.1%	62.2%	59.1%	58.5%	58.8%	58.4%	57.4%	57.5%	-	-			-	Nov-25			
	Referral to Treatment - % of open pathways waiting > 52 weeks ***NHSE NOF***	Chief Operating Officer	1.84%	1.71%	1.46%	1.65%	1.66%	1.72%	1.66%	1.57%	1.49%	1.51%	1.34%	1.24%	712	57,484			2.2%				
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	39	28	18	21	24	22	18	18	25	47	22	5					9,394				
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	100%	102%	102%	104%	105%	105%	100%	95%	100%	97%	106%	97%	20,130	20,650	101%						
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	103%	103%	99%	107%	106%	105%	103%	97%	102%	100%	105%	97%	58,705	60,603	102%						
	Total Elective Activity (volume v plan)	Chief Operating Officer	100%	99%	97%	106%	108%	98%	98%	98%	96%	97%	100%	95%	7,688	8,075	103%						
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	81%	80%	80%	83%	84%	84%	83%	83%	83%	82%	84%	81%			83%		80%	Dec-25			
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)	Chief Operating Officer	45	32	33	40	37	55	50	21	46	32	36	50			367		21,053	Q4 23-24			
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	16.0%	12.0%	14.4%	16.8%	16.2%	21.0%	24.9%	26.4%	24.9%	28.1%	27.4%	29.6%	3,705	12,519			21.7%	Nov-25			
Maternity	% of women who have been booked to see a midwife by 9 weeks and 6 days of pregnancy	Chief Nursing Officer	29%	34%	33%	37%	37%	42%	47%	42%	49%	54%	55%	56%	236	419	47%						
	Maternity Activity (Deliveries)	Chief Nursing Officer	353	343	393	384	403	420	432	419	450	441	373	402			3,724						
Outpatient transformation	Missed outpatient appointments (DNAs) rate	Chief Operating Officer	4.8%	4.6%	4.6%	4.5%	4.7%	5.0%	5.2%	4.9%	5%	5%	5%	5%	3,041	60,225	5%		6.6%	Nov-25			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	89%	90%	90%	89%	90%	90%	89%	89%	89%	89%	90%	88%	32729	37146	89%						
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	105%	104%	97%	109%	108%	105%	105%	98%	103%	102%	104%	97%	38,575	39,953	103%						
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	17%	17%	17%	17%	18%	16%	17%	17%	18%	18%	17%	19%	10,904	58,765	18%		18%	Feb to Jan			

Prevention long term conditions	Maternity - Women who were smokers at time of delivery (SATOD)	Chief Nursing Officer	7.9%	7.3%	4.3%	3.9%	6.5%	5.7%	4.4%	5.0%	4.4%	4.1%	4.0%	3.2%	13	402	4.6%					
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	96%	96%	94%	96%	96%	95%	94%	93%	94%	94.5%	94.6%	93.4%	786	842	95%		95%	Oct-25		
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	50	48	55	55	62	46	60	52	55	53	56	61			383		4,263	Sep-25		
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	8.3	8.5	7.6	7.3	7.4	7.3	7.0	6.7	7.1	7.24	6.92	6.58	22989	3494	7.1		4.4	Feb to Jan		
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	3.1	3.1	2.7	3.1	3.1	3.3	2.5	3.6	3.4	3.16	3.7	3.63	1529	421	3.3		3.1			
	Medically fit for discharge - Acute	Chief Operating Officer	15%	15%	15%	12%	14%	16%	15%	15%	12%	12%	12%	11%	85	804	12.0%		23.1%	Dec		
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	4.3%	4.2%	4.63%	4.65%	4.87%	4.62%	4.73%	4.67%	4.69%	4.44%	4.84%	4.86%	582	11985	4.6%		7.5%	Jan to Dec		
	Mortality SHMI - Rolling 12 months ***NHSE NOF***	Chief Medical Officer	108.00	110.00	110.00	110.71	110.55	111.77	111.51	111.51								As expected				
	MRSA Bacteraemia ***NHSE NOF***	Chief Nursing Officer	0	0	0	1	0	0	1	1	2	0	0	0			5					
	Number of external reportable >AD+1 clostridium difficile cases ***NHSE NOF***	Chief Nursing Officer	11	5	9	4	8	14	10	11	14	12	8	14			95					
	Number of falls with moderate harm and above	Chief Nursing Officer	6	4	2	5	4	4	4	4	4	1	1	1			28					
	VTE Risk Assessments	Chief Medical Officer	95%	97%	91.66	91.07	90.52	90.54	91.37	91.63	92.50%	92.95%	91.34%	92.14%	10,888	11,817	92%					
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	57%	65%	73%	48%	57%	57%	66%	67%	78.6	63.6	68.7	66.70%	42	63	63%					
	Complaints resolved within policy timeframe	Chief Nursing Officer	71%	46%	54%	64%	69%	78%	54%	79%	67%	63%	65%	61%	46	75	66%					
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	80%	79%	82%	84%	81%	85%	84%	80%	80%	82%	81%	82%	1375	1720	82%		77%	Nov-25		
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	97%	97%	96%	96%	96%	96%	96%	95%	96%	97%	95%	95%	3525	3699	96%		95%			
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	96%	95%	97%	98%	93%	96%	97%	96%	97%	94%	94%	95%	81	85	96%		91%			
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	4%	12%	20%	13%	25%	16%	24%	19%	18%	16%	15%	12%	1720	14275	18%					
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	25%	36%	37%	32%	36%	35%	36%	31%	31%	38%	33%	32%	3699	11752	34%					
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	22%	22%	18%	26%	21%	11%	23%	18%	14%	14%	17%	10%	85	880	17.0%					

