NHS Resolution

Maternity incentive scheme - Year 7 Guidance

Trust Name	**Worcestershire Acute Hospitals NHS Trust**
Trust Code	**T567**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.

Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	Yes
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	Yes
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	N/A
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	N/A

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Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	No
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
12	Was the above action plan shared with the LMNS?	Yes
13	Was the above action plan shared with the Neonatal ODN?	Yes
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
17	Was the above action plan shared with the LMNS?	Yes
18	Was the above action plan shared with the Neonatal ODN?	Yes

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Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

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Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	N/A
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	Yes

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Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	N/A
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A

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Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

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Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

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Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	Yes
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

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Section A : Maternity safety actions - Worcestershire Acute Hospitals NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

NHS Resolution

Section B : Action plan details for Worcestershire Acute Hospitals NHS Trust

An action plan should be completed for each safety action that has not been met

Please refer to the guidance sheet to ensure correct entries into the action plan: Return to Guidance Sheet

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
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Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
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Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
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Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Worcestershire Acute Hospitals NHS Trust**
Trust code	**T567**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Worcestershire Acute Hospitals NHS Trust
Name:	
Position:	
Date:	

Goodman Tilda 09/02/2026 17:33:12

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Worcestershire Acute Hospitals NHS Trust
Name:	
Position:	
Date:	

WORCESTER ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**10/02/2026**
Title of Report:	**Midwifery Safe Staffing Report December 2025**
Lead Executive Director:	**Chief Nursing Officer**
Author:	**Justine Jeffery – Director of Midwifery**
Reporting Route:	**Quality Governance Committee**
Appendices included with this report:	**None**
Purpose of report:	**☒ Assurance ☐ Approval ☐ Information**

Brief Description of Report Purpose

The purpose of this report is to provide assurance that midwifery staffing is monitored and to note actions taken to mitigate any shortfalls

Recommended Actions required by Board or Committee

The committee is asked to note how safe midwifery staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of midwifery staffing

Executive Director Opinion[1]

The report offers assurance to the Board that there are robust processes in place to monitor midwifery staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur.

[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

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- Sickness absence, vacancy and turnover rates
- Recruitment & retention rates
- Monthly report to Board

In addition to the above actions, a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits.

The summary of the workforce KPIs are as follows:

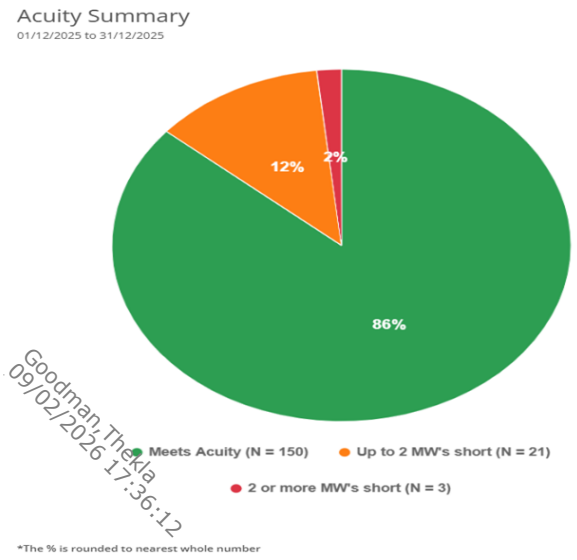
Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	5.2%	6.3%
Turnover rate (rolling)	11.5%	4.4%	14%
Vacancy rate (MW)	7%	2%	18%
Maternity Leave	-	4.35%	0%
Midwife to birth ratio (in post)	1:24	1:19	
1:1 care in labour	100%	Achieved	
Shift leader SN	100%	Achieved	

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 93% of the expected intervals and therefore the data presented is reliable. The diagram below presents when staffing met or did not meet the acuity.



From the information available, the acuity was met in 86% of the time and recorded at 19% when it was not met prior to any actions taken. This is higher than the previous month' performance. Safe staffing levels were maintained on all shifts in December following mitigation.

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=18) of when staff are reallocated from other areas of the inpatient service. The community/continuity teams were not required to support the inpatient area. There were 2 reports of staff not being able to take a break and 2 occasions when the mamnger/matron were working clinically to support

Number of Management Actions
01/12/2025 to 31/12/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	18	75%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	2	8%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	2	8%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	2	8%
MA11	Maternity Unit on Divert	0	0%
TOTAL		24	

*The % is rounded to nearest whole number

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

NICE recommended red flags are reported in the acuity app and are presented below. There were no red flags in December.

Number of Red Flags recorded
01/12/2025 to 31/12/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	0	0%
TOTAL		0	

*The % is rounded to nearest whole number

Birth Centre

In month, the completion rate for the acuity app for the birth centre was at 80%. The acuity was met 99% of the time. The birth rate remains consistent

Intrapartum & Non-Birthing Categories
01/12/2025 to 31/12/2025

Categories	Number in Categories	Percentage
Cat I	42	44%
Cat II	17	18%
Cat PN	35	36%
Cat X	2	2%
TOTAL	96	

*The % is rounded to nearest whole number

Staffing incidents

There were eight staffing incidents reported via datix

1. No MSW available to chaperone/support USS list
2. Reduced Band 7 cover (n=3)
3. 3rd MW not available in Triage
4. Telephone Triage MW not covered (2)
5. Only one MW allocated to MBC

Medication Incidents

There were eight no harm incidents

1. Medication missed (3)
2 Self administrating contraindicated medication
2. Readmission due to non-compliance with medication
3. Discharged with incorrectly labelled medication
4. Discharged without TTOs
5. Insulin not prescribed timely

Monitoring the midwife to birth ratio

The ratio in December was 1:19 (in post) and 1:18 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Maternity SitRep

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

National Maternity SitRep

The current national maternity submission is completed each fortnight; it is expected that the new national SitRep will be rolled out across England in January 2026 which will combine the national and regional submissions into one return.

Unify Data

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

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	87%	100%	n/a	n/a
Antenatal Ward/Triage	90%	92%	87%	95%
Delivery Suite	87%	93%	75%	80%
Postnatal Ward	88%	85%	85%	99%
Meadow Birth Centre	90%	88%	81%	94%

Daily staff safety huddle

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

Vacancy

There are 6 unfilled midwifery roles (Fetal Medicine & Sonography Lead) and 4.0 WTE band 6 midwifery roles. There are 10 WTE MCA vacancies – 10WTE in pipeline to start over next 3 months.

Sickness

Sickness absence rates for midwives are reported at 5.2% and 6.3%% for non-registered staff – this is a decrease for both groups and is the lowest rate of reported sickness since monthly reporting began.

The following actions remain in place:

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

Turnover

The rolling turnover rate is at 4.4% for midwives and at 14% for non-registered staff – this an improved position for non- registered staff.

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- SitRep report completed three times per day

- Monthly ‘drop - in’ sessions led by the DoM/DDoM.
- Safety Champion walkabouts
- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

Risk Register –staffing

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

Conclusion

To maintain safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. The escalation policy was utilised on 18 occasions to maintain safety. The community and continuity of carer midwives were not required to support the inpatient team.

There was 2 reports of staff not being able to take a break and no report of a staff member staying beyond the end of their shift; the supernumerary status of the shift leader at the onset of the shift and 1:1 care in labour were achieved following deployment of staff.

There was no harm caused from the reported staffing and medication incidents.

Sickness absence rates have improved and are remain above the Trust target however there is a high level of assurance that absence is being managed in alignment with the polic.

The vacancy rate is 2% for MWs and 18% for MCA’s. Further recruitment is planned for midwives in January and the pipeline remains at 10WTE for MCAs.

Recommendations

The Committee is asked to note the content of this report for information and assurance.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**10/02/2016**
Title of Report:	Safer Staffing report - Nursing
Lead Executive Director:	**Chief Nursing Officer**
Author:	Sue Smith, Deputy Chief Nursing Officer
Reporting Route:	NWAG
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

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

Recommended Actions required by Board or Committee

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

Executive Director Opinion[1]

Staffing on Neonatal and all Adult in patient areas have been maintained at safe levels throughout December 2025. In paediatrics whilst BAPM level were not achieved on 100% of shifts, professional judgement indicates that areas and staffing were safe.

There were 74 red flags raised, all were deemed insignificant and minor harms relating to nursing / midwifery staffing being largely reported as near misses due to staff absence, rather than patient harm.

Due to the continued increase in pressures, additional capacity has continued to be utilised, with PDU being open throughout December 25. In addition to this overnight surge areas have also been in use in MSDEC. The impact of the above and the additional ED's staffing is the requirement for an extra 90.93 WTE per month for both registered and unregistered staff which significantly contributes to the nursing temporary staffing costs.

Nursing and Midwifery have achieved the reduction of agency to 2.16% of total staffing spend in Month 9 from 4.31% in Month 1. The Price Cap Compliance (PCC) work has been increasing gradually and now sits at 98% compliance, with the final Paediatric agencies moving to Tier 1 within price cap from 1st December 25.

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

Worcestershire Acute Hospitals NHS Trust

Nursing Staffing Levels
January 2026 (December 2025 data)

Title:	Monthly Report on Nursing Staffing Levels for January 2026 date (December data)
Responsible Director:	Chief Nurse
Lead:	Deputy Chief Nurse
Reported by:	Lead Nurse for Workforce

1. Introduction

1.1 This briefing provides the QGC with an overview of the Nursing and Midwifery workforce for December 2025 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016. It provides assurance that arrangements are in place to safely staff our services with the right number of Nurses and Midwives, with the right skills, at the right time.

2. Key highlights

2.1 Table 1 and 2 outlines the key performance workforce indicators for Registered and Unregistered (Band 2 and 3) staffing in Nursing mapped against the Trust target with comparison to the previous month's performance.

Nursing (Registered)

Key Performance Indicator	Target	Dec-25	Nov-25	Additional notes
RN Vacancy rate	n/a	3.72%	3.76%	
RN Annual turnover	11.5%	5.82%	6.46%	
RN Sickness rate	4%	6.28%	5.85%	Active sickness management in place and staff well being supported
HCSW Vacancy rate	n/a	11.21%	11.09%	Healthy pipeline in place and active recruitment continues
HCSW Annual turnover	11.5%	12.01%	12.45%	
HCSW Sickness rate	4%	8.17%	8.40%	Improving sickness position

3. Expectation 1: Right Staff

3.1 Evidence Based Workforce Planning

3.1.1 Safer Nursing Care Tool (SNCT)

- SNCT data collection period took place over September 2025 and October 2025, utilizing the following Safer Nursing Care Tools: 'Adult Inpatient Wards in Acute Hospitals', 'Adult Acute Assessment Units' and 'Children's and Young People's Inpatient Wards'.
- The report is being formulated for submission to Board next month (February 2026)

3.1.2 Bi-Annual Establishment Reviews 2026

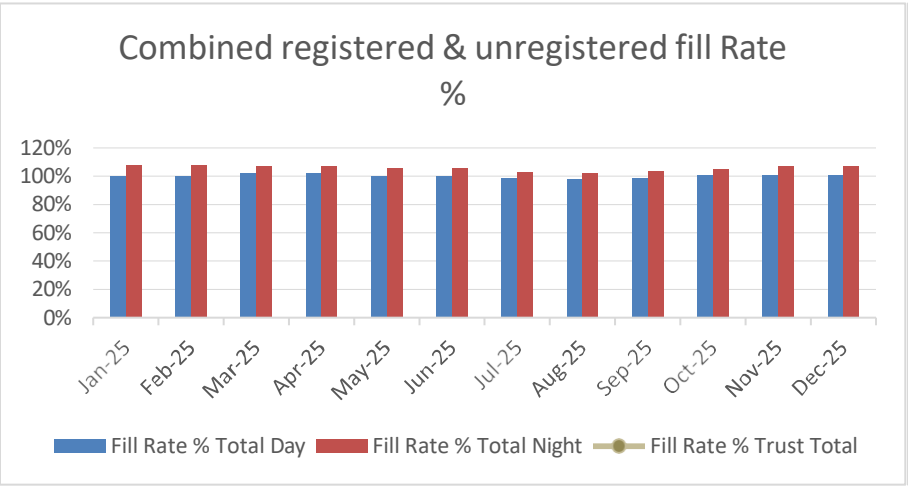
- The first bi-annual review is due to commence in April 2026 using the relevant SNCT
- The second review will be undertaken in October 2026 using the relevant SNCT
- Any change in ward template or specialty will trigger a SNCT review of establishment

