Public Trust Board

Tue 09 June 2026, 13:00 - 14:30

Teams

Agenda

13:00 - 13:05
5 min

1. Welcome and Apologies for Absence

Information *Frances Martin*

13:05 - 13:05
0 min

2. Declarations of Interest

Information *Frances Martin*

13:05 - 13:05
0 min

3. Minutes of Trust Board Meeting held on 14 April 2026

Decision *Frances Martin*

No actions outstanding

3. Public Trust Board Minutes 14 Apr 26.pdf (5 pages)

3.1. Foundation Group Workshop Report

Information *Stephen Collman*

3.1 Report from Foundation Group Workshop May 2026.pdf (2 pages)

13:05 - 13:10
5 min

4. Managing Director's Report

Information *Stephen Collman*

4. WAHT MD Report Final.pdf (3 pages)

13:10 - 13:25
15 min

5. Integrated Performance Report

Information *Stephen Collman*

5. Trust Board IPR Jun-26 (Apr-26_Data).pdf (24 pages)
5. 1 20260601 - WAHT IPR Metrics Dashboard (up to Apr-26) v1.pdf (3 pages)

5.1. Introduction

Stephen Collman

5.2. Quality & Safety

Jules Walton/Hayley Flavell

5.3. Operational Performance

Chris Douglas

5.4. Workforce

Alison Koeltgen

5.5. Finance

Katie Osmond

13:25 - 13:30
5 min

6. Quality

6.1. Quality Governance Committee Escalation & Assurance Report

Assurance *Julie Moore*

- 6.1 Quality Governance Escalation & Assurance Report April 2026.pdf (3 pages)

6.2. Quality Account

Decision *hayley flavell*

- 6.2 1 Quality Account 2025-26 Board Coversheet June 2026.pdf (4 pages)

6.3. MOSS Report

Assurance *Justine Jeffery*

- 6.3 WAHT MOSS-critical-safety-check Board.pdf (21 pages)

6.4. Midwifery Safe Staffing Report

Assurance *Justine Jeffery*

- 6.4 1 Midwifery Safe Staffing Report March 2026.pdf (6 pages)
- 6.4 2 Midwifery Safe Staffing Report April 2026.pdf (6 pages)

6.5. Nursing Safe Staffing Report

Assurance *Hayley Flavell*

- 6.5 Board covering report for nursing safer staffing report May 26 (April data).pdf (1 pages)
- 6.5 Nursing safer staffing paper May 2026 (April data).pdf (19 pages)

13:30 - 13:30
0 min

7. Finance

7.1. National Cost Collection Report

Information *Katie Osmond*

- 7.1 NCC Board paper - Pre-Submission 2025-26.pdf (3 pages)
- 7.1 NCC 25-26 Work Plan v3.pdf (1 pages)

13:30 - 13:35
5 min

8. Workforce

8.1. People & Culture Committee Minutes

Information *Karen Martin*

- 8.1 People and Culture Committee minutes April 2026.pdf (4 pages)

13:35 - 13:45
10 min

9. Governance & Risk

9.1. Audit & Assurance Committee Escalation & Assurance Report

Assurance *Colin Horwath*

- 9.1 Audit and Assurance Committee Escalation and Assurance Report 13 May 2026 v1.0.pdf (3 pages)

9.2. Emergency Preparedness Resilience and Response (EPRR) Annual Report

Decision *Chris Douglas*

9.2 EPRR 2026 Annual Report.pdf (12 pages)

9.3. Bi-Annual Register of Trust Seal Report

Assurance *Gwenny Scott*

9.3 BiAnnual Register of the Trust Seal.pdf (1 pages)

13:45 - 13:45
0 min

10. Date of Next Meeting

Information *Frances Martin*

14th July 2026

13:45 - 13:45
0 min

11. Any Other Business & Questions from the Public

Information *Frances Martin*

13:45 - 13:45
0 min

12. Acronyms

Information

12. Acronyms.pdf (3 pages)

Trust Board
14 April 2026 at 1:00pm
Via Microsoft Teams and live streamed on YouTube
Part 1 in Public

Board Members Present (voting)			
Frances Martin, Chair	FM	Simon Murphy, Non-Executive Director/Deputy Chair	SM
Colin Horwath, Non-executive Director	CH	Dame Julie Moore, Non-Executive Director	JM
Tony Bramley, Non-Executive Director	TB	Karen Martin, Non-Executive Director	KM
Glen Burley, Chief Executive Officer	GB	Stephen Collman, Managing Director	SC
Jules Walton, Chief Medical Officer	JW	Hayley Flavell, Chief Nursing Officer	HF
Katie Osmond, Chief Finance Officer	KO		
Board Members Present (non-voting)			
Chris Douglas, Chief Operating Officer	CD	Rebecca Brown, Chief Digital Information Officer	RB
Julian Berlet, Chief Clinical Strategy Officer	JB	Sue Sinclair, Associate Non-Executive Director	SSi
Ali Koeltgen, Chief People Officer	AK	Catherine Driscoll, Associate Non-Executive Director	CDr
Attending			
Gwenny Scott, Company Secretary	GS	Jo Wells, Deputy Company Secretary	JWe
Richard Haynes, Director of Communications & Engagement	RH	Justine Jeffery, Director of Midwifery	JJ
Chris Dixon, Registrar in Anaesthesia (shadowing JB)	CDi	Kimara Sharpe, Vice Chair of Patient & Public Forum	KS
Liz Watkins, Director of IPC	LW	Anna Sterycx, Head of Patient, Carer & Public Engagement	AS
Apologies			
Michelle Lynch, Associate Non-Executive Director	ML		

Ref	Item	Lead	Purpose	Format
1	Welcome and Apologies for Absence	FM	Information	Verbal

FM welcomed all to the meeting.
GB was welcomed back to the Trust following his secondment to NHS England. Thanks were extended to SC for deputising during this period and thanks were also extended to Russell Hardy as the previous Trust Chair.

2	Declarations of interest	FM	Information	Verbal

FM reminded the Board that her role as Chair of Wye Valley NHS Trust is recorded on the Trust's Register of Interests.

3	Minutes and Actions Arising	FM	Approval	Report 1

The minutes of the Trust Board meeting held on 10 February 2026 were approved as an accurate record.
All actions arising from the previous meeting had been completed.

4	Chief Executive's Report	GB	Information	Report 2

GB presented the report and highlighted the following:

- Appreciation to staff for maintaining patient safety during recent resident doctors' strike action, noting the financial cost implications.
- Thanks to Russell Hardy and GB wished him well in his regional chair role. The Trust welcomed FM. SC was thanked for deputising.
- The four group Trust Boards met recently and there was future intent to hold further meetings as workshops. Comparative performance data would be made available.
- Positive staff survey results were reported across the group. Improvements, particularly in Worcester, were encouraging.
- The Trust had submitted a challenging three-year plan. Finances required to be balanced within the funds secured.
- Improvements were highlighted within urgent and emergency care, ambulance handovers at the Alex and multi-agency discharges.

The Board noted the report.

5	Integrated Performance Report	SC	Information	Report 3

SC introduced the report, highlighting challenges with winter pressures, workforce, emergency care performance and the fractured neck of femur pathway. Improvement had been seen with urgent and emergency care performance, ambulance handovers and MRI waits.

Quality (HF and JW)

- Mortality remains within the expected range.
- New sepsis screening module to go live imminently.
- Fractured neck of femur pathway performance remains variable and requires sustained improvement.
- Improvement was reported against the c.diff threshold.
- The first phase of Martha's rule launches this month.
- Challenges remain with complaints, though there have been small improvements.

Operational Performance (CD)

- Increased levels of activity were reported. A 45-minute handover programme had launched.
- Improvement had been seen in urgent and emergency care performance, with early March data exceeding 70%.
- Challenges remain with long delays and flow. The Trust continued to work with partners.
- There were cancer performance challenges, particularly within breast and urology pathways.
- There had been improvements in skin cancer pathways, supported by tele-dermatology and service redesign.

Workforce (AK)

- Workforce stability was reported as a result of improved vacancy and turnover rates.
- Establishment numbers are increasing with activity.
- Continued high agency and bank spend, though medical locum expenditure had reduced.
- Sickness remains a significant concern with 32% related to stress and anxiety.
- Consultant job planning compliance had improve to over 80%. Appraisal compliance hotspots had been identified and further work planned in those areas.
- A wide range of support is available for colleagues but much is reactive. Focus was on cultural development work.

Finance (KO)

- Month 11 position was showing a £16.3m variance against plan.
- Challenges remained around the delivery of the CPIP and flow. Costs were partly mitigated with non-recurrent measures.
- The Trust was broadly on plan with month 11 of recovery trajectory. Mitigations were due in month 12.
- Productivity appears to have improved across the year.
- Deficit support cash has been received. At the end of February, the cash balance was £10m.

The Board noted the report.

6	Patient and Public Forum Report	HF	Assurance	Report 4

KS presented the report and raised the following key points:

- There had been an expansion of Forum membership and partnerships.
- A bid had been submitted to Charitable Funds for computers.
- Concerns regarding outpatient appointment cancellations had been raised along with the risks associated with the abolition of Healthwatch.
- Infrastructure concerns including accessibility issues had been raised.
- Appreciation was extended to the P&PF Chair.

The Board noted the report and thanked the Forum for its contribution.

7	Staff Survey Results	AK	Discussion	Report 5

AK advised that the Staff Survey had been open from September to November 2025.

- There was a 48% response rate, which was a 15% increase of the previous year responses.
- Results were split into 7 People Promise themes.
- Improvements were seen across all People Promise themes.
- There was significant improvement in four domains.
- Ongoing work is focused on harassment, protected characteristics and staff wellbeing.

The Board noted the report, welcoming the positive trajectory and noting the remaining challenges.

8	Antimicrobial Resistance	HF	Assurance	Report 6

HF introduced the report and welcomed LW to the meeting. The Trust had received a letter from NHSE regarding requirements and assurance.
The response was outlined:

- Three antimicrobial stewardship priorities had been agreed.
- Expansion of antimicrobial ward rounds.
- Development of real time prescribing dashboards.
- Oversight through Trust IPC Committee and the Quality Governance Committee (QGC).

The Board noted the report and delegated monitoring to QGC.

9	Perinatal Safety Report	JJ	Assurance	Report 7

The report was presented for assurance and had been reviewed by QGC:

- Triage attendance remained challenging, reflecting a sustained increase of 30-40% over the last year. Attendances had now plateaued.
- Over 90% of women were being assessed within 30 minutes and 15-minute standards were improving.
- Changes to the home birth service model had been implemented to delivery through continuity of carer midwifery teams.
- Perinatal mortality rates remained within expected ranges.
- Heat map scores showed continual improvement.