People		Responsible Director	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional	SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	6.9%	7.3%	5.8%	6.6%	4.8%	5.3%	4.6%	3.2%	4.6%	3.6%	4.1%	2.9%			4.4%					
	Appraisals - Non-medical	Chief People Officer	84.0%	83.0%	84.0%	83.0%	84.0%	84.0%	83.0%	82.0%	82.0%	83.0%	84.0%	85.0%	5,485	6,443	83.3%					
	Appraisals - Medical	Chief People Officer	96.0%	94.0%	94.0%	96.0%	96.0%	94.0%	94.0%	94.0%	93.0%	96.0%	95.0%	96.0%	573	599	94.9%					
	Mandatory Training	Chief People Officer	90.0%	90.0%	90.0%	90.0%	90.0%	91.0%	91.0%	90.0%	91.0%	90.0%	90.0%	90.0%	81,161	90,204	90.3%					
	Overall Sickness	Chief People Officer	6.1%	5.6%	5.1%	5.1%	4.8%	4.7%	5.2%	5.5%	5.5%	5.7%	5.6%	5.9%	13,238	223,082	5.3%					
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	9.7%	9.4%	9.2%	9.0%	8.9%	8.6%	8.4%	8.1%	8.0%	7.9%	8.1%	76.5%	491	6,424	15.9%					
	Vacancy Rate	Chief People Officer	6.2%	5.5%	5.0%	7.2%	7.4%	7.3%	7.6%	7.1%	6.8%	6.2%	6.6%	6.6%	512	7,190	7.0%					

Finance and Use of Resources		Responsible Director	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional	SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	£1	-£9	-£557	-£3,631	-£3,063	-£2,149	-£339	-£2,292	-£745	£2,773	-£4,741	-£2,037			-£16,222					
	I&E - Margin (%)	Chief Finance Officer	12.2%	-0.2%	-0.6%	-5.7%	-4.8%	-3.3%	-0.5%	-3.6%	-1.1%	-5.7%	-7.2%	-3.0%			-5.7%					
	I&E - Variance from plan (£k)	Chief Finance Officer	£457	£336	-£163	-£221	-£68	£141	£199	-£40	£23	-£12	-£6,148	-£3,559			-£9,685					
	I&E - Variance from Plan (%)	Chief Finance Officer	-100.0%	-97.0%	41.0%	6.0%	2.0%	-6.0%	-38.0%	2.0%	-3.0%	0.0%	-437.0%	-234.0%			6.0%					
	CPIP - Variance from plan (£k)	Chief Finance Officer	-£403	-£226	£831	-£593	£147	-£152	-£563	-£2,833	-£489	£2,346	-£4,574	-£4,190			-£8,812					
	Agency - expenditure (£k)	Chief Finance Officer	£2,756	£2,875	£2,404	-£2,294	-£1,983	-£2,215	-£1,988	-£1,275	-£1,404	-£1,501	-£1,825	-£1,234			-£15,718					
	Agency - expenditure as % of total pay	Chief Finance Officer	6.9%	7.3%	3.6%	5.5%	4.8%	5.3%	4.6%	3.2%	3.4%	3.6%	4.2%	2.9%			4.2%					
	Capital - Variance to plan (£k)	Chief Finance Officer	£2,580	£2,746	£12,471	£664	£328	-£378	£1,420	£11	£1,489	-£1,204	-£2,069	-£2,122			-£1,861					
	Cash - Balance at end of month (£m)	Chief Finance Officer	£14.106m	£18.729m	£35.262m	£21.887m	£21.443m	£17.673m	£18.698m	£15.859m	£6.160m	£6.39m	£4.638m	£4.478m			-					
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	74%	76%	77%	92%	94%	94%	92%	90%	91%	90%	98%	90%			-					
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	65%	67%	70%	91%	94%	91%	82%	90%	92%	94%	96%	89%			-					