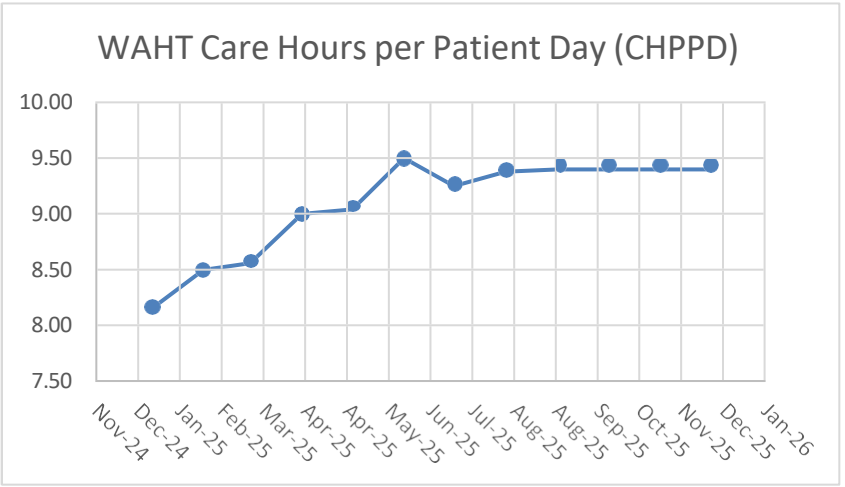
3.1.3 Electronic Rostering (Health Roster and SafeCare)

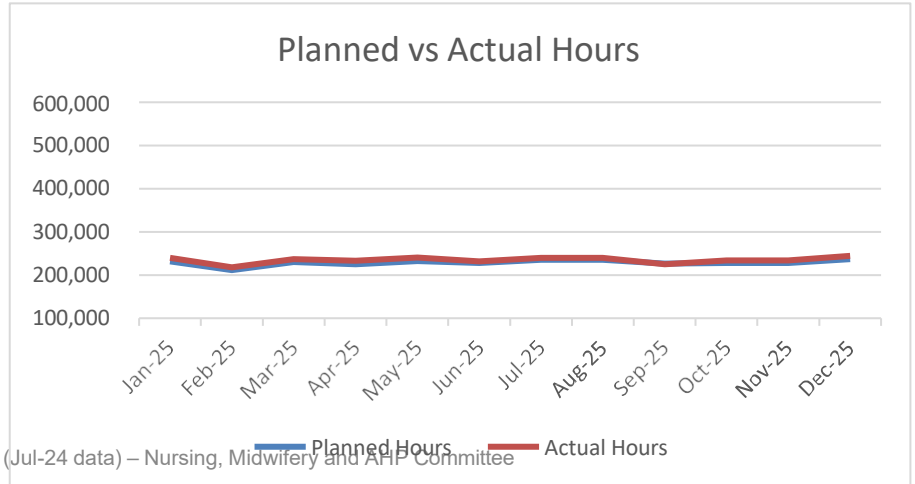
- LOOP application is in full operation with no issues reported
- E-Rostering KPIs are monitored through the Nursing, Midwifery and AHP Advisory Working Group and demonstrate good compliance

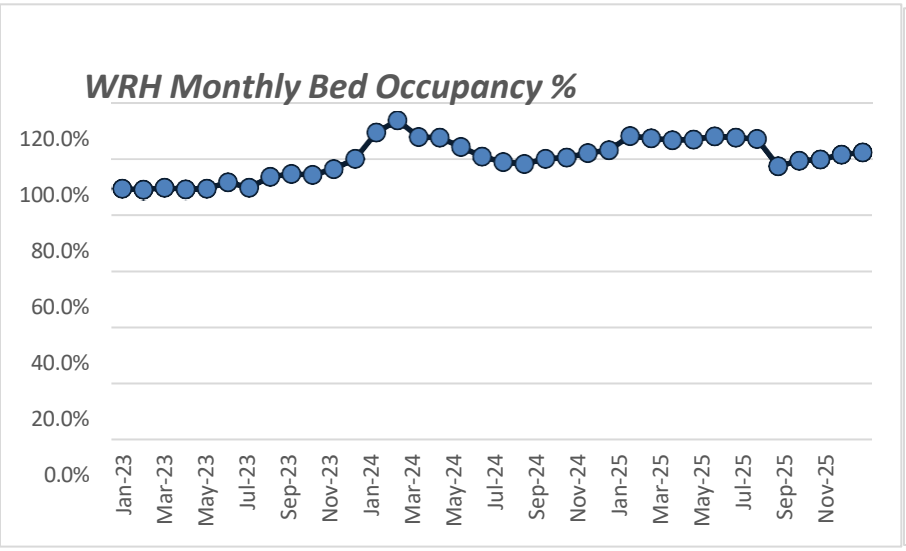
3. Expectation 1: Right Staff

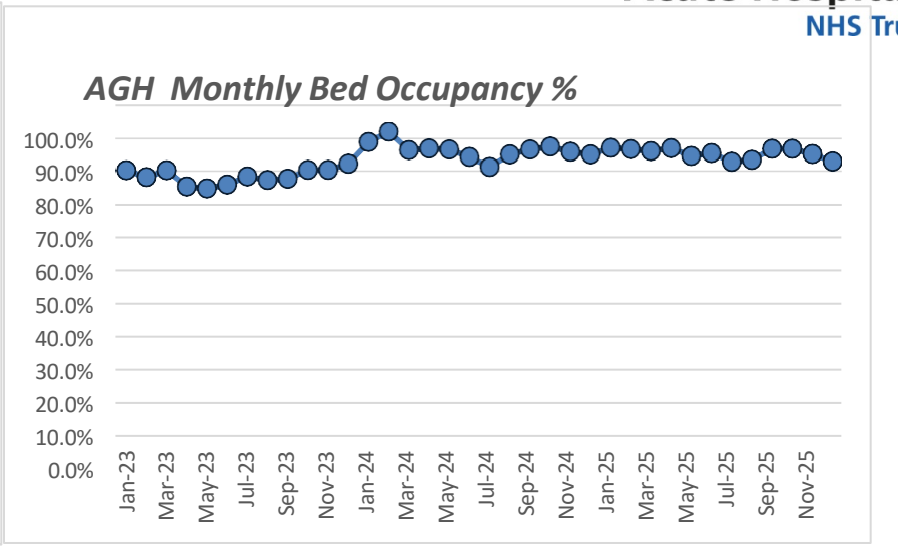
3.3 Safety performance metrics (WAHT)











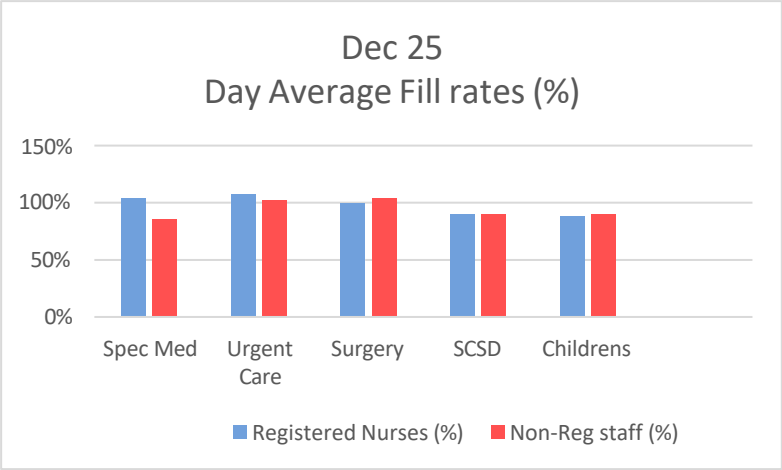
3.3.1

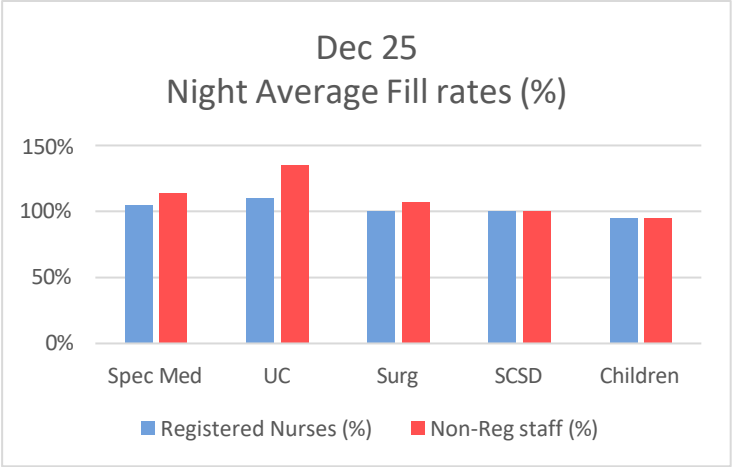
Narrative:

- Average fill rate % is consistent month on month.
- CHPPD in December was slightly improved at 9.2 (9.0 in previous month) and above the national lower advised range of 6.3
- No area fell below the 6.3 lower advised limit in December.
- Bed occupancy remains high across both sites

3. Expectation 1: Right Staff

Safety performance metrics

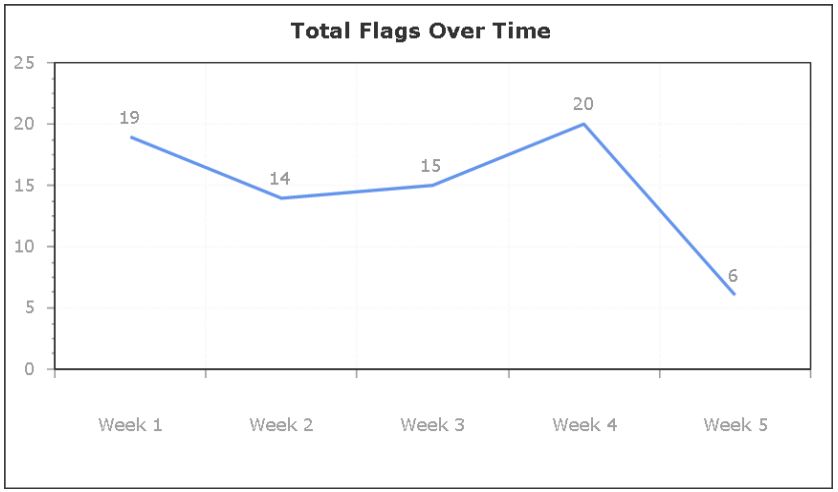


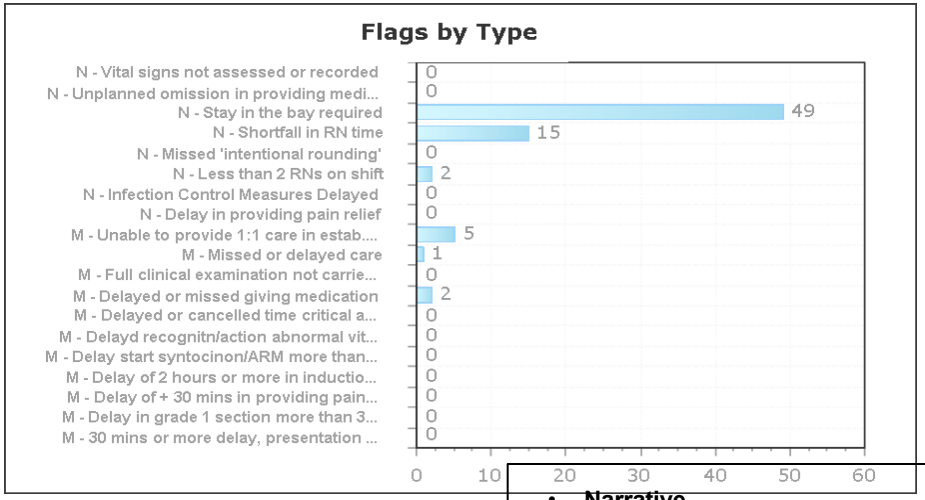


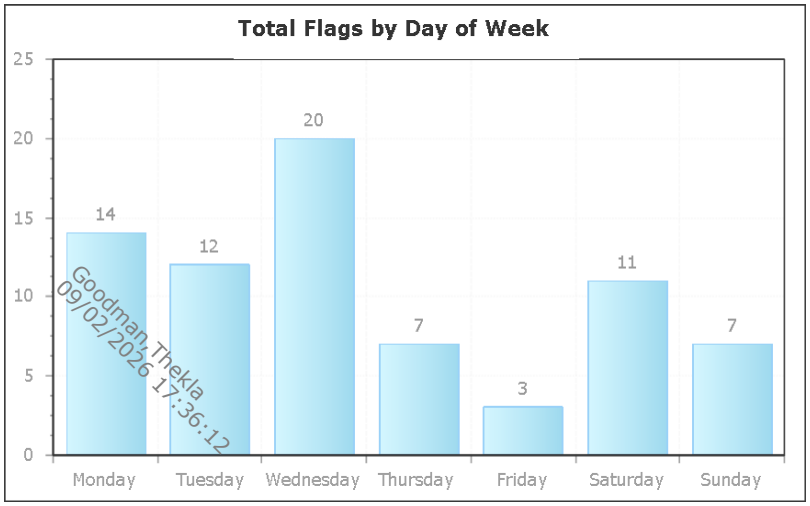
Narrative:

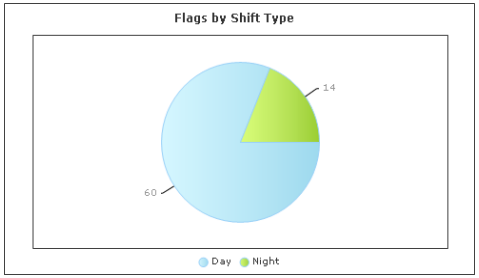
- Day and Night average fill rate analysis shows consistent fill across days and nights. ≤95 % only evident in SCSD and children's is indicative of variations in acuity and dependency with CHPPD remaining stable in these areas and no specific safety concerns.
- 1-2-1 and Enhanced therapeutic observations analysis to follow in future reports

3. Expectation 1: Right Staff – Red flag data for December 2025









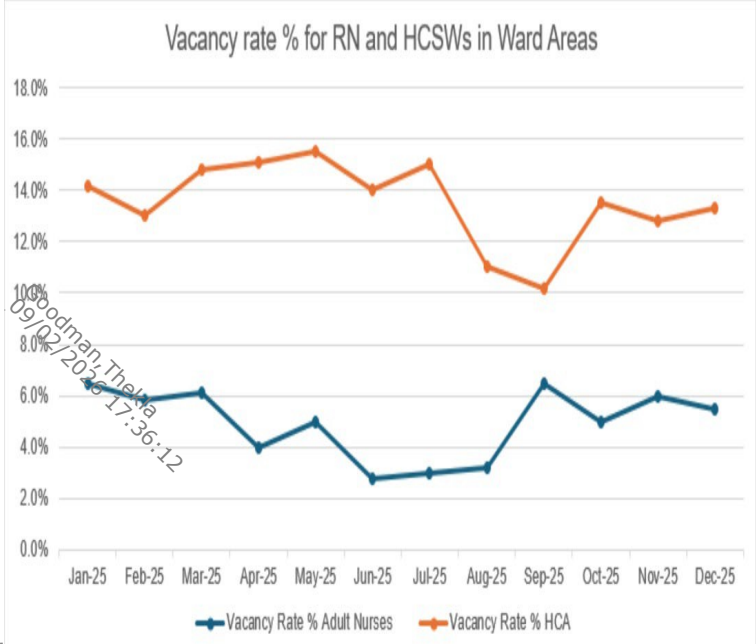
- **Narrative**
- Monitoring and reporting of red flags raised via safe care will be a focus in 2025 and has been added to both NWAG reporting and CEA ward accreditation.
- Dec 2025 saw 74 red flags raised with highest % for 'stay in the bay' and Rn shortfall'.
- Monitoring and reporting of red flags raised via safe care will be a focus in 2025 and has been added to both NWAG reporting and CEA ward accreditation. This will be supported by additional training for Matrons and wards.

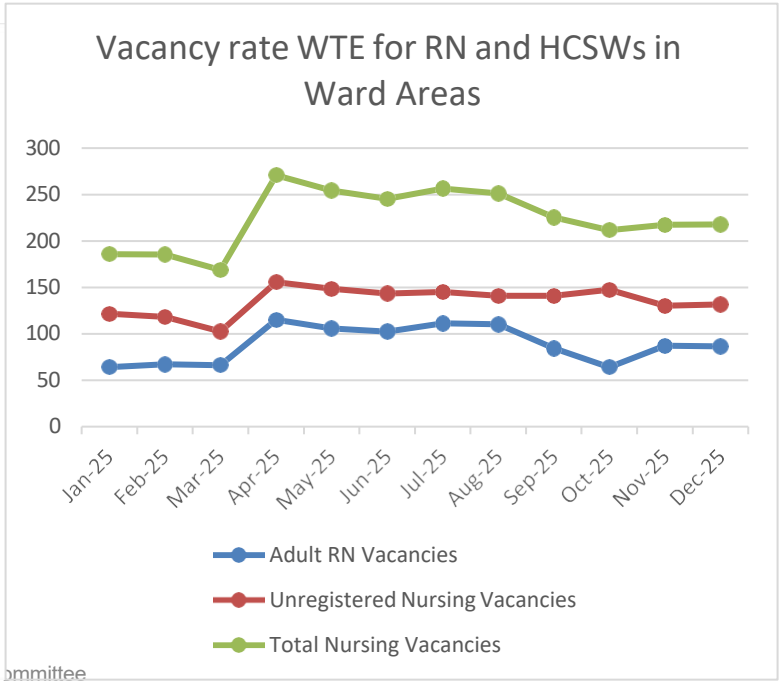
Worcestershire Acute Hospitals NHS Trust

3. Expectation 1: Right Staff

3.5 Vacant posts (Nursing)

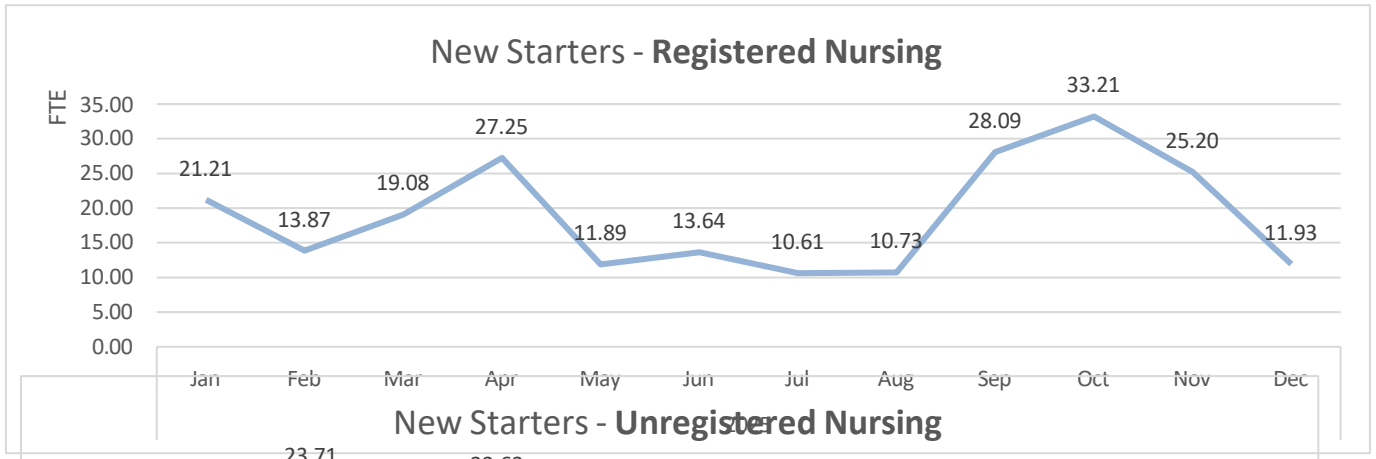
Month	Vacancy Rate % Adult Nurse	Vacancy Rate % HCA	Adult Registered Nursing Vacancies	Unregistered Nursing Vacancies	Total Nursing Vacancies
Dec - 25	3.72%	11.21%	86.35	131.59	217.94
Nov - 25	3.76%	11.09%	87.32	130.20	217.52

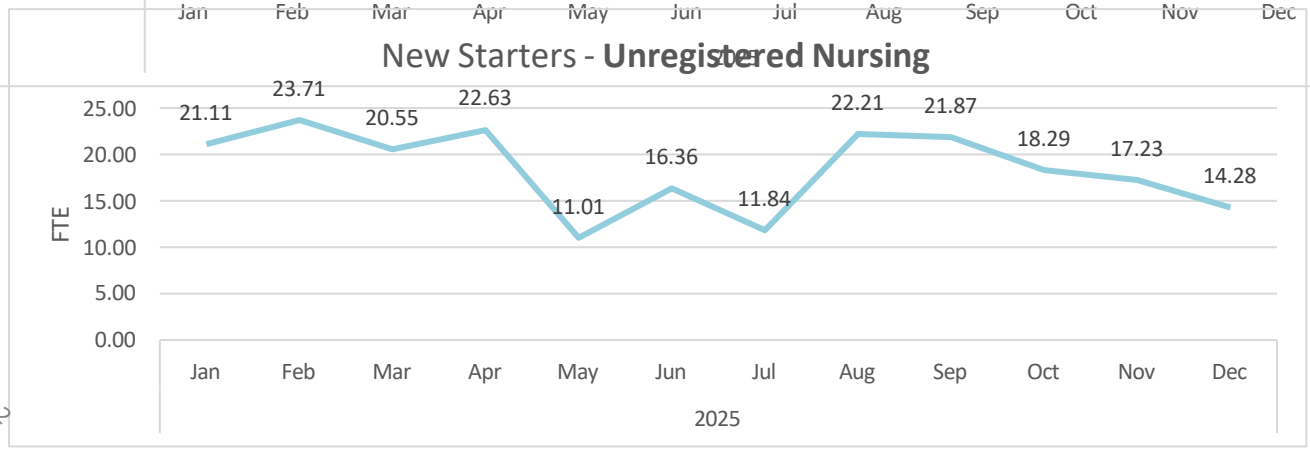




- **Narrative**
- RN vacancies for December are currently at 86.35WTE (3.72%) down marginally from November and below Model Health system level of 6.3%. This includes vacancies showing for areas not currently in use (Endoscopy at Evesham) and areas funded but not actively recruiting due to temporary status such as PDU.
- HCA vacancies remain a focus for ongoing work across division / workforce and jobs team.