The Board noted the report.

10	CNST	JJ	Assurance	Report 8

The Trust had now received formal external validation confirming achievement of 10 out of 10 CNST safety actions.
Initial information regarding the CNST year 8 scheme has been received and would present new challenges. A gap analysis was underway to identify risks.
QGC will be well sighted on year 8 progress and the risks.

The Board noted the report and the significant achievement accomplished.

11	Safe Staffing Reports	JJ/HF	Assurance	Report 9

Midwifery (JJ)

- Sickness remained challenging.
- Vacancies in Maternity Care Assistants remained an issue, though there were early signs of retention improvement.
- Midwife vacancy levels had improved and is now 1% following successful recruitment and onboarding.
- Acuity data for the reporting month is incomplete and therefore not reliable. The Matron is working with the teams to restore full completion of data.
- Support from continuity of carer teams had been deployed to ensure shifts were safe. There were also instances where staff were unable to take breaks, although this had improved significantly due to interventions started in Q3.
- No staffing incidents were reported.

Nursing (HF)

- RN vacancy rates are improving. There are currently 80 RN vacancies and 130 HCAs.
- Fill rates remained strong, with no reported issues.

- The Trust was participating in Cohort 3 of the National Enhanced Therapeutic Observations of Care Programme, which is expected to improve care for vulnerable patients and reduce reliance on agency staffing.
- The next Safe Care Nursing Review was scheduled to take place in May.

The Board noted the report.

12. FINANCIAL GOVERNANCE				
12.1	Standing Orders	GS	Approval	Report 10

Only 1 material change had been made regarding emergency powers and were endorsed by the Audit & Assurance Committee. The change was made throughout the foundation group.

The Board approved the Standing Orders.

12.2	Scheme of Delegation and Standing Financial Instructions	KO	Approval	Report 11

Some minor amendments had been made and were supported by A&AC.
A fuller refresh would take place later in the year.

The Board approved the Scheme of Delegation and Standing Financial Instructions.

12.3	Going Concern	KO	Approval	Report 12

The Trust continued to operate as a Going Concern and was endorsed by A&AC.

The Board approved Going Concern.

13	Integrated Plan Final Re-submission	JB	Approval	Report 13

JB presented the final plan, which had been discussed in detail at previous meetings and in Board Workshop. Approval was sought for the final Plan submitted at the end of March.

The Board approved the Integrated Plan.

14	Committee Summary Reports & Minutes	FM	Information	Report 14

Quality Governance Committee (JM)
Items within the escalation report had been highlighted during the meeting.

Audit and Assurance Committee (CH)
The Trust commissioned a joint Internal Audit report with the Health & Care Trust regarding transfer care with tissue viability. The review was complete and presented limited assurance. Issues and risks were discussed and further monitoring and oversight was delegated to QGC.

People & Culture Committee (KM)
Committee reviewed the Staff Survey in detail, which was highlighted during the meeting.

The Committee reports and minutes were accepted.

15	Risk Appetite Statement	GS	Approval	Report 15

The Risk Appetite Statement was last approved 2 years ago and was presented for review.
The majority of the ratings remain unchanged but there was 1 proposed amendment in respect of reputation. It was proposed that it be aligned to reflect the Trust strategy and set to 'seeking' level.

The Board approved the Risk Appetite Statement.

16	Board Assurance Framework	GS	Assurance	Report 16

Updates were highlighted in red text within the report. There were no significant changes.

The Board noted the report.

17	Date of Next Meeting	FM	Information	n/a
The next WAHT Trust Board meeting in public would be held on 9th June 2026.				
18	Any Other Business and Questions from the Public	FM	Information	n/a
There was no other business or questions from the public.				
The Board resolved to exclude members of the public from Part II of the meeting as matters under discussion were exempt from disclosure to the public under the Freedom of Information Act.				

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	9 June 2026
Title of Report:	Report from Foundation Group Workshop on 6 May 2026
Lead Executive Director:	Glen Burley, Chief Executive Officer
Author:	Chelsea Ireland, Foundation Group Executive Assistant
Reporting Route:	n/a
Enclosures included with this report:	n/a
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose
The purpose of this report is to provide the Joint Board with an overview of the Foundation Group Boards Workshop meeting held on the 6 May 2026.
Recommended Actions required by Board or Committee
The Board is asked to note the report.
Executive Director Opinion[1]

Wells Jo 03/06/2026 13:31:46

[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.

Report from Foundation Group Boards Workshop held on 6 May 2026

The second Foundation Group Boards Workshop was held on 6 May 2026, and the agenda was structured to provide both assurance and strategic insight across a range of priority areas for the Foundation Group.

The workshop opened with standard governance items, including apologies, declarations of interest, and a review of matters arising and previous actions, ensuring continuity and oversight from earlier meetings. This was followed by our mandatory Board level Cyber Security Training. Board members are required to complete this training every two years, and this year it highlighted the importance placed on digital resilience and organisational awareness in light of ongoing system risks.

The mid-morning agenda focused on operational performance and service quality. The Foundation Group Performance Report provided an overview of organisational delivery, followed by a dedicated deep dive into Children and Young People Services, indicating a targeted focus on this patient cohort. This was complemented by a Safe Staffing overview, including nurse-to-bed ratios, demonstrating the Board's continued scrutiny of workforce capacity and patient safety metrics across the Foundation Group.

In the latter part of the session, attention shifted towards strategic transformation programmes, particularly the "Big Move" initiatives. Updates were provided on 'Home First' - specifically on the New Hospital Programme Demand Model, and on 'Being a Very Flexible Employer', reflecting system-wide ambitions to modernise care delivery and workforce practices. The agenda also included discussions on succession planning and talent management, reinforcing the importance of leadership sustainability and future workforce capability.

The workshop concluded with a strategic update and discussion on shared Foundation Group objectives, alongside a spotlight session on improving outcomes through research. This reinforced the Group's commitment to innovation and evidence-based improvement. The meeting closed with standard governance items, including any other business and confirmation of the next workshop date which is the 5th August 2026.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board - Public**
Date of Meeting:	**9th June 2026**
Title of Report:	Managing Directors Report
Lead Executive Director:	**Managing Director**
Author:	Stephen Collman, Managing Director
Reporting Route:	N/A
Enclosures included with this report:	None
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

1. **Year end 2025/26**

The financial year ending 2026 saw the NHS deliver significant improvement milestones. It met the 65% 18-week target and saw waiting lists cut by 312,000. In Urgent and emergency care more patients were seen then ever with around 75% seen within four hours, the shortest wait since 21/22. Underlining this was a shift in the productivity and financial performance overall.

For the Trust, and outlined in our performance report, we have seen sustained improvement in reducing ambulance handover delays, improving our urgent care metrics and in our access standard performance. We still have a lot to do, to deliver the standards we want to see. For the Trust, the disappointing year end financial position means a renewed focus on our productivity and efficiency plans and delivery of those plans. We need to ensure that we are tackling those key areas that drive the position, and ensure the Trust reduces its deficit and reliance on deficit support.

2. **Neighbourhood Health Framework and Integrated Neighbourhood Teams**

We have received the nationally published policy document that outlines the development and implementation plan for Neighbourhood Health. It outlines the national objectives, goals and metrics that will be used to guide the next three years. These are centred around the following:

a. **Improving outcomes for priority cohorts** through proactive, coordinated care with INTs being the cornerstone of delivery with initial priority cohorts being for frailty, care home residents, end of life care, multiple long-term conditions, children and young people and local priority cohorts identified through population health data.

b. **Improving General Practitioner (GP) access** and the front door to primary care via phone, on-line and in-person options and ensuring community pharmacy is seen as a first point of contact.

c. **Transforming planned care through better coordination and access**, radically redesigning outpatient care with a single point of access for 10 high volume specialities and increasing follow-ups and specialist input into neighbourhood settings.

d. **Strengthening UEC pathways in the community,** expansion of community services in neighbourhoods and increasing capacity of urgent community response, virtual wards and intermediate care to reduce avoidable admissions.

e. **Improving patient and staff satisfaction.**

3. Place

Working with partners we are taking forward this guidance and building upon the care collaborative model that the ICB Cluster arrangement has operating in Coventry and Warwickshire. We are making positive strides with primary care colleagues in identifying and working up work programmes and arrangements to jointly provide care.

4. Industrial Action

We have been notified that there will be further industrial action in June. We will carefully need to plan and manage the impact given the impact on our patients, the activity we have planned and any financial consequence.

5. **More From Our Great Teams**

a. **Volunteers**: The first week of June is national Volunteers' Week, so I would like to say a huge thank you to the hundreds of volunteers who play a vital role in supporting patients, visitors, and staff across our hospitals every day.

Across our Trust, more than 300 volunteers give their time generously to help services run smoothly and enhance the experience of patients and families. In the past 12 months alone, volunteers have contributed more than 14,800 hours of support across a wide range of services, wards, and departments.

To mark the week, we hosted a series of "appreciation stations" across hospital sites, giving staff and patients the opportunity to share thanks and recognise the difference volunteers make every day. Board members and colleagues from our senior leadership team took part in the "Walk an Hour in a Volunteer's Shoes" initiative, spending time shadowing volunteers in a range of roles and gaining first-hand insight into the impact they make. They also met volunteers to thank them in person for their contribution. And of course there were appearances by our much-loved therapy dogs Olive, Bertie, Casper, and Aero.

We are keen to offer new volunteering opportunities for people who want to get involved. These opportunities range from supporting our Discharge Response Service, to joining our Patient and Public Forum or helping with a new service based at Kidderminster, where volunteers will support patients ahead of treatment by making telephone calls before appointments, offering reminders, and checking whether any additional support is needed.