NHS Worcestershire Acute Hospitals NHS Trust

WORCESTER ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**10/02/2026**
Title of Report:	Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme Year 7 Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Justine Jeffery – Director of Midwifery Laura Veal – Clinical Director for Obstetrics Jane Wardlaw – Assurance and Compliance Midwife
Reporting Route:	Quality Governance Committee
Appendices included with this report:	Prepared Board declaration
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

This report provides the perinatal services final position and process of evidence review to demonstrate full compliance with the CNST 10 safety actions for the Maternity Incentive Year 7 Scheme (MIS). The report provides all of the required evidence to support the Board to complete the declaration.

The service is declaring ***full compliance with all 10 safety actions*** following a robust review of the evidence locally and in addition the evidence was further reviewed as follows:

A line by line review of all available evidence presented by the Maternity Compliance & Assurance Midwife. Director of Midwifery to the CNO, Non-exec Board level Safety Champion and Chief Digital Officer.

An extraordinary Quality Governance Committee where the evidence was represented by the Director of Midwifery and the Clinical Director to Executive and Non-Executive colleagues.

The declared position was agreed at each review.

An external review will be undertaken by the Local Maternity & Neonatal System Programme team on 19th February 2026.

The Board declaration is required for submission to NHSR by 3rd March 2026 at 12 noon

Recommended Actions required by Board or Committee

- The Trust Board are asked to:
- **Review** the evidence submitted against the ten safety actions
- **Agree** the suggested level of compliance and complete the declaration and submit to NHSR by 3rd March 2026 at 12 noon.

Executive Director Opinion[1]

As CNO I am assured we have undertaken due diligence with the CNST process. The processes has included Executive and Non-Executive colleagues whereby the evidence in line with the technical guidance was presented and tested for all ten safety actions.

[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.

Introduction/Background

This report provides the perinatal services current position and process of evidence review to demonstrate full compliance with the CNST 10 safety actions for the Maternity Incentive Year 7 Scheme (MIS). The report provides all of the available evidence to support the Board to complete the required declaration.

The perinatal service is declaring full compliance with all 10 safety actions following a robust review of the evidence locally and in addition the evidence was further reviewed as follows:

- Quarterly CNST reports to QGC and Board outlining the required information and evidence as outlined in the scheme
- Line by line review of all available evidence presented by the Maternity Compliance & Assurance Midwife. Director of Midwifery to the CNO, Non-exec Board level Safety Champion and Chief Digital Officer.
- An extraordinary Quality Governance Committee where the evidence was represented by the Director of Midwifery and the Clinical Director with oversight of the Chair and attended by the CNO, CMO, COO(part), Non exec Board level Safety Champion, None Exec Director and Chief Digital Officer.
- In addition some safety action are also externally reviewed by the relevant external stakeholder as detailed below:

Issue and options

The following evidence is presented to support the declared position:

Safety Action	Externally validated	Compliant/Non-compliant
1	Yes MBRRACE	Compliant
2	Yes NHS Digital	Compliant
3	Yes WMPN	Compliant
4	Yes WWPN	Compliant
5	No	Compliant
6	Yes LMNS/Region	Compliant
7	No	Compliant
8	No	Compliant
9	No	Compliant
10	Yes NHSR	Compliant

Conclusion
The evidence to support full declaration with the Year 7 Maternity Incentive Scheme has been robustly reviewed as described within the report and it was agreed at each stage that the requirements as outlined within the scheme had been met. The Trust Board are asked to accept the evidence submitted against the ten safety actions, agree the suggested level of compliance and complete the declaration and submit to NHSR by 3rd March 2026 at 12 noon.