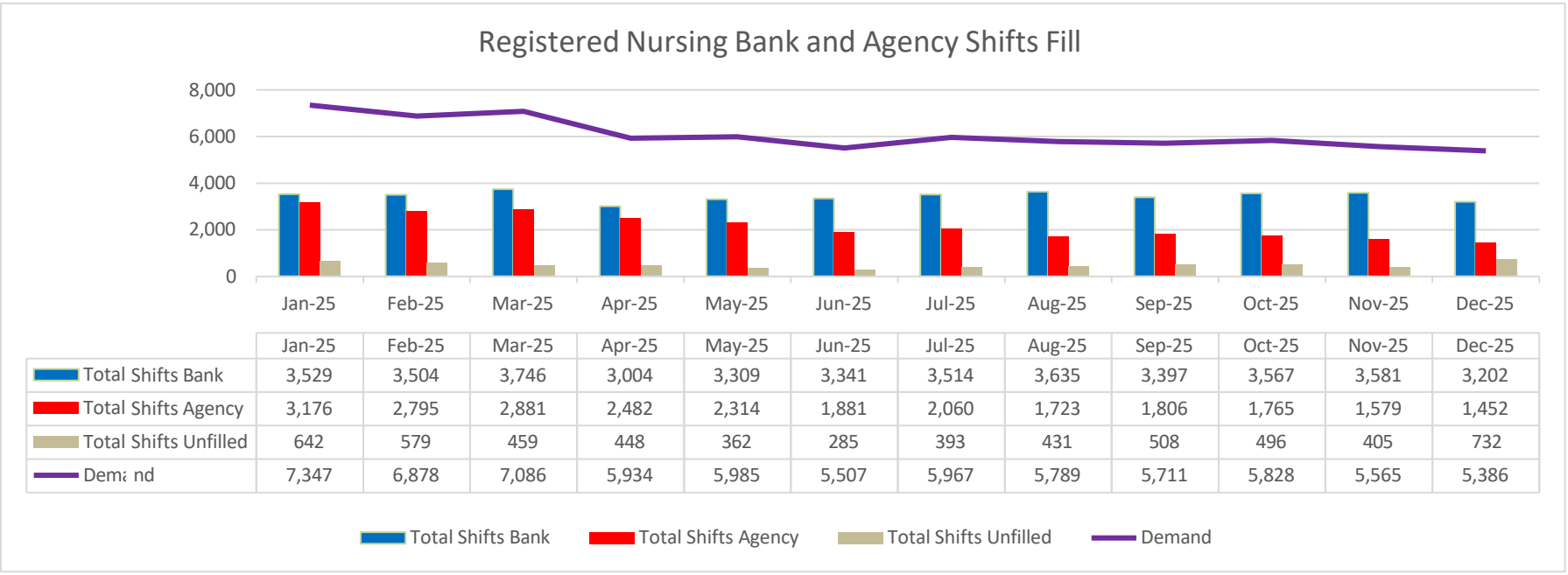
3. Expectation 2: Right Skills



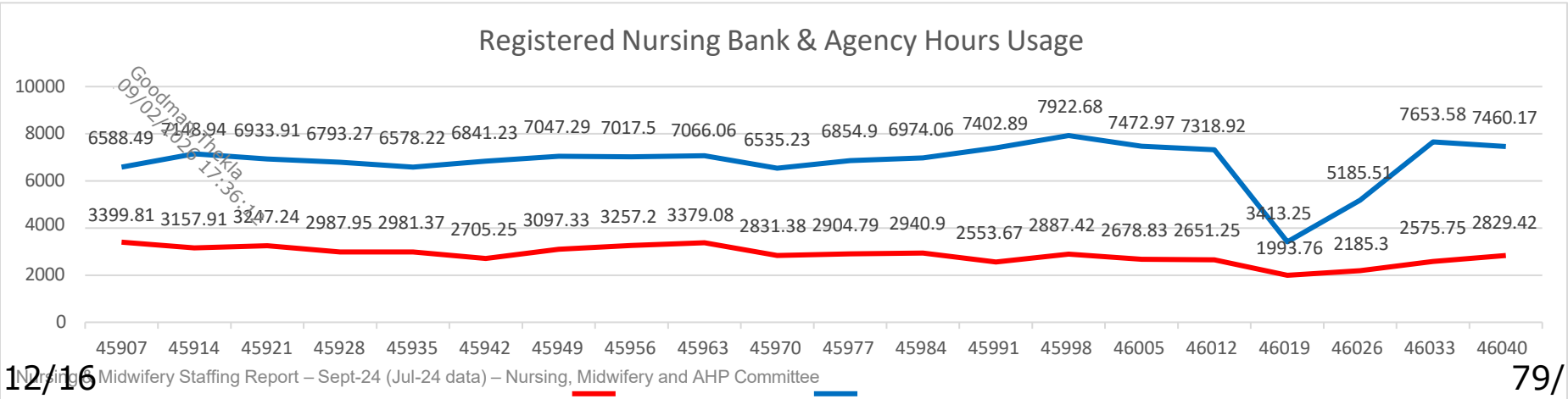


5. Expectation 3: Right Places

5.2 Effective Employment (Temporary Staffing)



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Total Shifts Bank	3,529	3,504	3,746	3,004	3,309	3,341	3,514	3,635	3,397	3,567	3,581	3,202
Total Shifts Agency	3,176	2,795	2,881	2,482	2,314	1,881	2,060	1,723	1,806	1,765	1,579	1,452
Total Shifts Unfilled	642	579	459	448	362	285	393	431	508	496	405	732
Demand	7,347	6,878	7,086	5,934	5,985	5,507	5,967	5,789	5,711	5,828	5,565	5,386



Total Hours Agency Total Hours Bank

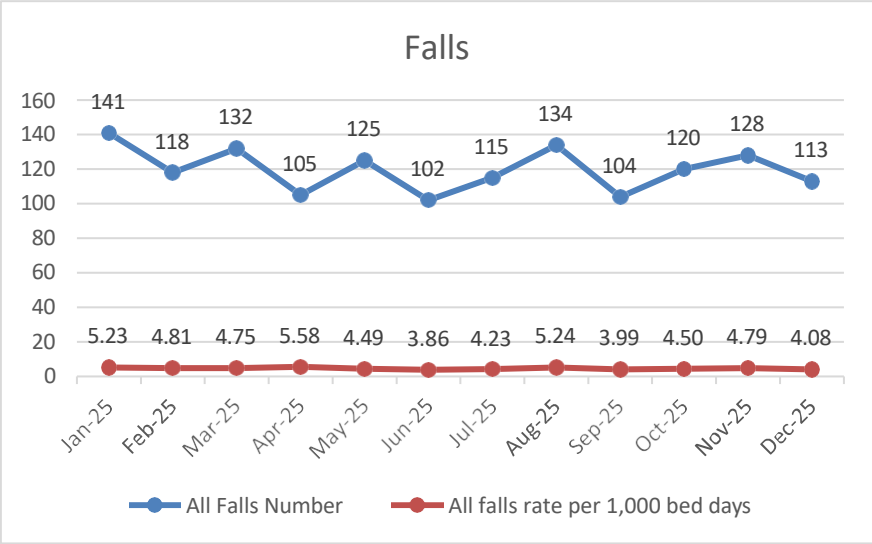
Worcestershire Acute Hospitals NHS Trust

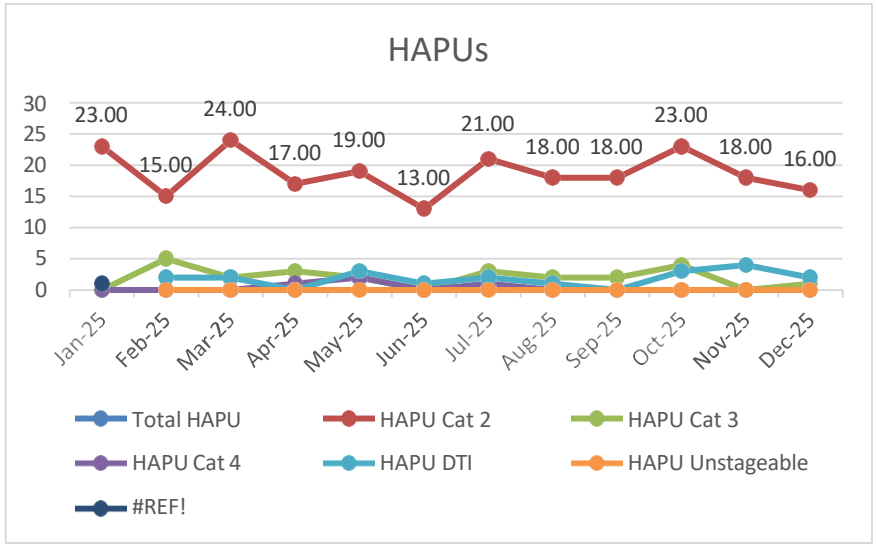
Narrative

- Staffing escalation meetings continue daily Mon-Fri, noting PA was ceased on 8th December.
- 2025 saw a notable decrease in temp staffing hours requested (7,347 in Jan to 5386 in December) with the vast majority of the reduced hours from agency usage.
- As per NHSE targets WAHT is on track to remove HCSW shift cascade to agency from Feb 1st with use being restricted through a 'break glass' process.
- This break glass process will be extended to RN shifts in a phased approach throughout March and April 2026.
- The use of agency as % of total nursing pay spend has reduced to 2.16% in Month 9 (from 4.31% in Month 1) with the further plans to reduce as above
- The continued use of surge areas such as MSDEC / CSDEC, use of surge areas in EDs (corridor care), PDU continuing to operate and the additional staffing in ED due to capacity and acuity continues to drive the nursing bank and agency spend
- The total additional WTE (RN & HCSW) requirements for ED equates to circa 47.12 WTE per month
- The total additional WTE (RN & HCSW) requirements for PDU equates to circa 36.66 WTE per month
- The additional WTE (RN & HCSW) requirements for the surge areas when open fluctuates but if MSDEC is used consistently equates to 7.15WTE per month

6. Measure and Improve

6.1 Patient outcomes



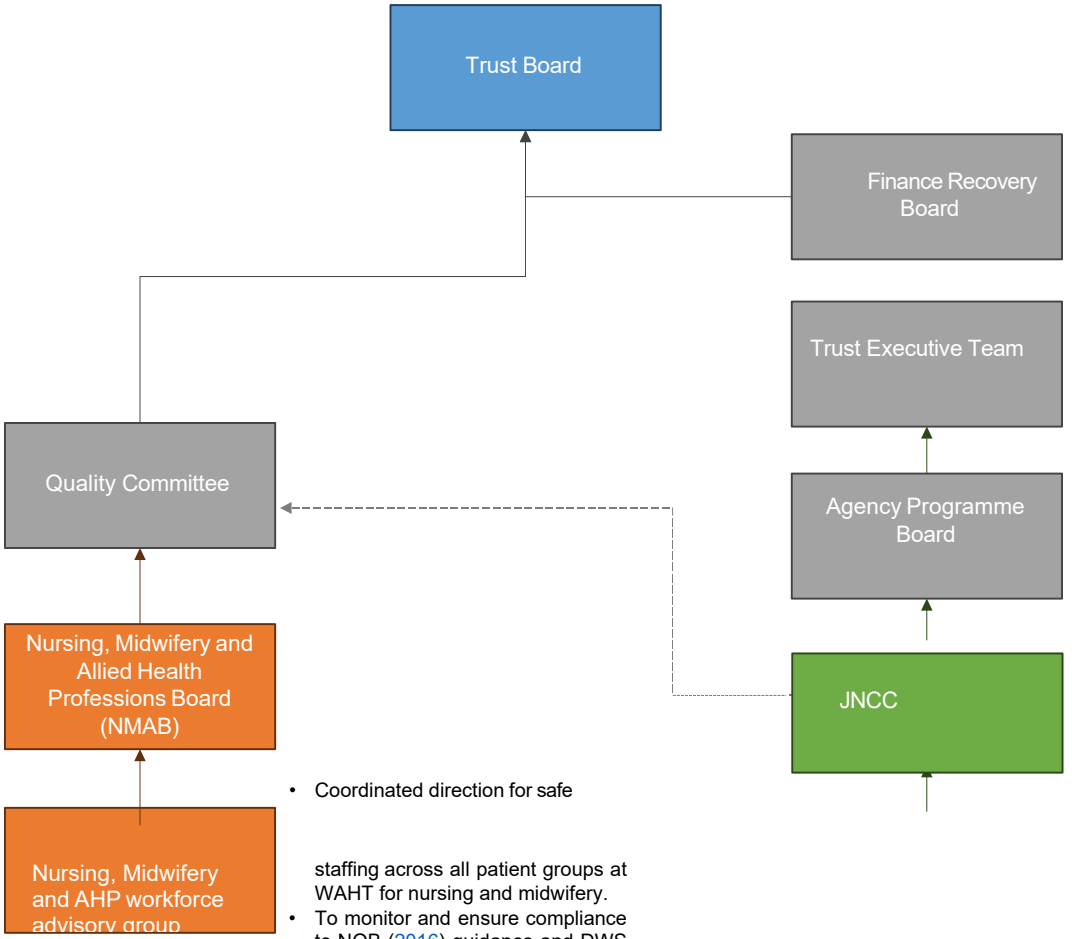


6.1.1

- The total number of falls have decreased as have HAPUs in December 25
- This decrease is assures with maintaining of Quality Measures when triangulating with the removal of PA enhanced bank rates at the beginning of December.
- There are initiatives taking place across WAHT in relation to falls and patient safety, including the introduction of roles which are intended to focus on education and assessments to proactively reduce the number of Nurse Sensitive Indicators.

7. Appendices

7.1 WAHT Safe Staffing and Workforce Applications governance structure



NHS
Worcestershire
Acute Hospitals
NHS Trust

Minutes for Quality Governance Committee

Thursday 25th November 2025 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	
	Justine Jeffery	Director of Midwifery	✓
	Baylon Kamalarajan	Consultant Paediatrician and POSCU Lead	
	Chris Douglas	Interim Chief Operating Officer	✓
	Simon Murphy	Non-Executive Director	✓
	Michelle Lynch	Associate Non-Executive Director	✓
	Edwin Mitchell	Deputy Chief Medical Officer	
	Stephen Collman	Acting CEO	
	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	✓
	Emma Fulloway	Infection Prevention Nurse Manager	✓
	Tracy Pearson	Deputy Chief Operating Officer	

	Rebecca Handley	Lead Nurse Colposcopist	✓
	Amrat Mahal	Director of Nursing for Women & Children	✓

Item	Title
QGC/25/1	**Welcome and Apologies for Absence**
	Ms Moore welcomed all present at the meeting. No apologies noted.
QGC/25/2	**Declarations of Interest**
	No noted declarations of interest
QGC/25/3	**Minutes of the last meeting**
	The minutes of the meeting held on 30 October 2025, were accurate and true reflection of the meeting.
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**
	Ms. Walton reported a patient death potentially linked to anaphylaxis after administration of a known allergen Flucloxacillin. The case is listed as a Patient Safety Incident and under full investigation. Immediate safety measures have been taken, and the coroner is involved. The committee was assured of oversight and that findings will be addressed in line with just culture. Ms. Jeffery informed the committee that a letter had been received from NHS England following a coroner's *Prevention of Future Deaths* notification report relating to a tragic outcome at a home birth in Manchester around 18 months ago. NHS England has asked the Trust to review its home birth services and report to the Board. She noted that the Trust is already ahead of this request, with a paper on the agenda covering the matter, and will expand further during that item. **Action: Ms. Jeffery to bring back a position statement on home birth services to the committee in January, following receipt of the NHS England letter and ongoing work across the Foundation Group.** Ms Flavell reported a letter has been received from NHS England regarding antimicrobial resistance. The requirement is for board-level review and executive oversight. The letter arrived this week and it was agreed the matter should be scheduled for this committee rather than directly to Board. It was noted that the annual Infection Prevention and Control report will also go to Board. Actions must be completed by the end of Quarter 1 to ensure compliance with national targets. Work will be undertaken to confirm requirements and schedule the report and presentation.