Anyone interested in volunteering can find out more by visiting

https://www.worcsacute.nhs.uk/working-with-us/volunteering/ or emailing wah-tr.volunteers@nhs.net

b. **Communications**: Congratulations to our Communications team who bagged two top awards from the Chartered Institute of Public Relations (CIPR) at the CIPR's annual Midlands Awards, an event which celebrated the very best in PR and communications from across the region. Faced with competition from agencies and in-house teams, our Comms team took Gold awards in two categories - Best Use of Video/Podcast and Best Internal Comms Campaign (for comms around our Staff Survey) - and almost

made it a hat trick with team member Curtis Bucktin making it through to the final three for the Rising Star Award.
Recommended Actions required by Board or Committee
To note the above report.
Executive Director Opinion[1]
N/A

[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.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Integrated Performance Report

Trust Board

JUNE 2026

MANAGING DIRECTOR – EXECUTIVE SUMMARY

Stephen Collman

Managing Director

The Trust continued to operate under sustained system pressure. High demand, limited capacity and workforce challenges continued to affect quality, access and financial delivery. There were clear signs of improvement, particularly in ambulance handovers, elective productivity and infection control, but corridor care, delayed discharge and constrained flow, remain the primary drivers of risk across the organisation. Operational performance stayed below national standards in urgent care, cancer and diagnostics, with backlog pressures persisting despite targeted recovery action. Workforce indicators improved incrementally but continued to constrain delivery, mainly through vacancies and reliance on temporary staffing. Financially, the Trust started the year behind plan, with early shortfalls in CPIP delivery and continued dependency on deficit support and cash management measures. Taken together, this position confirms that flow, eliminating corridor care, accelerating backlog recovery, reducing the temporary workforce and delivering the cost improvement programme at pace are the priorities for securing sustainable improvement and reducing risk to patient care and organisational stability.

Quality & Safety

Infection performance broadly within thresholds (MRSA zero). Corridor care high (34 IP/day; 60 ED/day). Falls and harm stable/low. Complaints performance deteriorating (55%).

Risk: Patient safety and experience compromised by overcrowding

Operational Performance

EAS 69.6% (↓), but an improving trajectory. Ambulance handovers 87.1% within 45 mins (↑). RTT 62% (above plan) but 52-week waits rising. Cancer below target (31-day 83%, 62-day 53%). Diagnostics backlog persists (27.6% >6 weeks)

Risk: Flow constraints and backlog recovery pace

Workforce

Vacancy rate 7.25% (↑). Sickness improved to 5.0%, stress remains high. Agency decreased however off set by bank spend increased. Job planning 85% (below target)

Risk: Key workforce gaps constraining delivery and cost improvement

Financial Position

£2.7m deficit vs £2.1m plan (–£0.6m). CPIP under-delivered in M1. Cash constrained (£4.5m) with support likely required. Productivity improving year-on-year

Risk: Financial plan dependent on CPIP delivery and DSF (Deficit Support Funding)

OUR QUALITY & SAFETY

Dr Jules Walton

Chief Medical Officer

The sepsis module is now in action on EPR, and early feedback has been positive from users. Hopefully this will improve clinical engagement with the process and resolve some of the data collection problems we have had previously. Antimicrobial stewardship has slightly deteriorated in the past quarter and we continue to reinforce the message of good antibiotic prescribing practice.

Martha's rule (Call for concern) has been established on both sites, with some phone calls from staff received and dealt with. We have been regionally praised for consideration of the needs of our deaf community by advertising the service through a sign language video on the Trust's website.

Fractured neck of femur performance is essentially unchanged. We have had our trauma service peer reviewed in the past month, and we anticipate the report of that to accelerate any necessary changes.

Hayley Flavell

Chief Nursing Officer

In April 2026 cases of CDiff increased to 9 (from 8 in March) but below monthly threshold of 12. MSSA, EColi, Klebsiella, Pseudomas have all decreased in April and cases of MRSA remain unchanged at zero. All of the 11 high impact intervention audits were compliant in April.

The complaints closed metric has now been amended to reflect that some complaints have agreed timescales of 40 days rather than 25. The complaint compliance target to close within 25/40 days has decreased to 55.2% in April 26. The Trust had 99 complaints still open (decrease from 105) at the end of April, and there were 68 new formal complaints received . Of the 99 open complaints, 26 have breached 25 days. A new process was introduced to support surgery's complaint management process with improvements being demonstrable as Surgery Division now accounts for 27.3%(decreased from 40% in March) of the open complaints (27).

The total number of falls in March has decreased to 106 and remains below the national benchmark with 3.9 total falls per 1,000 bed days (national benchmark of 6.63). There were 0.9% falls with severe harm in April . The total number of HAPUs in April is 21 (0.78 HAPU per 1,000 bed days). There were zero HAPUs causing moderate, severe, or catastrophic harm in April. There is continued training and education delivered by the TV team across the Trust, particularly in Surgery for bespoke wound care.

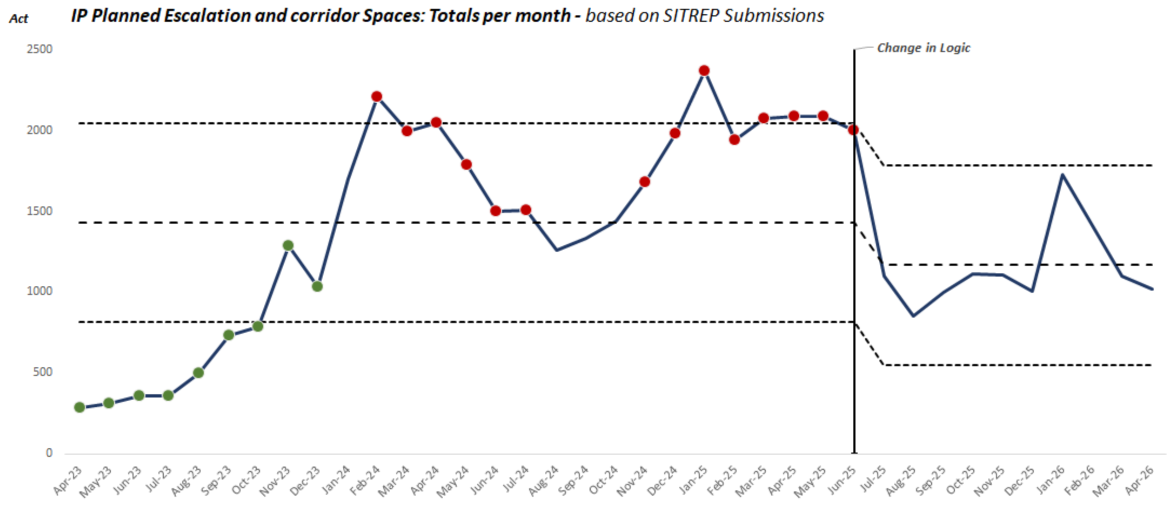
The friends and family recommended rates have failed to meet the target (95%) in A&E, Inpatients Outpatients in April, however Maternity achieved at 96.2%. All Divisional teams have been asked to raise awareness of FFT at internal meetings and to action and promote feedback making every contact count, noting the Big Quality Conversation has just been completed and the inpatient survey continues monthly.

Total number of patients in a Corridor Care space in April was 1021 an average of 34 patients per day. Across the 2 ED sites in April there were 1809 patients (average 60 per day) who spent time in a corridor or overflow space . Noting – the reporting has changed from April to Planned escalation and corridor care beds based on new national guidance.

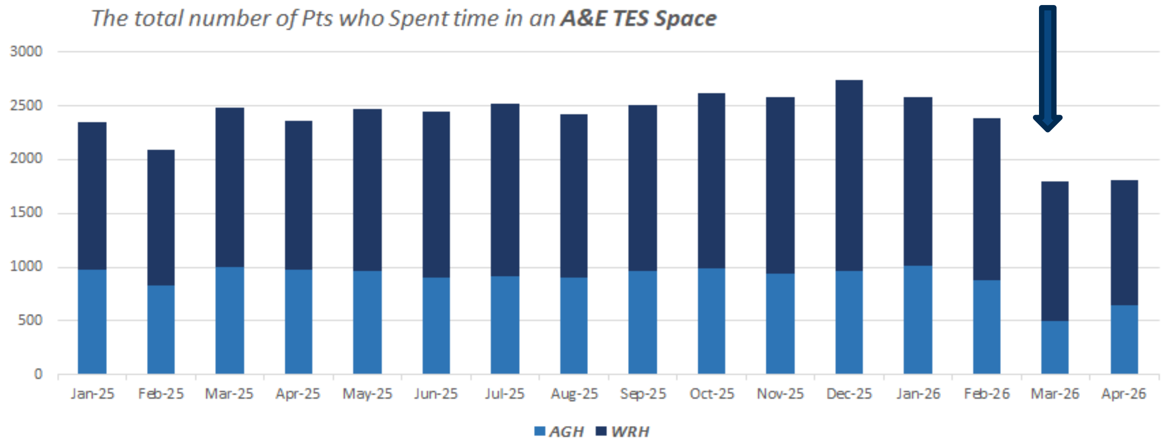
OUR QUALITY AND SAFETY – PLANNED ESCALATIONS AND CORRIDOR CARE

We are driving this measure because

The submission of Planned and Escalation spaces is part of our national Urgent Care SITREP Submission, and we are monitoring this to eradicate the use of temporary or planned escalation spaces used to treat patients. .



Change in logic Mid March



Understanding the performance

- Numbers submitted nationally for IP are split into two areas which are Planned Escalation spaces and corridor care spaces and are based on a snapshot of Pts in those spaces at 8am. Please note these changed in April based on new national guidance and have been reviewed internally.
- The total number of inpatients that spent time in a planned escalation or corridor care space in April was 1,021 patients which accounted for an average of 34 patients per day across WRH and ALX (based on 8am snapshot)
- 97% of these patients are at Worcestershire Royal Hospital .
- This has seen a reduction compared to the previous month of March where there were 1,102 patients who spent time in a planned or escalation space - which is 35 per day on average..
- Numbers submitted for A&E corridor care are based on any Patient in the previous 24-hour period who has spent over 45 mins in an ED planned escalation space which is identified as a Corridor. Pts are only counted once as part of their attendance should they occupy more than 1 planned escalation space. National guidance has changed this to over 45 minutes.
- In April across the 2 ED Sites a total of 1,809 patients met the above criteria – this was an average of 60 per day
- This has increased from March where there were 1,793 and an average of 58 per day.

Actions (SMART)

- UEC transformation work continues.
- De-escalation plans devised to reduce corridor care across ward areas, with consideration of planned escalation for periods of high activity in ED.
- Governance processes implemented, to track quality and safety, including GIRFT standards (tracked through UEC reset)

Risks

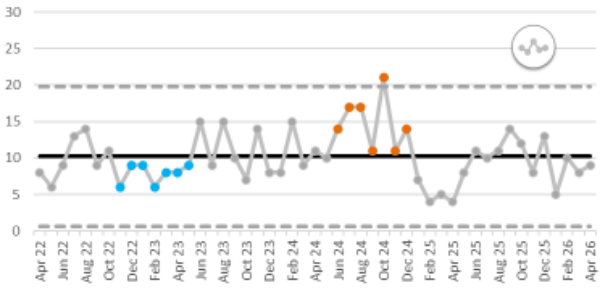
- Risk to the quality of care received by the patient due to being in an inappropriate clinical area
- Overcrowding in A&E and on IP wards
- Reputational damage to the Trust due to high numbers.

OUR QUALITY AND SAFETY – INFECTION PREVENTION & CONTROL (IPC)

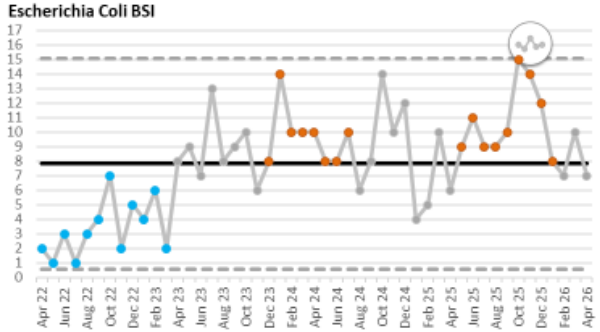
We are driving this measure because

There is a need to embed our current infection prevention , control policies , practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.

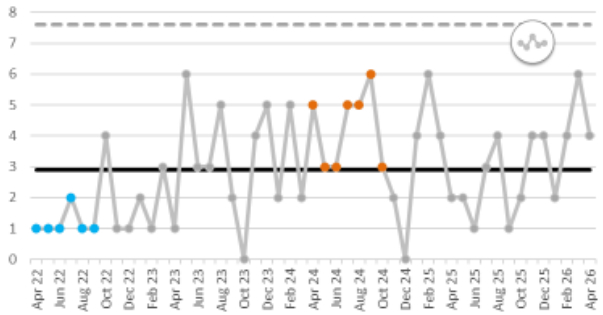
Clostridioides difficile



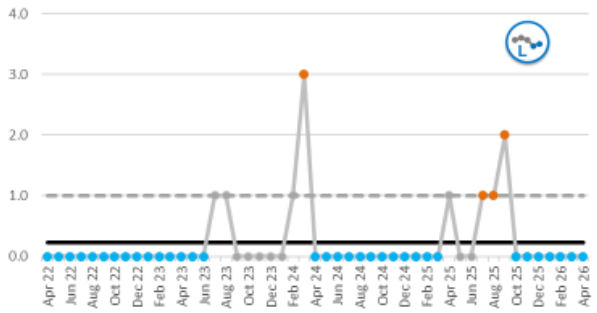
Escherichia Coli BSI



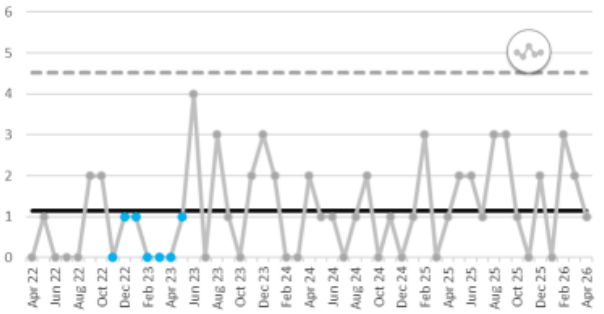
MSSA BSI



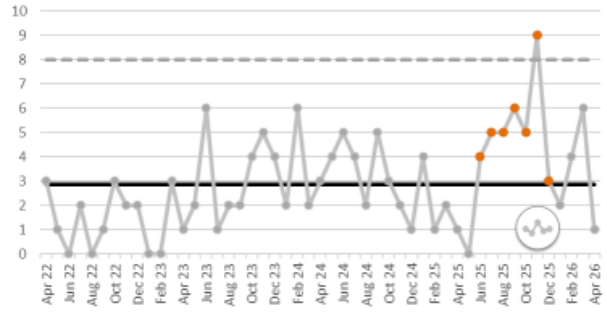
MRSA BSI



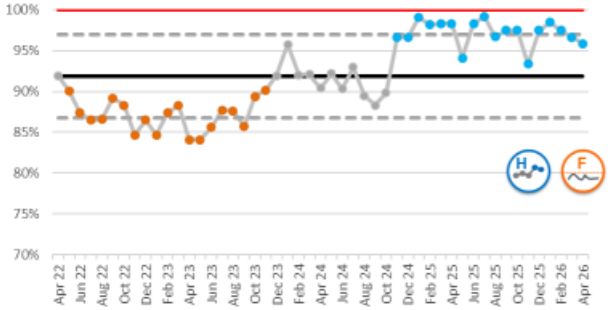
Pseudomonas BSI



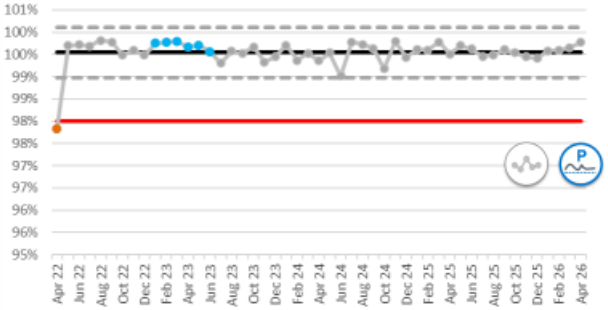
Klebsiella BSI



Hand Hygiene - Audit Participation



Hand Hygiene - Compliance



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OUR QUALITY AND SAFETY – INFECTION PREVENTION & CONTROL (IPC)

We are driving this measure because

There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.

Understanding the performance

- *Clostridiodes difficile* (C.diff) increased in Apr-26 (9 c.f. 8 in Mar-26) but is **below** the monthly threshold of 12.
  HOHA 4 COHA 5.
- E-Coli BSI dropped in Apr-26 (7 c.f. 10 in Mar-26) and is **below** the monthly threshold of 9.
  HOHA 4 COHA 3.
- Internal ambition: MSSA BSI dropped in Apr-26 (4 c.f. 6 in Mar-26) and is **below** the monthly threshold of 6.
  HOHA 3 COHA 1.
- MRSA BSI was unchanged in Apr-26 (0) and **met** the monthly threshold of 0.
  HOHA 0 COHA 0.
- Klebsiella species BSI dropped in Apr-26 (1 c.f. 6 in Mar-26) and is **below** the monthly threshold of 3.
  HOHA 0 COHA 1.
- *Pseudomonas aeruginosa* BSI dropped in Apr-26 (1 c.f. 3) but is **above** the monthly threshold of 0.
  HOHA 1 COHA 0.
- Hand Hygiene Compliance (99.8%) has met the target (98%) every month since Apr-22 and is showing common cause variation.
- Hand Hygiene Audit participation dropped slightly in Apr-26 (95.8%), failed to reach the target (100%) but is still showing special cause variation of improvement.
- All of the eleven High Impact Intervention (HII) audits were compliant (95%) in Apr-26.

HCAI Thresholds for 2026-27 have not yet been released. The Trust is benchmarking against 2025-26 figures.

Winter respiratory infections influenza, RSV and COVID have reduced significantly during this reporting period although the Trust has reported both COVID and norovirus outbreaks during this period.

Actions (SMART)

•C.diff IPC to continue weekly surveillance and reviews, and focus on AMS, use of Rediairs, cleaning.
•C.diff reduction : Antimicrobial Stewardship work lead by AMS Pharmacist and AMS committee continues
•Gram negative blood stream infections: E.Coli, Klebsiella and pseudomonas, new Datix proforma process was commenced at the start of April - to be completed by clinical team caring for the patient focusing on hydration, UTI prevention, urinary catheter and PVD care (scrub the hub).
•Our internal ambition for no more than 40 cases of MSSA per year will remain in place for the new financial year, focus needs to continue on the use of PVD packs, scrub the hub and documentation on EPR system.
•Focus on prevention of splash contamination and IVs-installation of splash screens, installations began at WRH site, yet to start at Alex site, awaiting estates quotes to progress, poster to raise awareness of splash risk shared with divisions.

•MRSA/MSSA Focus continues on device care VIP, scrub the hub (poster shared with divisions), updated policy in place
•Monitoring of cleanliness via monthly 3 star and below meetings continues
•MRSA, E.coli, Klebsiella and Pseudomonas bacteraemia's are reviewed weekly with IPC team, consultant microbiologists, AMR pharmacist, and ICB. NHSE IPC lead has attended the meetings and was assured by the Trust review process.
•Divisional, High Impact Interventions completion and compliance for PVD insertion and on-going care, urinary catheter insertion and ongoing care is monitored via TIPCC on a monthly basis
•Divisional compliance with IPC Level 2 training is monitored via TIPCC on a monthly basis
•Divisional Hand Hygiene audit compliance via TIPCC on a monthly basis .

Risks

Capacity: Extreme risk 4816. The level of activity and high level of bed occupancy limits the ability to isolate patients in a timely manner, increasing risk of infection spread. IPC team attend capacity meetings to ensure flow through the organisation
•IPC staffing: The Data Administrator has retired, and the nursing staff have picked up some of the roles but are unable to take on all-background codes for ICNet, this will affect how the surveillance system functions. Permission has been granted to go out to advert for the post.. Long term sickness is being managed via Occupational Health and HR.
•Continuing bedpan washer issues at WRH impact the ability to undertake high level disinfection of bedpans and other items. Work on a solution is in progress with trials of equipment now completed and a preferred supplier identified. Estates are working with Equans on the commercials to replace the bedpan washers with maceraters.
•Food macerators in zonal kitchens have now been removed.
•Mattresses – concerns have been raised that mattress covers are failing their fluid ingress tests sooner than expected and soiled mattress covers returned to the company for disposal have been returned to site. The mattress team have robust procedures in place to ensure that the damaged mattresses and covers are not being reused. Meetings are taking place with the company to resolve the issues.
•Citrobacter outbreak declared on NNU 2 cases confirmed as linked by typing, one case has died other case is well. Internal and external meetings held, action plan in progress, report being taken through PSIRF by divisional governance team. Mitigations and surveillance in place.
•Two patients with confirmed measles have been diagnosed at the Trust. Contract tracing has been completed for staff, patients and visitors in the departments involved. Warn and inform letters have been issued. Polices and procedures have been recirculated to staff and departments. Reminders to staff that the MMR vaccine is available from OH Department have been circulated.