	Action: Discussion to take place with Liz to confirm requirements and inform Sam when the antimicrobial resistance report and presentation will be scheduled for committee. Ms Flavell discussed the use of TES spaces as temporary escalation areas, broken down into both ED and inpatient perspectives, alongside the use of boarding spaces. A recent NHS England document, *What Good Looks Like*, provided governance guidance for these spaces and required a gap analysis, which has been completed by the deputy chief nurses. The analysis confirmed that processes for using these spaces are strong but highlighted the need for greater transparency to both the committee and the Board. This includes clarity on how often TES and boarding spaces are used, the reasons for their use, and the assurances in place when they are utilised. Work has been undertaken to align definitions with national standards, including a cleansing exercise to ensure consistency. Updates will be reflected in the UEC assurance report and the IPR, with new slides on TES spaces included. Reference was also made to learning from Wye Valley's approach, ensuring transparency of challenges is maintained.
QGC/25/6	**Quality & Safety**
QGC/25/6.1	**Maternity Safe Staffing Report**
	Safe staffing for October was reported as maintained across all shifts. Sickness levels showed a slight increase, thought to be seasonal, while turnover in the MCA group has begun to reduce, though this will take time to be reflected in the rolling 12-month data. Recruitment is ongoing for a small number of midwife vacancies, with some MCA posts still in the pipeline despite one candidate being lost prior to onboarding. Requirements for one-to-one care in labour and the supernumerary status of shift leaders were met. Compliance with acuity was lower due to sustained high activity since May, with staff redeployment and reliance on community continuity colleagues to maintain inpatient safety. There were 32 reported incidents, none resulting in harm, though staffing incident reports increased significantly, particularly regarding the availability of a second band 7 in triage. Development roles are in place and succession planning is underway for upcoming retirements. Medication incidents were noted, mainly minor errors symptomatic of workload pressures, such as women discharged without TTOS or early administration of medication, particularly on the postnatal ward. A pilot is planned to increase daytime midwife staffing from four to five, with three at night, supported by a higher number of MSWs overnight, to address discharge issues, patient flow, and overall pressure.
QGC/25/6.1.1	**The Current Provision of Care for Women who request Care Outside of Guidance**
	Ms. Jeffery outlined the categories of home birth: planned, outside of guidance, and free birth. She noted rising requests for home birth outside guidance, stressing the need for clear processes to support informed decisions and avoid disengagement. A consultant midwife-led working group is drafting a standardised framework, with MMVP engagement ongoing. The focus is on counselling, documentation, and unbiased information for families. She highlighted an NHS England letter following a prevention of future deaths report, calling for national oversight of home birth outside guidance and midwife competence. Weaknesses in community teams are being addressed, including a proposed change for continuity midwives to attend all home births. The regional team has shown interest in the framework and toolkit, expected before Christmas and spring respectively. Ms. Jeffery

	recommended continuing the work, sharing outputs nationally, and reporting back to the Board. An LMNS visit with regional involvement was described as very positive, with the chief midwifery officer attending to gain first-hand understanding. The formal report will be included in the safety report appendices once received, with actions and improvements reviewed by the committee.
QGC/25/6.2	**Nurse Safe Staffing Report**
	Ms. Flavell presented the safe staffing report, noting it was detailed with plans to refine its format. Best practice from a recent national webinar highlighted triangulation of fill rates, sickness, and turnover, and work is underway with the Deputy Chief Nurse to adapt this approach locally. Current data shows fill rates remain strong at over 95%, with care hours per patient per day stable, though best considered at ward level. Agency cap compliance is good, and there are plans to eliminate agency use for healthcare and RN roles by March, with decisions aligned to vacancy levels and a limited break-glass process. Bank rates are under review, with the planned activity enhanced rate to be removed from 8 December, supported by clear communication. RN vacancies have improved, though healthcare support worker vacancies remain at around 12%. Work has begun on enhanced care therapeutic observation as part of a national cohort, which should support vulnerable patients requiring one-to-one care and reduce reliance on agency staff. It was queried whether the escalation assurance report would be presented separately or incorporated within the safe staffing report. The format was noted positively. Discussion followed regarding recruitment into maternity leave posts, with acknowledgement that substantive recruitment is not currently possible but ongoing work is in place to address this. The risk associated with maternity leave cover was highlighted, and it was noted that maternity colleagues manage this pragmatically and effectively. Similar approaches have been used in other trusts, and work continues on the general side to strengthen arrangements. The committee recognised this as an important area of focus.
QGC/25/6.3	**UEC Harm Review/ Assurance Dashboard**
	Ms. Flavell presented the escalation assurance report, noting its detailed focus on areas needing improvement could appear overly negative. The report covers 12 fundamentals of care, with October data showing over 14,000 ED attendances and information on escalation spaces and occupancy. It triangulates areas for improvement with the risk register and complaints, highlighting that while patients receive appropriate care, some are treated in corridors, impacting dignity. Complaints about staff attitude are under review. Further work is planned to make escalation reporting more meaningful. Medicines management at the Alexandra Hospital has improved, with clinical excellence accreditation now achieved at a “good” level. Mr. Murphy referenced a Health Service Journal article on low four-hour admission rates. Ms. Walton questioned the accuracy of the figures, noting they did not match local data and reflected national flow challenges already recognised locally, particularly at Worcester. Ms. Harris raised concern about patient safety data at the Alexandra, where escalation audit figures appeared low but may reflect small sample sizes. She requested clarification and improvement plans **Action: Ms. Flavell to review escalation audit data at the Alexandra Hospital, confirm whether percentages reflect audit size or performance, and outline improvement plans for reporting back to the committee.**
QGC/25/6.4	**TIPCC Q2 Report**

	Ms. Fulloway presented the IPC quarter two report. The Trust remains under trajectory for C. diff and E. coli, though Klebsiella and Pseudomonas are over trajectory. MRSA bloodstream infections remain a key focus, with five cases reported against an objective of zero, prompting updated policy, targeted communications, and process reviews. MSSA infections are under trajectory. Covid outbreaks rose in quarter two but have since subsided, while flu activity has increased. Ongoing risks include ageing sterilising equipment in the SCSD division, lack of decant space for deep cleans, and maintenance concerns with the hydrotherapy pool at Worcester. A new water safety risk assessment has been commissioned. Ms. Fulloway also noted that the Trust has received a Regulation 28 notice (reference 2324) regarding repeat MRSA screening for a patient in care for over 28 days who should have had a rescreen. One of the actions identified was to create a 28-day pop-up alert in the Sunrise system. This remains outstanding, as the EPR team are currently focused on EPMA. The issue is recorded on the risk register. It was reported that the Trust currently has one part-time face mask tester, so the number of masks tested per staff member will be reduced from three to one to ensure all staff are fit tested. Recruitment is underway for a full-time mask fit tester post (24 hours, not 22 as stated in the report). Concerns were raised about respirator hoods used for staff unable to be fit tested for FFP3 masks. Several hoods had gone missing across sites during monthly checks, though some have since been located. Further searches are ongoing given the cost of replacement. Ms. Moore asked about the ageing sterilisation equipment, noting concerns that it is over 25 years old. and Ms. Fulloway confirmed that a task and finish group is in place to address the issue Ms. King explained that CPDG bids are being supported to replace equipment on a plug-and-play basis, while the task and finish group considers longer-term solutions, including a centralised location. Any new equipment purchased will be capable of being reutilised within the future facility.
QGC/25/6.4.1	**NHSE IPC visit to Worcestershire Royal Hospital Sep 2025**
	Ms. Fulloway reported that IPC teams have visited Worcester twice and will next attend the Alexandra site on 4 December, where a master class will be held following the September visit. Improvements were noted in staff engagement and clinical cleaning, though further work remains around environmental issues such as flooring and doors. Ms. Flavell added that the teams are working closely with staff and plans are in place to ensure the Alexandra site receives the same level of support, with a visit to Kidderminster also being arranged for the new year.
QGC/25/6.5	**Fundamentals Of Care Q2 Report**
	Ms. Flavell presented the fundamentals of care report, noting it provides a high-level overview of the last quarter. She emphasised that while the report highlights key care elements, challenges, and examples of good work, it does not fully reflect the breadth of activity being led by Alison Robinson in this area. Ms. Flavell invited questions and feedback on the report and welcomed suggestions for additional content that could better capture the scope of work underway. Ms. Moore suggested that the fundamentals of care report should be developed into a live dashboard to provide clearer visibility of key measures. She noted that while not all elements would be suitable, many could be represented in this format. Ms. Flavell agreed and confirmed discussions have already taken place with Nikki O'Brien from Rebecca's team and John Redding to explore how this could be achieved. She emphasised the need for a dashboard that demonstrates both processes and outcomes.

	Action: Ms Flavell to aim to bring new FOC template to January's meeting.
QGC/25/6.6	**Blood Transfusion Q2 Report**
	Ms. Walton presented the blood transfusion committee report, focusing on reducing wrong blood and tube events and improving medical representation. She noted ongoing work to address causes of errors and the need for stronger engagement from medical teams. Ms. Moore queried the lack of engagement, and Ms. Walton confirmed discussions with the Divisional Director of Surgery to secure involvement. Ms. Sinclair highlighted national requirements to reduce blood usage in the pre-operative period, stressing the importance of surgeon engagement. Ms. Walton agreed, noting good ground-level practice but limited attendance at committee meetings. Ms. Smart questioned the effectiveness of training given the number of incidents. Ms. Walton explained that while staff complete training, practice does not always follow, with steps sometimes rushed. She emphasised reinforcing safety processes, comparing them to the "stop and block" principle, as essential for patient safety.
QGC/25/6.7	**Cervical Cytology Annual Report**
	Mr. Douglas introduced the annual cervical screening programme report, noting it is a statutory requirement and highlighting the strong work undertaken by the team, while recognising areas needing further support. He then handed over to Ms. Handley, lead nurse colposcopist, to present the detail. Ms. Handley reported that the Trust continues to meet key standards across colposcopy and histopathology despite ongoing pressures. Activity levels for new referrals and treatment follow-ups have slightly decreased, while follow-up appointments have increased, largely due to national changes allowing conservative management of CIN2. Waiting times have improved across all sites, with patients seen within required targets. DNA rates remain within standards, though with a slight increase, expected to be addressed through revised follow-up booking processes introduced in summer. Biopsy reporting times met national standards, but biopsy-to-treatment times fell below the eight-week target, achieving 54%. However, 90% of patients received treatment within four weeks. Delays were attributed to MDT review processes, patient choice of conservative management, and some administrative issues. A Kaizen improvement event is scheduled for 12 December to address these challenges. Patient satisfaction remains high, with 98% rating the service good or excellent. Wayfinding to clinics was identified as an area for improvement. Histopathology capacity has strengthened with three full-time consultants and the rollout of digital pathology. Sixteen cervical cancer cases were diagnosed during the period, consistent with the previous year, with audit completion ongoing. In summary, the programme remains safe, effective, and well governed, with clear plans in place to improve timeliness and enhance administrative processes.
QGC/25/6.8	**Learning From Deaths Q1 Report**
	Ms. Walton clarified that the report presented was for quarter two, noting a typo on the cover. She explained that two reports had been combined, with the second now largely moot but included for completeness. She highlighted concerns raised earlier about an increase in SHMI at the Alexandra site, which had approached upper control limits. Following detailed analysis, Dr. Mitchell and Mr. Stovin concluded that the data was being affected by same day emergency care (SDEC) activity, which lowered the expected number of deaths in the model and made observed mortality ratios appear higher. Recent figures show the numbers at the Alex are now settling, supporting this conclusion.

	Patient-level reviews confirmed no imbalance between the Alex and Worcester sites, though transfers from Alex to Worcester skew the data as mortality remains attributed to the admitting hospital. Work is required to improve the timeliness of transfers, and operational teams will focus on this pathway. Ms. Walton also noted an upward trend in respiratory conditions, with further work planned to review this patient group. The committee acknowledged that the latest learning from deaths report shows improvement, with Alex figures moving away from upper control limits. Ms. Sinclair commended Ms. Walton's explanation of SHMI data, noting it was clear and plausible. She observed that while the paper was reassuring in terms of mortality ratios, it did not provide commentary on the quality of care for patients who die within the Trust. She highlighted the importance of recognising late identification of dying and suggested benchmarking resuscitation calls per thousand admissions, as recommended by Resuscitation UK, as a potential surrogate measure for end-of-life care quality. **Action: Ms Walton to explore options for incorporating measures of end-of-life care quality, including benchmarking resuscitation call rates, into future reporting.**
QGC/25/6.8.1	**Summary Hospital-level Mortality Indicator update paper**
	Summarised in the earlier report
QGC/25/6.9	**Patient Experience, Patient Carer, Community Experience Q2 Report**
	Ms. Flavell presented the patient and carer engagement update, noting strong collaboration with the Patient and Public Forum (PPF) and praising the work led by Ms. Smart. Recent improvements include reviewing complaint letters to strengthen how patients and carers are invited to meetings. She confirmed regular meetings are taking place with Healthwatch colleagues and highlighted three major frameworks currently in progress: Accessibility Information Standards, Experience of Care, and Interpreting/Translation. These will form the focus of quarter three's work. Ms. Flavell also reported ongoing efforts to reinvigorate the patient voice and involvement strategy, with assurance reports showing positive progress. Volunteer work continues to expand, including the recent launch of end-of-life volunteers, which was shared with the Patient and Public Forum this month. Mr. Murphy asked whether there has been an increase in patient complaints relating to staff behaviour, referencing a recent board patient story. Ms. Flavell confirmed that while concerns about behaviours are raised within complaints, there is no evidence of a rising trend. She noted that nine complaints in the UEC paper included behaviour concerns, which are addressed through the complaints process and reinforced by organisational values work. Ms. Sinclair asked whether the Trust is recording or monitoring progress on the "Right to Me – copy of my GP letter" initiative as part of patient experience. Ms. Flavell confirmed this is not overseen through her committees, and Ms. Walton acknowledged responsibility for the area, noting that work had stalled but will be revisited with her team. Ms. Sinclair recognised the challenge of engaging some specialties but stressed the importance of monitoring progress. **Action: Ms. Flavell to ask the complaints team to review data for any emerging trends in behaviour-related complaints and report back.** **Ms. Walton to review current progress on the "Right to Me – copy of my GP letter" initiative and reinvigorate monitoring with her team.**
QGC/25/6.10	**Trust wide Quality Priorities Q2 Report**
	Ms. Flavell provided an update on the quality governance policy priorities for quarter two, noting the report had been presented at ISAG last month. The update shows areas of

	progress as well as those off track, particularly relating to before-midday discharges and length of stay. She confirmed that these priorities will continue to be monitored through the ISAG process at both divisional and Trust level. The report is for information at this stage, ahead of the requirement to publish the annual quality priorities in June.
QGC/25/6.11	**Patient Safety & Complaints Q2 Report**
	Ms. Flavell presented the quarter two patient safety and complaints report, describing it as a comprehensive document that provides a detailed breakdown of incidents and organisational activity. She highlighted that the Trust continues to maintain a strong incident reporting culture, with no never events recorded in the quarter. One Regulation 28 was issued by the coroner in relation to dermatology and fragile services, with follow-up work being led by Mr. Mitchell and reported through ISAG. The Patient Safety Incident Response Group (PSIRG) process is now well embedded, and work is underway to implement the *Being Fair* framework, which replaced the *Just Culture* approach, with alignment to HR processes being developed in collaboration with clinical teams. Improvements have been made in reducing overdue actions, though further progress is required. The rapid review process has been well received across divisions, providing timely assurance.
QGC/25/7	**Performance Reports**
QGC/25/7.1	**Integrated Performance Report**
	Mr. Douglas presented the operational update, highlighting continuing pressures in urgent and emergency care. Emergency departments remain very busy, with too many patients waiting over 12 hours and insufficient numbers seen within 4 hours. A review of rotas, supported by GIRFT, suggests Worcester may be 14 doctors short. Immediate actions include realigning rotas to demand and considering additional medical staffing or alternative patient streams. He reported the launch of Acute Medical Assessment (AMA) units at both sites last week. In the first week, 250 patients were managed through 12 beds, with 40% discharged and an average stay of 13.5 hours. This is already improving patient flow, with surgical assessment units planned to follow. A new frailty assessment model will also launch next week to support timely discharge and reduce functional decline in older patients. On cancer performance, diagnosis within 28 days has improved overall, but concerns remain for patients with confirmed cancer, particularly those waiting over 62 and 104 days. One patient has waited over a year due to complex tertiary centre pathways. Executive actions are underway to strengthen links across care settings. Elective recovery continues, with the Trust on track to achieve zero patients waiting over 65 weeks by year-end and less than 1% waiting over a year by the end of the financial year, in line with national targets. Work is ongoing to reduce routine follow-ups and expand patient-initiated follow-up options, supporting productivity and outpatient strategy development.
QGC/25/8	**Governance & Risk**
QGC/25/8.1	**Improving Safety Action Group Escalations**
	Ms. Flavell presented the escalation report from ISAG, noting significant progress across key workstreams and regulatory areas. She highlighted ongoing work on nutritional support following a previous Regulation 28, with recruitment completed and KPIs in place to provide assurance. Sepsis will go live digitally from January, with training uptake already at 60% at the time of reporting and improving further. Agile services continue to be developed through ISAG, and medicines management will be a forthcoming focus. She emphasised the importance of understanding the gap between “work imagined” and “work done,” particularly in medicines management. A task and finish group has been established, including an anonymous survey to capture current practice around

	prescribing, preparation, and administration. Early findings suggest two-person checking at the bedside is not consistently undertaken. Ms. Flavell confirmed that tangible actions will be developed to address these gaps and strengthen patient safety. Ms. Moore asked about the extent of patient self-administration of medicines, noting that in some cases, such as once-a-day prescriptions, patients may be better placed to administer their own treatment. Ms. Walton clarified she had initially understood the question to relate to staff but confirmed she would investigate patient self-administration further. Ms. Flavell agreed that the matter would be followed up. Mr. Murphy questioned whether gaps between “imagined” and “real” work practices stem from staff training, noting limited practical skills in areas such as dressings. Ms. Flavell confirmed this is part of ongoing work, citing incidents with newly qualified and student nurses. She highlighted collaboration with the University of Worcester and will attend the student forum to gather feedback on training and workplace experience. **Action: Ms. Walton and Ms. Flavell to review and report on current practice and monitoring of patient self-administration of medicines.**
QGC/25/9	**AOB**
	No AOB
QGC/25/9	**Next Meeting Date 08th January 2026 (Extraordinary QGC)**
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 11:35**
QGC/25. 11	**Confidential/Closed Executive Session**

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Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 8 January 2026
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation	
None	
Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Internal Audit Review: Consent**
Rating rationale	The review was rated *Limited assurance,* with two medium priority recommendations. The review has been instigated by the Chief Medical Officer (CMO) who had identified some issues in one area and wished to determine whether there were wider concerns. The review found that there was an appropriate policy in place but that there were issues with documentation, including consent forms inconsistently completed or missing, old forms remaining in circulation and unreadable forms. The CMO welcomed the report and was reassured that the issue was one of documentation rather than one of understanding the principles of consent. It was expected that the planned implementation of electronic consent would improve documentation and the report would provide a helpful benchmark. All management actions were due for implementation by the end of February and the CMO would work with teams to support expedient closure.
Outcome	The Committee was assured by the management response and welcomed use of internal audit to resolve a known concern. **Actions:** • Present the report to Quality Governance Committee • Provide a more detailed report to this Committee, expanding on the management actions and any human factors involved.
Item/Topic	**Board Assurance Framework (BAF)**
Rating rationale	The Committee reviewed the BAF in its new format, which was continuing to be developed. It was agreed that quality risks could be more prominent and this would be considered with the Chief Nurse and Chief Medical Officer. The Committee also welcomed a high level review of the Board and committee oversight of key sources of assurance.
Outcome	The Committee welcomed the new format and approach and was assured that: • The way the BAF was developed was robust and relevant • The format was appropriate for the Trust and provided clarity. • The BAF reflected the Trust's priorities and the risks were linked to the strategic objectives • The controls were sound • The assurances and underlying data were reliable • There were suitable actions planned to address gaps in control, with appropriate timescales.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 8 January 2026
Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	**Counter Fraud, Bribery and Corruption Progress Report**
Rating rationale	Proactive work was progressing according to the annual plan. Regarding reactive work, one new incident had been reported since the last report. Two others remained under investigation; some issues had already been addressed to prevent recurrence.
Outcome	The Committee was assured regarding progress against the plan.
Item/Topic	**Internal Audit Progress Report**
Rating rationale	Delivery of the plan was slightly behind trajectory but there was confidence that this would be recovered. Five of 13 planned reports were now complete. The planned data quality review would cover the skilled worker visa process; the Committee approved the terms of reference for the review. KPIs were all positive except for some delays in receiving the management responses to final reports; it was agreed that managers should be provided with more clarity on the metrics. Progress on implementing recommendations was positive.
Outcome	The Committee was assured by progress on both the internal audit plan and closure of management actions. **Action:** Provide clarity to individual managers on the 'client' metrics.
Item/Topic	**Independent opinion on accounting considerations for car park**
Rating rationale	The report had been commissioned from KPMG as a source of assurance on the accounting treatment for the carpark solution. The report was in draft but had been agreed and would not change before finalisation. The conclusions were positive about the Trust's approach. The External Auditor confirmed they been engaged in the process and would consider the report as part of the audit planning process.
Outcome	The Committee was assured by the report and about the process through which the Trust had sought the advice.

To Note: Items received for information or approval	
Item/Topic	**External Audit update**
Summary	The Audit was about to commence; the Committee noted the timescales The report made some suggestions of issues for non-executive directors to consider. It was agreed that these should be reviewed and added to the Committee work plan as appropriate.
Outcome	Noted
Item/Topic	**Annual Accounts and Report Timetable**
Summary	The Committee noted the timetable for Committee and Audit review prior to the submission date of 26 June.
Outcome	Noted.

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

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Boardroom , Alexandra Hospital
Tuesday 2nd December 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
	Sue Sinclair (SSi)	Non-Executive Director
	Colin Horwath (CH)	Non-Executive Director
	Hayley Flavell	Chief Nursing Officer
Attendees	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Rachael Hayter (RH)	Director of AHPs
	Liz Faulkner (LF)	Deputy Chief People Officer
	Rich Luckman	Assistant Director of People & Culture
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Louise Pearson	Associate Director (Nursing) Workforce and Education
	Stacey Waldron	Divisional Director of Nursing (Surgery)
	Bec Harris	Organisational Development Practitioner, Chair LGBTQ+ Network
	Jenni Carr-Smith	HR Business Partner
Apologies	Richard Haynes	Director of Communications
	Justine Jeffery	Director of Midwifery
	Chris Douglas	Chief Operating Officer
	Neil Cook	Chief Finance Officer

	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 7th October 2025 were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly.	
	Staff Story – Supporting transgender patient – incident review	
	Stacey Waldron shared the case of a patient born male who identified as female with pronouns she/her, who had been admitted to the ward with abdominal pain and required re-catheterisation. The patient was admitted to a side room in line with Trust policy, however the reassignment surgery had not been documented appropriately, and this was not raised for 2 days. An infectious patient then required the side room, and the patient was moved into a male bay, which was raised by an F1 Doctor. There was no justification on the CLIP system why the patient had been moved into a male bay and the site team attempted to find a side room. There	

is learning with regards to nurse advocacy; there was only one entry on the system from a nurse regarding the bed moves. In total the patient received care in the male bay for around 25 hours and the team attempted to maintain dignity and privacy as much as possible. The family were contacted and there have been no PALS concerns or complaints however it was also noted that the patient was confused and was not able to advocate for themselves.

The Trust policy and support guidance has been reviewed as part of the investigation including NHSE guidance issued in April; patients should be admitted to same sex accommodation and treated as the gender they identify as regardless of how they look. The case was discussed at Patient Safety Incident Review Group (PSIRG) to capture learning and prevent reoccurrence, and it was also shared across the Division for wider awareness. A verbal apology was noted but no formal duty of candour, although the team appreciate the psychological damage that this may have caused.