OUR QUALITY AND SAFETY – ANTIMICROBIAL STEWARDSHIP (AMS)

We are driving this measure because

We need an approach to promote and monitor judicious use of antimicrobials to preserve their future effectiveness and using Start Smart The Focus principles to reduce the risk of antimicrobial resistance (AMR) while safeguarding the quality of care for patients with infection.

Audits carried out in 2025/2026, Quarter: 4

Division	Site	Ward	Total Audits	Drug Allergy Status Documented	Proportion of Patients on Carbapenems	IV Antibiotics for >72 hours	Total Course > 5 Days	Indication Documented	72 Hour Review	Antibiotic In Line With Guidance
⊞			2	100.00%	0.00%	0.00%	0.00%	100.00%	NaN	100.00%
⊞SCSD			29	96.55%	14.29%	33.33%	39.29%	100.00%	100.00%	85.71%
⊞Specialty Medicine			169	85.21%	6.36%	75.41%	51.82%	99.09%	70.45%	88.18%
⊞Surgical			114	98.25%	6.85%	58.14%	45.21%	98.63%	88.24%	78.08%
⊞Urgent Care			38	94.74%	0.00%	33.33%	10.53%	94.74%	0.00%	57.89%
⊞Womens & Childrens			11	100.00%	0.00%	50.00%	20.00%	100.00%	75.00%	100.00%
Total			**363**	**91.74%**	**6.64%**	**60.90%**	**43.57%**	**98.76%**	**75.15%**	**82.99%**

Understanding the performance

The Quarterly Antibiotic Point Prevalence Survey, carried out by the Pharmacy team, results for 2025/26 Q4 are;

- Total Audits: **363** *(437 in Q3 2025/26)*
- Drug Allergy Status Documented – **91.74%** *(90.16%)*
- Proportion of Patients on Carbapenems – **6.64%** *(6.13%)*
- IV Antibiotics for more than 72 hours – **60.90%** *(50.75%)*
- Total Course more than 5 days – **43.57%** *(38.96%)*
- Indication Documented – **98.76%** *(96.93%)*
- 72 Hour Review – **75.15%** *(76.32%)*
- Antibiotic in line with guidance – **82.99**% *(84.66%)*

Actions (SMART)

- Working with EPMA on extracting the PPS audit and creating an AMS dashboard. EPMA lead requested a report a review allergies submitted on Sunrise as target is 100%.
- Continuing to monitor the compliance with antimicrobial guidelines and consumption to achieve reduction targets specified in standard contract for Watch and Reserve categories.
- Antimicrobial ward rounds- focusing on Meropenem and Piperacillin-tazobactam prescribing. Ward rounds have now increased too twice weekly.
- Collaborating with the ICS Forum to align hospital formulary and guidelines. Had the first combined meeting of Coventry & Warwickshire AMR Strategy Group and Herefordshire & Worcestershire AMS Forum, in view of the recent clustering of our two ICBs. Terms of reference (TOR) to be set for group.

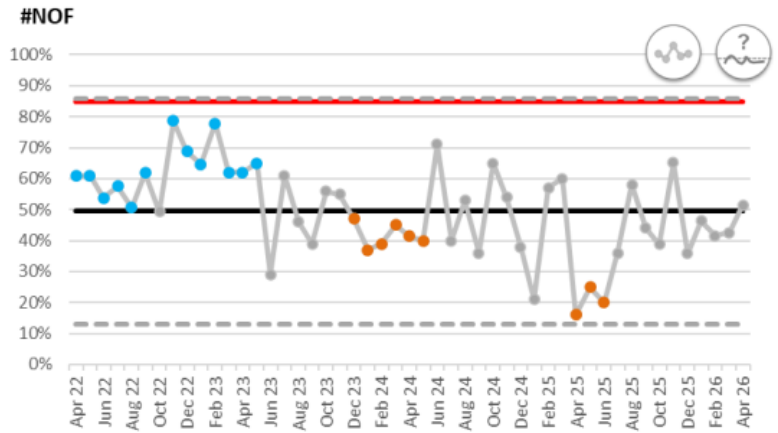
Risks

- Operational pressures prevent necessary attention to AMS

OUR QUALITY AND SAFETY – FRACTURED NECK OF FEMUR (#NOF)

We are driving this measure because

Prompt surgery and appropriate involvement of geriatric medicine has benefits in terms of improved patient outcomes, increased number of independent individuals and reduced mortality, shorter length of stay and more cost-effective care.



Understanding the performance

Externally Reported – BPT #NOF Patients

- #NOF compliance increased in Apr-26 to 53.0%.
- The target (36 hours) has still not been achieved since Mar-20.
- There were 66 #NOF Admissions in Apr-26
- There were a total of 31 breaches in Apr-26.
- The primary reasons for breaches in Apr-26 were Theatre capacity (15), medically unfit patients (9) and bed issues (8).
- The average time to theatre was 35.4 hours.

Internally Monitored – All #NOF Patients

- #NOF compliance increased in Apr-26 to 51.4%.
- There were 72 #NOF Admissions in Apr-26.
- There were a total of 35 breaches in Apr-26.
- The average time to theatre was 36.6 hours.

Actions (SMART)

Improvements ongoing:

- Beech Trauma continues to positively impact flow for trauma patients and reduce the number of outliers. Although this was initially intended as a temporary arrangement, and despite several documents submitted from General Surgery to highlight the requirement for the beds to be allocated back to General Surgery, the action remains ongoing.
- The two biggest recognised causes for delay remains; Bed capacity and theatre capacity. This is exacerbated by winter pressure and critical incidents and effects the effectiveness of the pathway.
- The "Out by Day 5" initiative continues to be effective in reducing overall length of stay. Updated LOS data from the H&C Trust is awaited
- Daily reviews of theatre lists remain in place to accommodate trauma patients. Where elective lists finish early, Trauma is utilising available theatre time at the end of those sessions.
- Extending the working day within NOF theatres has the potential to increase procedural capacity. This is under review, with an audit planned to identify patients who could have undergone surgery if extended hours had been available. This audit has been rolled over due to issues relating to cement/Striker and access to equipment.
- Daily trauma huddles continue each morning, involving the theatre team, TNPs and clinicians. Golden discharge patients are identified collaboratively, including input from the anaesthetics team.
- The updated analgesia pathway (implemented from end of July) continues to demonstrate improvements in delirium rates, reduced length of stay, and earlier mobilisation of patients.
- Ongoing improvements have been seen in **bone health prescribing** and **orthogeriatric review**, with PSDA data indicating that 94% of patients are reviewed within 72 hours and an increasing number are receiving timely and appropriate bone protection treatment.

Risks

- **Risk 4873 (15)** - Risk of patient harm due to exceeding 36 hours to theatre for repair of fractured neck of femur. Risk action 30877 – 30/04/2026 Continue to monitor effectiveness of Beech Trauma as a temporary solution

- Theatre and bed capacity continue to be the biggest risks to the effective delivery of the #NOF pathway.

OUR OPERATIONAL PERFORMANCE

Chris Douglas

Chief Operating Officer

Our April 2026 system wide EAS concluded at 69.6%, which was 1.9% less than our end of year performance in March. The beginning of April proved challenging for our teams with the post Easter performance mirroring the seasonal trends. The Easter Bank Holiday alongside Industrial action posed a challenge for our Divisional teams. Whilst recovery was swift, with team efforts de-escalating the site position, the impact is demonstrable in April's figures.

The Trust type one position, whilst below March outturn, was an improving picture for a second month. Attendances were higher than 2025, with a continued 3.3% increase during April 2026, with Monday's activity being the highest attendance day of the week. Overnight activity is a hotspot for our Emergency Departments. Our Medical Divisional team are undertaking a deep dive into activity and resource There are plans underway to reconfigure and increase rota support late afternoon/evening to support a reduction in the cumulative patient queue, before midnight. Despite the challenges linked to activity and the higher rates of admission at weekends, it is pleasing to report, that analysis shows a (continued) improving position in relation to Ambulance Handovers within 45 minutes. In April, 87.1% of Ambulances were handed over within 45 minutes, this is in comparison to 83.4% in March. So far in May this is at 89.5%.

WRH achieved 80.7% in April (+7.2% improvement) while the Alex achieved 96.2%. May to date has seen our Alexandra Site reporting at 98.9% month to date with 18/19 days seeing performance at 100%. A move towards a release to respond approach is planned, in line with a likely a regional maximum offload delay on 2 hours. Internally we are working on an agreed pause process to support this, and analysis has been completed to demonstrate the impact of this next stage action.

Long length of stay patients decreased from 145 to 137 in April, however we continue to see a number of extensive delays on our Pathway Discharge Unit. A SOP has now been agreed system wide to support pathway discharges and enable transparent and localised monitoring of delays, this is a positive move towards further collaborative working to support earlier discharge of our patients needing onward care.

Our performance in cancer is still not in a position we would want for our patients, though we expect FDS position to have improved in April compared to March we are below our plan and we continue to see low performance 31- and 62-day metrics. Cancer performance is mainly driven by three specialties, urology, skin and breast services. For our breast services there is reassuringly clear evidence of recovery, with patients now been seen for their first appointment at 9 days and through increased capacity patients are been seen and treated more quickly. Whilst our urology service has seen some improvements in the beginning of the patient journey and overall backlogs have reduced, there is still further work to do this more quickly against a growing a demand. The team are working closely with WMCA to provide a structured programme of improvement to address both short and long-term constraints. Our patients seen in our dermatology services have seen a deterioration in in the time it takes to receive treatment compared to last month, and the backlog for treatment has increased. Our service leads are working rapidly to improve this position as we move to a new independent sector provider and have plans in place to increase our treatment capacity, whilst we progress with longer term solutions and recruit substantive workforce and work closely with our commissioner to roll out a digital referral solution to the rest of the County. This solution will support a quicker referral tirage process and enable our most at risk patients to access the treatment they need in a timelier manner.

Our elective recovery for RTT continues to perform above our annual plan with April at over 62% for RTT, as teams continue to maximise on the progress made during the sprint which saw a reduction in the time our patients wait for their first appointment. We do still have patients waiting in excess of 52 weeks before receiving treatment and this mainly impacted by three specialties, ENT, OMFS and T&O. All three services have developed plans to eradicate 52 week waiting times by September, with T&O aiming to achieve this by July. Teams are now focussed on delivering this year's activity and performance plan, by driving productivity and reducing waste through further improvement of cancellations and unnecessary appointments which do not add value to the patient's journey.