SW explained that there has been learning for staff as the patient was placed in a bay a male bay due to their appearance instead of reading the patient's documentation regarding what they identified as. It was felt that Nurse advocacy had been lacking and HF has recently met with student nurses to encourage escalation. SW also noted that when considering patients to be moved out of side rooms due to level 4 or infection control, this patient would not have been considered as suitable. HF added that where it is deemed as necessary it should be mitigated with screens for example and documented on Datix appropriately.

It was noted that due to the Supreme Court ruling this is a vulnerable time for the Transgender community and it is important for staff to feel they can raise concerns and have clear guidelines of what to do in such situations. Work is taking place with the Staff Networks on how to manage differing opinions in a sensitive way whilst also maintaining Trust values.

The policy states that Transgender patients will be placed in side rooms, however due to capacity and infection control issues that may take priority, this may not always be possible. There was discussion about how other patients in a bay may perceive a patient who does not appear to be 'typically' female/male, and whether guidance is clear for staff on how to manage this. An action has been identified through PSIRG that the policy and its practical application should be reviewed, recognising that side rooms are a premium, to make it clear how staff should manage the situation. It was noted that EHRC has not yet issued guidance on how Transgender patients should be placed so policies may need to be reviewed again in future, and that this pertains to patient experience rather than patient safety. **ACTION: HF to pick up.**

Staff Network Updates: Faith & Spirituality

The Network has been run for over 2 years and provides a safe space where individuals can express their beliefs and concerns without discrimination, harassment and victimisation. It is run primarily remotely however faith walks will be taking place for staff to meet each other in person.
Working closely with the Chaplaincy team to look into providing a catholic mass onsite and also with the EmbRACE Network on a faith calendar. A Christmas carol event will be held on the 16th December in Worcester.

The Network supported the Executive team with communications following civil unrest and riots earlier in the year. A Wudu facility is now available at WRH, and the Network collaborated with staff and management to resolve a dispute over faith-related jewellery.

Chief People Officer Report

More effort is needed on the Trust's Flu campaign and peer vaccinators have been arranged to visit areas as well as additional clinics at Occupational Health. AK explained there is a general decline due to vaccine fatigue, additionally where the Trust previously had funding in the pandemic to pay staff to take shifts administering vaccines, this is funding is no longer available, and staff are trying to find time within their normal day jobs to vaccinate.
SC felt it was reflective of the wider culture and that there needed to be more motivation to improve the rate.

A new national management and leadership framework is launching, with updates to come back to this committee, including how this will be consolidated in the People strategy.

This year's Staff Survey has now closed and early indications are that WAHT is leading in the Foundation Group at 48.3%, which is also above the national benchmark. The Trust has surpassed last year's score however not achieved the 50% it was aiming for.

The long waiting list for mental health support was discussed, noting that some staff may be off sick waiting for this. NOSS counselling sessions are available via Occupational Health, as well as the Staff Psychology service, but the Trust should consider commissioning additional mental health support. Staff also need to be supported in returning to work if they are off sick due to work related stress and potentially returning to the same environment.

Discussed the risks of new working models if staffing and skills are not aligned and whether it is possible to track the progress. AK explained that the shift is happening in silos and at such a pace that it is difficult to have assurance across the wider Trust. There was discussion regarding links between the People, Clinical and Digital strategies and considering added the risk to the Board Assurance Framework however it was decided that the risk was difficult to articulate and likely be more regarding staff needing to change role or organisation and rather than skills.

People Strategy Pillar – Digital

LF provided an update on the Admin review meetings and informed of the continuing overlap with digital technology such as T-Pro, Robotics and Copilot. The group is in the process of finalising recommendations of moving towards an Admin strategy with a focus on digital elements. The Trust needs to have the right staff numbers and skills for the digital advancements to be successful. Regarding whether the timeline is achievable with the current resources, LF emphasised the importance of stakeholder buy in and commitment. The timeline needs to be carefully considered although there are some immediate actions that can be implemented such as temporarily restricting admin and clerical posts to fixed term only to protect roles for individuals who may be redeployed, whilst awaiting the recommendations from the Admin Review Group. Discussed the need to encourage staff of all generations to embrace digital solutions.

Medical eroster roll out will not be achieved by the end of March 2026 as originally planned and is now scheduled for completion by December 2026. The rollout is taking longer than anticipated due to operational pressures and the rostering team undertaking the rollout themselves. The team have been working closely with operational teams on implementation. Allocate have been contacted for a quote however even if the Trust did engage additional resource, it would not bring the project forward enough. Additionally, the pilots took place in smaller more straight forward areas, and the rollout is now being looked at in ED which is more complex. Agency Programme Board is improving ownership of medical agency spend within Divisions as well as providing a space to share learning of the rollout and understand the benefits. LF added that a culture shift is needed to encourage medical colleagues to work in a different way and JW explained that it is not prioritised above other issues such as capacity and flow and job planning. The importance of setting realistic goals and managing expectations was discussed. **It was agreed for a detailed plan of the eroster project to be brought to the committee.**

'Stream' (previously Wagestream) has launched within the Trust; a financial support package for staff allowing them to access wages as they are accrued, as well as money management sessions. There is no fee for the Trust, the individual pays a small fee when they draw down their wages.

The NHS Business Services Authority (NHSBSA) has awarded a £1.2 billion contract to Infosys to deliver a new and enhanced workforce management solution for the NHS, which will succeed the Electronic Staff Record (ESR).

Freedom to Speak Up

There was an increase in concerns in October about attitudes and behaviours but this has now steadied. Anonymous concerns continue to decrease.

MS raised issues regarding neurodiversity and reasonable adjustments, expressing concerns that the organisation may not be providing sufficient support for employees with disabilities in

	the workplace. Additionally, there has been an increase in reported incidents of racism affecting both staff and patients. Posters and business cards featuring a QR code have been produced to improve accessibility, and MS has been developing the Trust Induction video to introduce new employees to FTSU. **MS and HF discussed triangulating concerns raised by midwifery students via the university for wider sharing and learning.** HF added that some concerns raised via the FTSU route may be a more general grievance or disagreement between staff and it may be more appropriate for this to be raised via HR. It was felt that the line may have been blurred over time and that the Trust may benefit from a FTSU relaunch and encouraging staff to use the appropriate channels available. KM asked whether there is a central leaflet or document that clearly outlines the different routes to escalate concerns, and AK advised that there will be an opportunity to do so in the coming months alongside the early resolution work.	
	Temporary Staffing Reduction Plan	
	There is a sustained improvement in agency spend and there is more ownership at divisional level. AK noted that recruiting permanent medical staff can be a lengthy process, but some agency conversions are already happening. Work is ongoing regarding workforce plans for emergency and urgent care teams. The next area of focus will be bank usage and rates, with some plans already in place to switch off programmed activity rates over the coming weeks. At the recent intensive support meeting with NHSE there were no further actions for the Trust.	
	Annual EDI Report	
	The Public Sector Equality Duty recommends that the Trust publish its data on flexible working requests, to then be analysed by protected characteristics. The team have found that EST is data is not reliable for this use; 500+ flexible working requests have been made on ESR, but it is unclear how many were approved. Reports will now be pulled regularly and managers contacted to ascertain whether requests have been actioned. JCS assured that an audit will be completed for those that are outstanding. BH highlighted 4 ongoing AHP projects, Widening access and participation, cadets and reciprocal mentoring detailed within the report. The Neurodiversity hub needs to be promoted to staff and managers. BH raised the format of the report, noting its publication on the trust's website. RL updated on the Trust's EDI priorities; this has been simplified following feedback with the actions now encompassed within the people strategy. ***The report was circulated following the meeting for comments on the 2nd December. Suggested feedback was incorporated into the document and published on the Trust's website on the 22nd December 2025.****	
	Job Planning	
	Work is progressing on the Trust's action plan, which is based on NHSE best practice guidance. Some actions particularly those regarding Allocate, require amendment to the timescale. Current compliance across the Trust is 71%, with Women & Children at 94%. Divisional Directors are working hard to drive compliance and particularly pushing on old job plans so that new ones can be agreed. Finance and HR teams have been helping to identify the financial implication of the SPA (support professional activity) allocation, but this is more complex than initially thought. Recruitment for consultants is strong and vacancies are reducing which was the purpose of increasing the core SPA allocation from 1.5 to 2, as most Royal College recommendations are 2.5. Many consultants in the Trust were already on 2 SPAs so the definition of "Core SPA" has been expanded to integrate additional SPAs that were already in job plans, meaning many would not have an increase. 2 Divisions are overspent and 2 have managed within budget.	

	Compliance with 10 point Resident Doctor plan
	Work progresses on the NHS 10-point plan to improve the working lives of Resident Doctors. A Working group has been arranged which includes colleagues from Medical Education, the and the Head of Chief Medical Officer services, and is led by the Deputy Chief Medical Officer. The action plan will progress onto Trust Board for assurance. In relation to the sleep pod, it was raised that other members of staff also work long shifts or nights and equity was discussed. The committee felt that fatigue management facilities should be available for all groups of staff who may need them including sleep pods and taxi services. ***The Committee approved for the report to progress to Trust Board.***
	International Students Charity Bid
	The Trust has applied for a workforce wellbeing grant and has been awarded £50k to support staff and students appointed from overseas. This will be in partnership with the Citizens Advice Bureau and will provide access to financial and housing support. The Trust's own Health and Wellbeing support will continue to be promoted to staff. Terms of Reference have been developed, with work commencing at the beginning of January. Building Belonging events will take place regularly at all three sites, with an elearning package and webinars also provided. Discussed the current support for students through the university but agreed that the support needs to be more proactive, noting individuals are hesitant to ask for help. The programme board will be developing KPIs over the next few months, with further updates to come back to the committee. SS highlighted how workplace hierarchies vary between cultures and emphasised the need to support and encourage international staff to voice concerns, especially those related to clinical governance. JCS added that familiarisation events will be shaped by feedback and that escalation routes will be communicated. Progress will be monitored monthly via the Health & Wellbeing Steering Group, with quarterly updates to this committee.
	People & Culture Risk Register
	There remain two risks rated over 15 and these are regarding job planning and temporary staffing. The thresholds to reduce the scores have not been met; there has been a reduction in agency usage but bank remains an issue, and whilst the work is ongoing against the action plan, the Trust has not yet met its target of 95% compliance. Splitting the risk into bank and agency, or Medical and Nursing was discussed, given that Nursing will be eliminating agency as of March 2026 and PA shifts. **ACTION: to consider splitting the temporary staffing risk.**
	Any Other Business (AOB)
	Hayley Flavell and Alison Koeltgen introduced a new approach to patient safety incidents, moving from parallel HR and safety investigations to a systems-thinking, learning-focused model. The "Being Fair" framework will only trigger HR processes for wilful neglect, recklessness, or malicious behaviour. The approach aims to foster a psychologically safe, learning culture, encouraging staff to be open and honest about incidents. Policies are being aligned and will soon be submitted to TMB, with further updates to come back to the committee. SS highlighted concerns about the fragility of the fetal medicine service, noting that as a regional provider, the team has only three doctors instead of four, and that one trainee became a consultant and left for another Trust before WAHT could offer a position. There had been a business case previously but it's unclear where this is. HF advised there is work ongoing for the Trust to be able to early identify fragile services and this is being tracked via Improving Safety Actions Group. SC suggested it would be useful to understand how long it takes for a business case to be fully approved, and from business case approval to having an individual in post. **ACTION: LF to track.**
	Date of Next Meeting
	The date of the next meeting is Tuesday 3rd February 2026, Friends room, CHEC.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**10/02/2025**
Title of Report:	Provider Revenue Support Application
Lead Executive Director:	**Chief Finance Officer**
Author:	Lynne Walden, Associate Director of Finance Charlotte Ogden, Senior Financial Accountant
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

In month 8, the system reported a variance from the plan, leading to the Deficit Support Funding (DSF) allocated to Herefordshire and Worcestershire ICS being unavailable to the Trust for the last quarter of the financial year (January to March 2026), which amounts to £11.8m. The Trust has not received the DSF for January and February (£7.9m) and now expects not to receive the funding for March (£3.9m). This also applies to Wye Valley NHS Trust whose plan also included receipt of Deficit Support.

At the December 2025 Financial Recovery Board the monthly position, particularly in relation to cash, was outlined in detail; some modelling within the report gave cash flow forecasts scenarios to the end of the year. Due to projected low cash balances, to meet payroll and creditor obligations in March 2026, the Trust requires Provider Revenue Support.