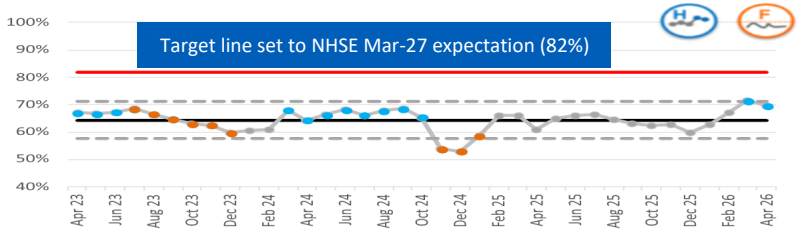
During May we have taken part in hub optimisation week (HOW), this is a nationally driven event which our two elective theatre hubs (Alexandra and Kidderminster) have both participated in. The aim is to improve theatre throughput ensuring our resources are fully maximised with an improved outcome for our patients by been able to treat more patients and reduce waiting times. The event encourages services to explore new initiatives and test new ways of working. Our teams selected a variety of initiatives which included introducing standby patients for general anaesthetic lists, telephone calls to patients 3 to 5 days ahead of surgery to reduce on the day cancellations and T&O patients been in the theatre department by 08:15 to reduce delayed starts. Early indications from week 1 suggests an improved theatre utilisation exceeding the national GRFT standard of 85% and a 2% reduction in on the day cancellations and 50% of our stand-by patients been treated on the day. It has been a real team effort across divisions and services to ensure our patients are theatre ready and that the day of surgery runs as smoothly and efficiently as possible. Thank you to everyone involved in this event and for taking the learning and practice forward to support our journey of continuous improvement.

OUR OPERATIONAL PERFORMANCE – URGENT & EMERGENCY CARE

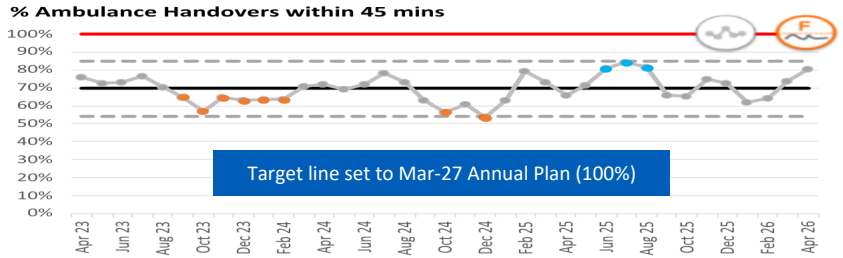
We are driving this measure because

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

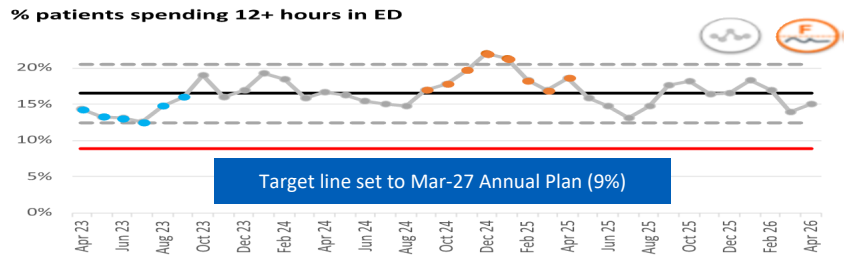
% within 4 hours (EAS All)



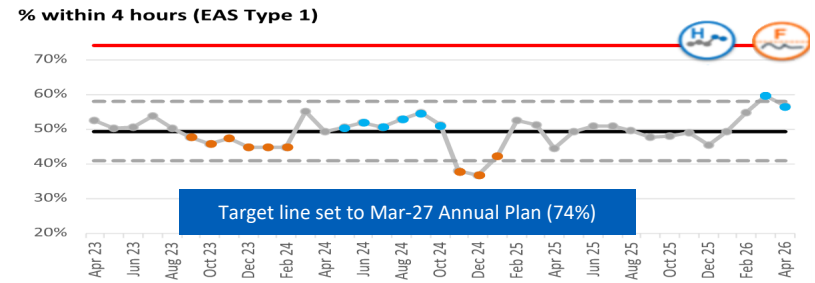
% Ambulance Handovers within 45 mins



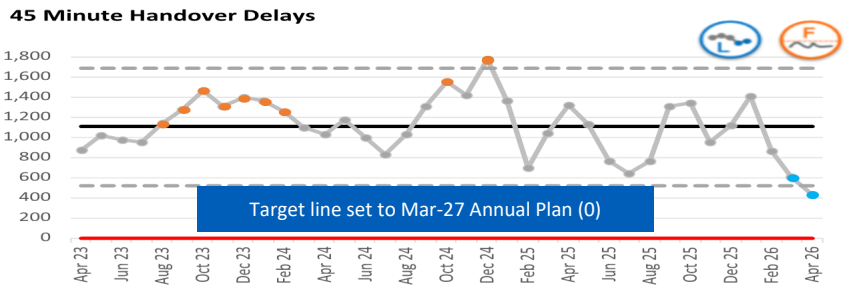
% patients spending 12+ hours in ED



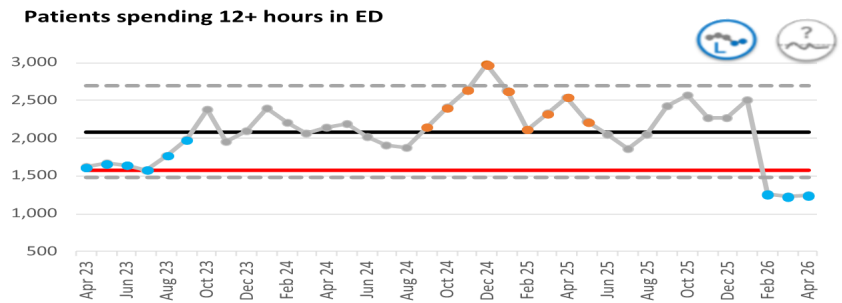
% within 4 hours (EAS Type 1)



45 Minute Handover Delays



Patients spending 12+ hours in ED



Understanding the performance

- Overall System EAS declined by 1.9ppt from 71.5% to 69.6% but remains special cause improvement;
- Type 1 decline by 3.0ppt from 59.6% to 56.6% but remained special cause improvement (2nd consecutive month with >14,000 attendances).
- NANR improved by 4.3ppt
- 14,067 patients attended our type 1 sites in April (at an average of 469 per day) which is a 3% increase compared to April 2025.
- 28% of attendances were conveyed by an ambulance and 72% of attendances were patients self-presenting at our EDs.
- The percentage of ambulance handover breaches under 45 minutes improved to 87.1% (a 26% reduction in actuals from Mar-26).
- Long length of stay patients decreased from 145 to 137 per day in April.

Actions (SMART)

- UEC recovery reset workstreams now up and running with particular focus on discharge pathways, closure of pathway discharge unit, improving specialty review times and ED front for improvement plans including assessment unit improvements and 45-minute implementation..
- Continued focus on 45 Minute Ambulance implementation. Release to Respond pause point in draft and 2-hour maximum handover time set with Region
- Live reporting on discharges continue to raise visibility of patient flow barriers, clear action plans requested at huddles and site meetings for patients that are at risk of breaching W45% red lines.
- LOS reporting now to include phased reduction in line with PDU closure and corridor care eradication plans.
- Children's ED improvement – EAS improvements increased to 86% since reporting period (May to date)
- The attending model and rota lines have now been reviewed and are ready for full implementation.
- Digital triage document in Sunrise to be completed by mid-April, including a demo phase (for May roll out) – this will cut triage times and improve overall triage performance
- Daily focus on ward level discharges- reviewing the previous days and adding additional focus where there have been no or very few discharges- board round attendances (both sites)
- ASA workforce paper being discussed within surgery division, PDSA complete and awaiting budget approval to be made BAU.
- Acute Medical Assessment PDSA phase 2 workshop held May 8th May– actions in place, commencement date to be confirmed.

Risks

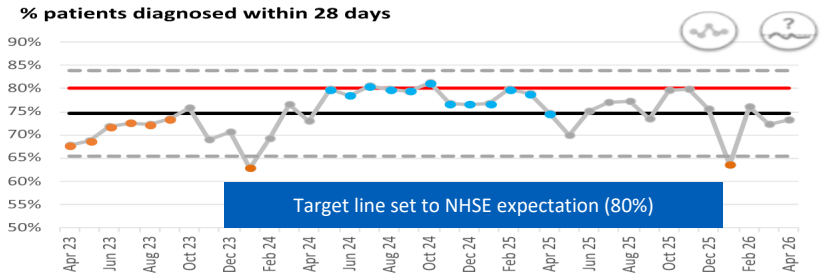
- Cessation of UEC Sprint schemes on 1st April and impact of additional resource on performance delivery
- Pace on agreement for discharge pathway metrics system wide
- Continued engagement in 45, coupled with system wide metric visibility
- LOS increase on General Medical wards
- Overnight Primary Care delays and public behaviour (attending ED as opposed to accessing alternatives)
- Inconsistency in offer of alternative pathways for ED/SPOA to access
- Hospital flow and late discharges featuring
- Radiology in MIU – future model required
- Paediatric – Medical support required for ED, business case proposal needed from Division
- Organisational change/structure – impact of pending change for divisions
- Increase in MFFD numbers across sites – in particular pathway 2
- Potential closure of PDU reducing bed base this year impacting on capacity and requirement to focus on reducing Corridor Care – June deadline
- Risk associated with patient care/outcomes and Corridor Care