The Board approved the submission virtually on 4/2/2026 for the request of £15.5m support to be received in March 2026 to mitigate the cash risk given our deficit position and current withholding of DSF. This will be ratified at the Board meeting on 10th February.

The Trust remains focused on maximising the benefit of financial recovery actions. There are cash management measures in place and rolling cash flow forecasting to ensure we are clear where pinch points are and that the scale of cash support requested is the minimum required to sustain day to day running.

In line with NHS England's 2025/26 Provider Revenue Support guidance, the Trust has completed the required Quarter 4 cashflow forecast and supporting documentation to be submitted with the application.

Recommended Actions required by Board or Committee

It is recommended that the Board formally ratifies the application by the Trust for Provider Revenue Support.

Executive Director Opinion[1]
Our cash balances are severely restricted. The suspension of access to deficit support in Q4, linked to our adverse variance to plan and forecast deficit, risks cash balances falling below the minimum required to sustain day to day running. I am supportive of the application for cash support, whilst we continue to pursue all credible mitigations to the in year financial position and to stabilise the exit run rate.

[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.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT

Report to:	**Public Board**
Date of Meeting:	**04/02/2026**
Title of Report:	Appointments and Remuneration Committee Terms of Reference
Lead Executive Director:	**Chief Executive Officer**
Author:	Gwenny Scott, Company Secretary
Reporting Route:	Appointments and Remuneration Committee
Appendices included with this report:	1. Amended Terms of Reference tracked version 2. Amended Terms of Reference clean version
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Appointments and Remuneration Committee reviewed its terms of reference and, alongside some minor amendments, four material changes are recommended:

1. The addition of a responsibility to consider and approve any retire and return plans for executives.
2. Removal of the responsibility to review the Trust's Fit and Proper Person Test, which has been adopted by the Audit and Assurance Committee as part of its assurance responsibilities.
3. Removal of a requirement for a formal report from each meeting of the Committee to the Board, in line with the Committee's practice. An annual summary of the Committee's decisions is included in the Annual Report.
4. A change to the quorum to align with the Audit and Assurance Committee.

Recommended Actions required by Board or Committee

The Trust Board is asked to approve the recommended changes to the terms of reference.

Executive Director Opinion[1]

Not applicable. The recommended changes have been approved by the Appointments and Remuneration Committee.

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

Worcestershire Acute Hospitals NHS Trust
Appointments and Remuneration Committee

TERMS OF REFERENCE

Remit	The Committee is established by the Trust Board (hereafter referred to as the Board) to perform the duties prescribed by Standing Orders in relation to the appointment and remuneration arrangements of the Chief Executive, Managing Director and Chief Officers (also referred to as Executive Directors).
Accountability Arrangements	The Committee is accountable to the Board of the Trust to perform the duties prescribed by the following paragraphs of the Trust's Standing Orders: • *The non-executive directors shall appoint or remove the Chief Executive* • *A committee consisting of the Chairperson, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors* • *The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors*
Responsibilities	The Committee will: • Review the structure, size and composition of the Board (including the mix of skills, knowledge and experience) in the light of the strategy and priorities of the Trust, and make recommendations to the Board with regard to any restructuring or development needs. • Give full consideration to continuity in the executive team, including the Chief Executive, taking into account the challenges and opportunities facing the Trust and the skills and expertise particularly needed on the Board in future. • Determine, and review from time to time, the terms and conditions of office of the Chief Executive, Managing Director and Chief Officers including the Trust's policies for the remuneration and allowances applicable to these positions. • Approve processes for the annual performance review of the Chief Executive, Managing Director and Chief Officers, and receive an annual report on the outcome of these reviews. • Determine, and keep under review, the consolidated and non-consolidated remuneration of the Chief Executive, Managing Director and each Chief Officer. • Determine for all staff, under delegated powers, arrangements for any non-contractual payment, in line with Department of Health and Social Care and NHSE guidance. The Committee shall also sign-

	off the payment of contractual severance payments for individual Board level members of staff. • In the event of a vacancy for the Chief Executive, Managing Director or a Chief Officer position, approve the recruitment process, person specification and other particulars and instruct the Chief People Officer to undertake recruitment accordingly. • Identify a process for the short-listing and interview of candidates for the Chief Executive, Managing Director or a Chief Officer position. • To agree an interview panel and delegate authority to such a panel which shall be responsible for identifying and nominating for appointment candidates to fill posts for any Chief Executive, Managing Director or Chief Officer vacancies as and when they arise provided that: o the appointment is within the parameters set by the Appointments and Remuneration Committee; o any proposed non-conformance to the parameters is referred back to the Appointments and Remuneration Committee for consideration and approval prior to any appointment being made; o a report confirming the appointment is submitted to the next Appointments and Remuneration Committee meeting. • Consider and decide upon any matter relating to the continuation in office of the Chief Executive, Managing Director and a Chief Officer, including suspension or termination of service in accordance with the terms and conditions of office. • Consider and approve any retire and return plans for executive directors. • Review succession planning and talent management for the positions of Chief Officers and recommend to the Chief Executive and Chief People Officer such development activities as may be needed to ensure the continued executive and senior management capability of the Trust. • Approve an annual statement of the Committee's processes and activities for the Chairperson to report to the Board, in a suitable form for inclusion in the Trust's Annual Report. • Receive information on any concerns relating to the Chief Executive, Managing Director or Chief Officers identified as part of the Fit and Proper Persons Test checks. • Receive adhoc reports from the Chairperson, Chief Executive or Managing Director.
Membership / Attendance 	The members of the Committee are: • The Trust Chair • The Non-Executive Directors (Voting, Non-Voting and Associate) The Chief Executive shall be invited to attend the Committee and will be:

	• excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. • a voting member for any decision related to the appointment or removal of the Managing Director or a Chief Officer except themselves. The Managing Director shall be invited to attend at least annually to discuss the performance of the Chief Officers. The Chief People Officer (or a deputy) will attend to advise the Committee but will be excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. The Managing Director, other officers of the Trust or external advisers may be invited to attend as the Committee considers necessary.
Chair	The Chair of the Trust shall be the Chair of the Committee. The Vice-Chair of the Trust will deputise in the Chair's absence.
Quorum	The Chair (or Vice Chair) and one other voting NED will constitute a quorum.
Reporting Arrangements	An Annual Report of the Committee's compliance with these Terms of Reference, which includes an annual register of attendance, will be produced and submitted to the Board for information.
Frequency of Meeting	The Committee will hold scheduled meetings at least twice a year, and the Chairperson may convene additional meetings as necessary.
Administration	The Company Secretary (or a deputy) will attend to advise and support the Chair and will be responsible for ensuring that minutes of the meeting are taken.
Date Approved	
Date Review	To be reviewed annually. Next review due by January 2027.

Worcestershire Acute Hospitals NHS Trust Appointments and Remuneration Committee

TERMS OF REFERENCE

Remit	The Committee is established by the Trust Board (hereafter referred to as the Board) to perform the duties prescribed by ~~the Trust's Constitution[1] or~~ Standing Orders[2] in relation to the appointment and remuneration arrangements of the Chief Executive, Managing Director and Chief Officers (also referred to as Executive Directors). ~~It will also review the Trust's Fit and Proper Persons procedures and receive reports thereon.~~
Accountability Arrangements	The Committee is accountable to the Board of the Trust to perform the duties prescribed by the following paragraphs of the Trust's ~~Constitution or~~ Standing Orders: • *The non-executive directors shall appoint or remove the Chief Executive*[3] • *A committee consisting of the Chairperson, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors*[4] • *The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors*[5]
Responsibilities	The Committee will: • Review the structure, size and composition of the Board (including the mix of skills, knowledge and experience) in the light of the strategy and priorities of the Trust, and make recommendations to the Board with regard to any restructuring or development needs. • Give full consideration to continuity in the executive team, including the Chief Executive, taking into account the challenges and opportunities facing the Trust and the skills and expertise particularly needed on the Board in future. • Determine, and review from time to time, the terms and conditions of office of the Chief Executive, Managing Director and Chief Officers including the Trust's policies for the remuneration and allowances applicable to these positions. • Approve processes for the annual performance review of the Chief Executive, Managing Director and Chief Officers, and receive an annual report on the outcome of these reviews.

~~1 For SWFT~~
~~2 For WVT, GEH and WAHT~~
~~3 SWFT Constitution paragraph 27, WVT, GEH and WAHT Standing Order 3~~
~~4 SWFT Constitution paragraph 27.4, WVT, GEH and WAHT Standing Order 43~~
~~5 SWFT Constitution paragraph 33, WVT, GEH and WAHT Standing Order 43~~

	• Determine, and keep under review, the consolidated and non-consolidated remuneration of the Chief Executive, Managing Director and each Chief Officer. • Determine for all staff, under delegated powers, arrangements for any non-contractual payment, in line with Department of Health and Social Care and NHSE guidance. The Committee shall also sign-off the payment of contractual severance payments for individual Board level members of staff. • In the event of a vacancy for the Chief Executive, Managing Director or a Chief Officer position, approve the recruitment process, person specification and other particulars and instruct the Chief People Officer to undertake recruitment accordingly. • Identify a process for the short-listing and interview of candidates for the Chief Executive, Managing Director or a Chief Officer position. • To agree an interview panel and delegate authority to such a panel which shall be responsible for identifying and nominating for appointment candidates to fill posts for any Chief Executive~~6~~, Managing Director or Chief Officer vacancies as and when they arise provided that: ○ the appointment is within the parameters set by the Appointments and Remuneration Committee; ○ any proposed non-conformance to the parameters is referred back to the Appointments and Remuneration Committee for consideration and approval prior to any appointment being made; ○ a report confirming the appointment is submitted to the next Appointments and Remuneration Committee meeting. • Consider and decide upon any matter relating to the continuation in office of the Chief Executive, Managing Director and a Chief Officer, including suspension or termination of service in accordance with the terms and conditions of office. • Consider and approve any retire and return plans for ~~the Chief Executive, Managing Director and a Chief Officer~~executive directors. • Review succession planning and talent management for the positions of Chief Officers and recommend to the Chief Executive and Chief People Officer such development activities as may be needed to ensure the continued executive and senior management capability of the Trust. • Approve an annual statement of the Committee's processes and activities for the Chairperson to report to the Board, in a suitable form for inclusion in the Trust's Annual Report. ~~Receive Consider, approve and ratify amendments to the Trust's Fit and Proper Person Test Procedure as part of the review process or sooner if required.~~

~~6 For SWFT, the appointment of the Chief Executive is to be approved by the Council of Governors, in accordance with the Trust's Constitution.~~

	• Receive information on any concerns relating to the Chief Executive, Managing Director or Chief Officers identified as part of the Fit and Proper Persons Test checks. • Receive adhoc reports from the Chairperson, Chief Executive or Managing Director.
Membership / Attendance	The members of the Committee are: • The Trust Chair • The Non-Executive Directors (Voting, Non-Voting and Associate) The Chief Executive shall be invited to attend the Committee and will be: • excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. • a voting member for any decision related to the appointment or removal of the Managing Director or a Chief Officer except themselves. The Managing Director shall be invited to attend at least annually to discuss the performance of the Chief Officers. The Chief People Officer (or a deputy) will attend to advise the Committee but will be excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. The Managing Director, other officers of the Trust or external advisers may be invited to attend as the Committee considers necessary.
Chair	The Chair of the Trust shall be the Chair of the Committee. The Vice-Chair of the Trust will deputise in the Chair's absence.
Quorum	The Chair (or Vice Chair) and onetwo other voting NEDs, with at least one being a Voting NED, will constitute a quorum.
Reporting Arrangements	The Committee will undertake an annual self-assessment of its effectiveness which will be reported to the Board for information. Also an An Annual Report of the Committee's performance and compliance with theseagainst its Terms of Reference, which includes an annual register of attendance, will be produced and submitted to the Board for information.
Frequency of Meeting	The Committee will hold scheduled meetings at least twice a year, and the Chairperson may convene additional meetings as necessary.

Administration	The ~~Trust~~ Company Secretary (or a deputy) will attend to advise and support the Chair and ~~the Trust Secretary or nominated Executive Assistant to take the~~will be responsible for ensuring that ~~M~~minutes of the meeting are taken.
Date Approved	~~GEH Committee on 5 November 2024~~11 December 2025 ~~WAHT Vice Chair on behalf of the Committee on 29 January 2025 date to be confirmed~~ ~~SWFT Committee on 12 December 2024~~11 December 2025 ~~Foundation Group Boards on 5 February 2025~~4 March 2026
Date Review	To be reviewed annually. Next review due by January 2027. ~~Next Foundation Group Boards Review Date: February 2026~~March ~~2027~~

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