OUR OPERATIONAL PERFORMANCE - CANCER

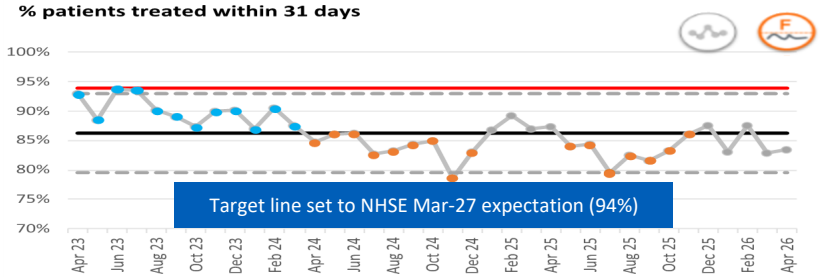
We are driving this measure because

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

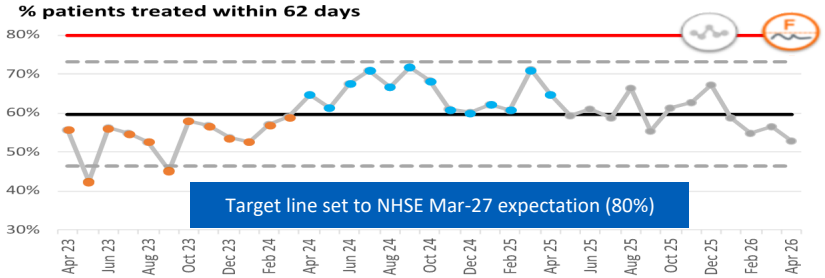
Y-axis does not start at 0%

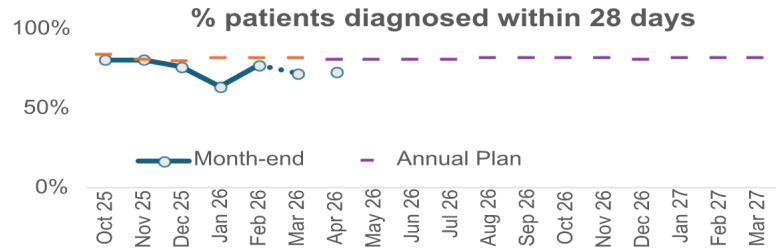


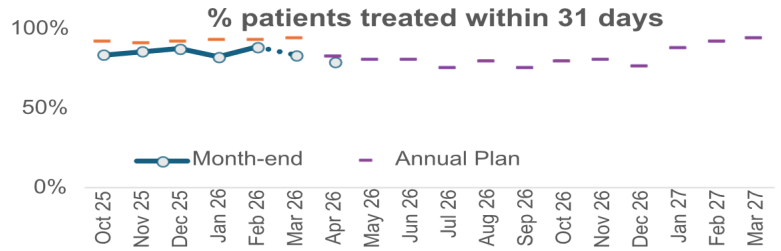
Y-axis does not start at 0%

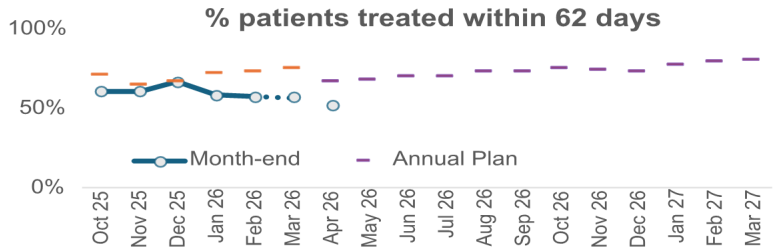


Y-axis does not start at 0%









Understanding the performance (provisional)

- We received 2,838 cancer referrals in April; the decrease from Mar-26 is normal seasonal variation
- 28-day performance is at 74% and is normal variation.
- The 31-day performance (83%) is below our annual plan target and normal vairation. Only 3 specialties have achieved the 96% operational standard.
- The 62-day performance (53%) is below our annual plan target.
- Skin and Urology are contributing 70% of patients to the backlog of patients waiting over 62 days.

Actions (SMART)

- **Urology** – WMCA are supporting a programme approach for the urology improvements, which include short term and medium to long term actions. The service continues to utilise increased capacity with locum consultants and middle grade doctors since January 2026 and increased LATP capacity in February via an insourcing provider and are seeking additional WMCA funding to bridge the gap to business case approval. These additional resources will support capacity for USC OPA, LATP and post MDT OPA, as well as provide additional theatre capacity. Mutual aid continues to be provided from WVT for 4 robotic cases per month, alongside weekend waiting list initiatives. The service is trialling remote monitoring and reviewing cases discussed at MDT with a view to move to protocolised treatments to reduce delays at MDT and support more time for complex case discussion.
- **Breast** –First seen now at 9 days. Supported by insourcing, agency and WLIs. Longer term plans to increase one stop breast clinic capacity through internal Consultant Radiographer training programme. Radiologist insourcing / agency plan to continue until this point. Low-risk /non urgent breast pathway commenced Feb 2026 monitor referral / A&G numbers and further comms to GPs undertaken. Increase in A&G seen – monitoring. New staffing models to be implemented – including trial of clinical fellow for service (funding agreed via WMCA). Review of future capacity and staffing requirement to be undertaken in Q1
- **Skin** – Teledermatology pilot extended to include a second PCN which commenced mid-January 26. RPA solution has moved from trial and is now live and providing positive results in terms of significantly reducing the time to move referrals on to the system. This will support more rapid roll out to remaining PCNs. This project aims to reduce demand on OPA capacity and allow more timely access to those who do need to be seen. The service are now developing a costing model for ongoing support and further roll out with commissioners. One stop clinics commenced in February; service has successfully recruited to 5 GPs with specialist interest who are now in post and will support the provision of sustainable service model along with recent approval to recruit to permanent dermatologist posts.

Risks

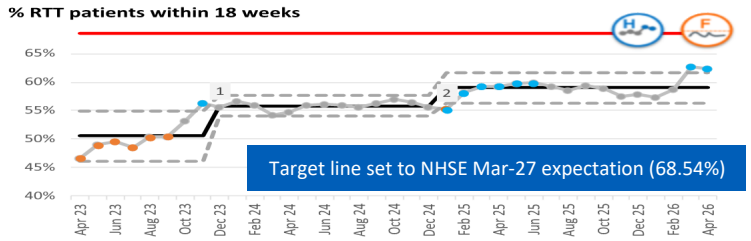
- Impact to achieving delivery of 31 and 62 days resulting from insufficient Oncology capacity.
- Failure to reach annual plan target for FDS due to the increasing demands and ability to flex up capacity to keep pace for Breast and Urology services
- Risk to delivery of FDS, 31- and 62-day targets due to service model fragility for Skin (which also relates to fragile Max Fax service)
- Risk to delivery of 62-day target resulting from Urology having insufficient capacity to meet demand and address current backlog.

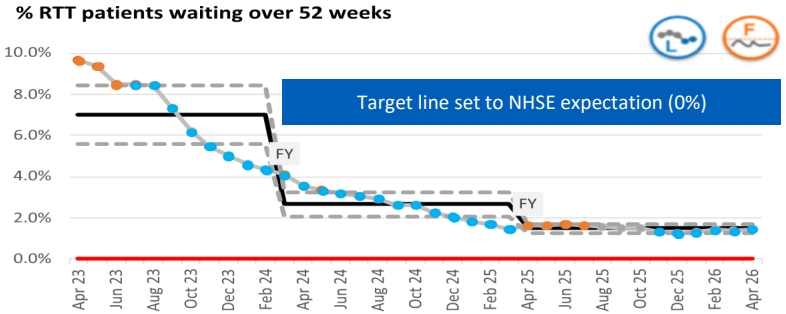
OUR OPERATIONAL PERFORMANCE – REFERRAL TO TREATMENT

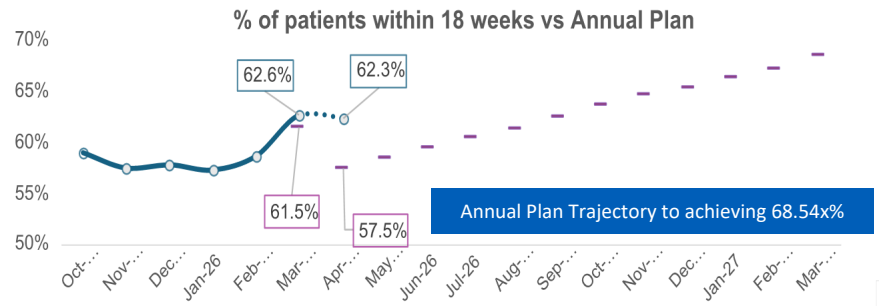
We are driving this measure because

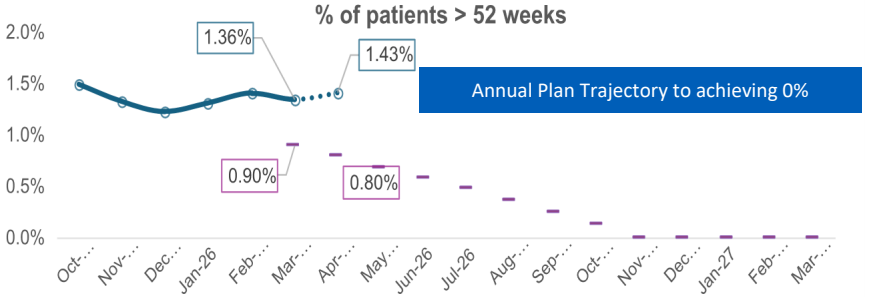
It is a key priority to ensure that patients can access the elective treatment they need in as timely a manner as possible and to continue to recover to the 18-week Referral to Treatment standard as set out in the NHS constitution.

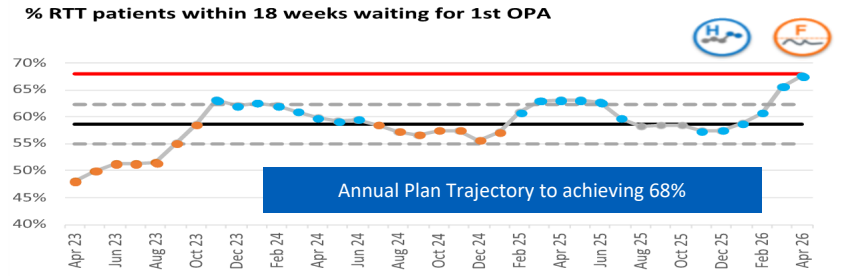
Y-axis does not start at 0%

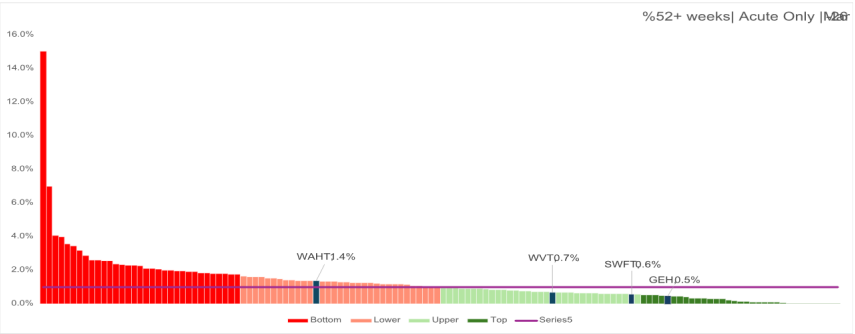












Understanding the performance (submitted)

- At the end of Apr-26, 62.3% of patients, of a waiting list of 57,248, were waiting less than 18 weeks for their first definitive treatment.
- For those patients waiting for their first appointment, the proportion waiting less than 18 weeks shows special cause improvement.
- The number of patients waiting over 52 weeks was reported as 818 which is higher than March, at 759. This is 1.43% of the total waiting list.
- 3 specialties with 52-week waiters at month end (ENT, T&O and OMFS) contribute 86% of patients to the Trust overall position.
- In March's NHSE RTT publication, WAHT has moved to the lower quartile of performance with 1.4% of the waiting list over 52 weeks.

Actions (SMART)

- Weekly oversight, monitoring and support from ICB and NHSE
- Weekly DCOO oversight and monitoring of our longest wait patients
- **ENT** are progressing with a pilot and service redesign of their pathways including using digital solutions to support changes from point of referral and reducing follow-ups through increased discharge or to increase PIFU in line with peer benchmarking.
- In addition in order to manage the current backlog of patients over 18 weeks waiting for treatment and specifically at risk of 52-week breaches, a proposal for additional activity to support recovery by September has been developed which includes a ring-fencing beds for elective activity and increasing throughput through theatres
- **OMFS** recovery plan to address 52 weeks and support RTT performance through increased capacity from a locum providing oral surgery and MOS from May. Additional WLIs to increase MOS capacity from June. Additional paediatric specific lists to commence June. Close management of booking practices to maximise utilisation and ensuring the longest patients are prioritised. Due to the size of backlog, the service are exploring an insourced solution to support and eradicate breaches over 52 weeks before September.
- **T&O** – The service has a recovery plan to eliminate 52 week waits by July, this will be achieved by improving utilisation with the routine use of stand-by patients, improvement in booking practices, support from IS providers for 250 hands/upper limb cases, continued use and high performance through treatment room 2 went live at the end of March.

Risks

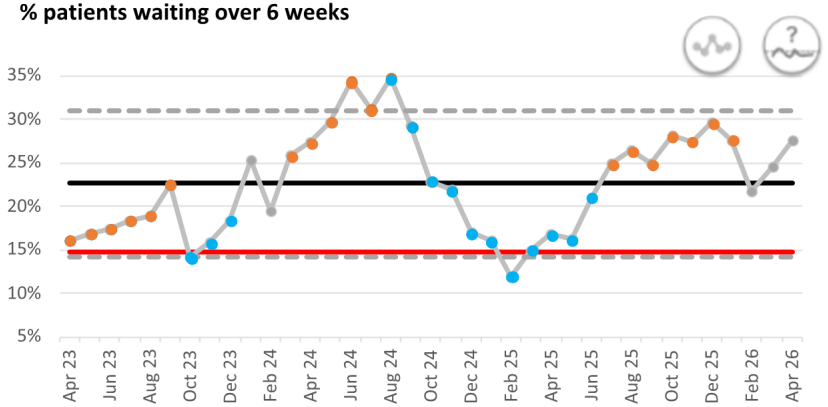
- Risk to elimination of 65+ week waiters due to late onward referral to diagnostic services with limited capacity such as NOUS or specialist services provided externally, such as HIDA scan, Bravo etc
- Risk to delivery of eliminating all waits over 52 weeks by Sept 26 particularly for ENT, T&O, OMFS and urology
- Financial impacts of ongoing use of insourcing and outsourcing solutions
- Impact from further Resident Doctor Industrial
- Deterioration of 18-week performance over summer from high volume in referrals in March and April

OUR OPERATIONAL PERFORMANCE – DIAGNOSTICS

We are driving this measure because

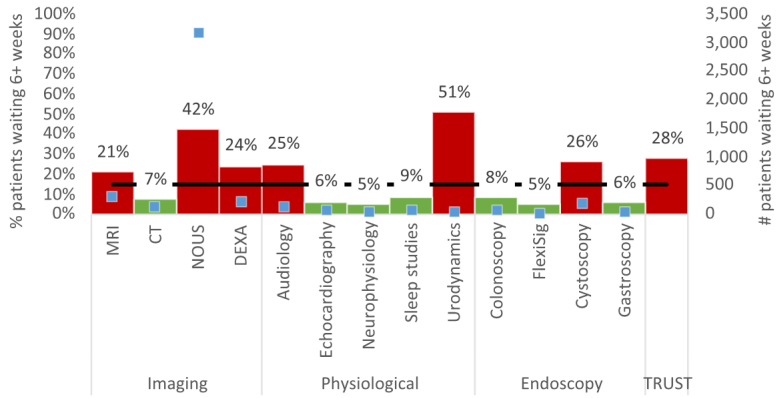
Early diagnosis is important to patients and central to improving outcomes, for example early diagnosis of cancer improves survival rates. Bottlenecks in diagnostic services can significantly lengthen patient waiting times to start treatment.

% patients waiting over 6 weeks

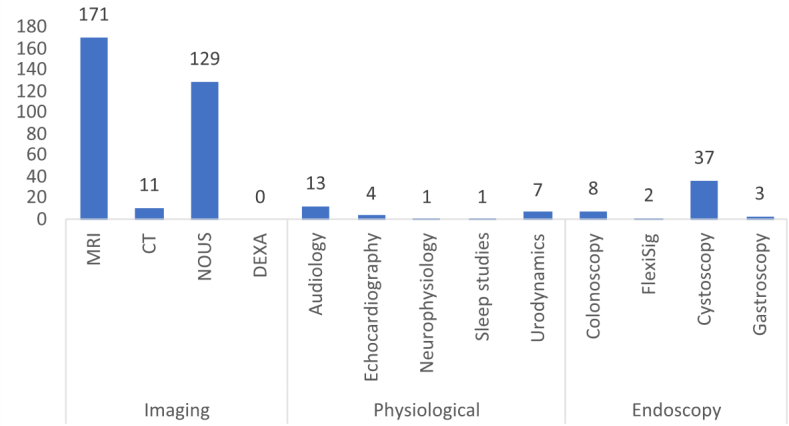


Target line set to Annual Plan Mar-27 Target (no more than 14.8%)

DM01 - % and # of patients waiting 6+ weeks | Apr-26



Patients waiting 13+ weeks for a diagnostic test | Apr-26



Understanding the performance (provisional)

- 4,291 (27.6%) patients were waiting over 6 weeks at the end of Apr-26. This continues performance that is common cause variation.
- The target remains achievable, although not consistently.
- 6 modalities are above the year end target. They account for 92% of all patients breaching 6 weeks at the end of April.
- NOUS still has the most patients over 6 weeks (74% of all 6-week breaches) followed by MRI, DEXA, Cystoscopy and Audiology.
- The number of patients waiting more than 13 weeks at the end of April has increased to 387 (from 257). With 171, MRI accounts for 44% of the patients reported as breaching 13 weeks at the end of the month.

Actions (SMART)

- **MRI** – Cardiac MRI is driving the current longest waiters exceeding 13 weeks due to insufficient core capacity to meet demand. The service have developed a recovery plan to address the backlog and maintain the position below 6 weeks through use of IS mobile. The proposal will be finalised and presented in May for approval. The routine and cancer work is continuing to be supported with an MRI mobile.
- **CT** recovery plan is now delivering a positive position.
- **NOUS –** Insufficient capacity and high referrals continue to be a challenge. The service has been unsuccessful with provision of WLIs to meet demand therefore an insourced solution has been proposed for short to medium term in order to support recovery of over 6 weeks waits. Review of increased demand (14%) underway to understand drivers and whether there are opportunities to support demand management initiatives.
- **Audiology** Volumes of adult demand are continuing to outstrip capacity, and the service are developing a plan to tackle current backlog.
- **Echocardiography –** Recovery plan has significantly improved position and continues to perform well.
- **Cystoscopy and urodynamics** – Continued use of waiting list initiatives to reduce backlog.
- **Dexascan** – Limited success with voluntary additional hours. Service is developing a proposal to increase core capacity by 2hrs per day.

Risks

- Risk to delivery of DM01 performance resulting from carve out of capacity to support cancer pathways e.g. urology prostate MRI – mitigated with additional mobile resource
- Risk to permanent recruitment to audiology vacancies.
- Insufficient capacity at subspecialty level such as cardiac CT and MRI resulting in waits exceeding 13 weeks.
- Volume of demand alongside a national shortage of sonographers impacting on capacity to deliver performance

OUR WORKFORCE

Ali Koeltgen

Chief People Officer

Recruitment

This months substantive funded establishment has increased at budget setting by 57.88 wte which is 49.93 wte in Medicine, 15.63 wte in Estates and Facilities, 10.79 wte in SCSD and 6.64 wte in Digital. Reductions have been transacted in Corporate, Women and hildrens and Surgery. Funded establishment at 7779.02 is 181.06 wte higher than M1 last year. We have recruited 81 new staff and have 33 more starters than leavers this month with increases in all clinical divisions.

Vacancy Rate

Our vacancy rate has increased to 7.25% (563.84 wte vacancies) which is directly due to increased establishment and is above the Trust target of 6.5%. Some vacancies are being held intentionally in line with the annual plan and a MARS scheme has been introduced to enable skills mix reviews of corporate/non-clinical posts.

Non-Clinical vacancies - We have 134.32 wte Admin and Estates vacancies (11.19%), 6.02 wte Managers vacancies (2.11%), and 20.79 wte other infrastructure support (7.23%).

Monthly Bank and Agency Spend

Temporary staffing spend remains a considerable challenge. There has been a 96.97 wte reduction in agency worked in April but a 0.77% increase in agency spend as a % of gross cost. We are 94.08 wte ahead of our 26/27 plan overall but 91.54 wte over for Agency worked. Medicine are outliers with 3.98% of gross cost. We are quartile 4 (worst) on Model Hospital (January 2026 rates).

Annual Staff Turnover

Our annual staff turnover has increased to 7.55% which continues to comfortably meet our target of 11.5% and is on an improving trajectory compared to rates of 9% last year. We benchmark well against other Trusts remaining at Quartile 1 (best) on Model Hospital (December 2025 rates). Estates and Facilities are outliers at 10.81%. All Divisions continue to comfortably meet the target.

Sickness Absence

Monthly sickness absence has reduced by 0.42% from last month to 5%. This is 0.05% better than the same month last year. The % of absence attributed to stress has reduced to 29.27% of total sickness. Women and Children are outliers with 40.48% of all absence attributed to stress (reduced). The highest sickness levels are in Estates and Facilities (reduced to 7.08% overall with 4.63% long term sickness which is very high. This group are historically higher nationally than other staff groups, but we remain in Quartile 4 on Model Hospital in September 2025 for Estates and Ancillary staff groups.

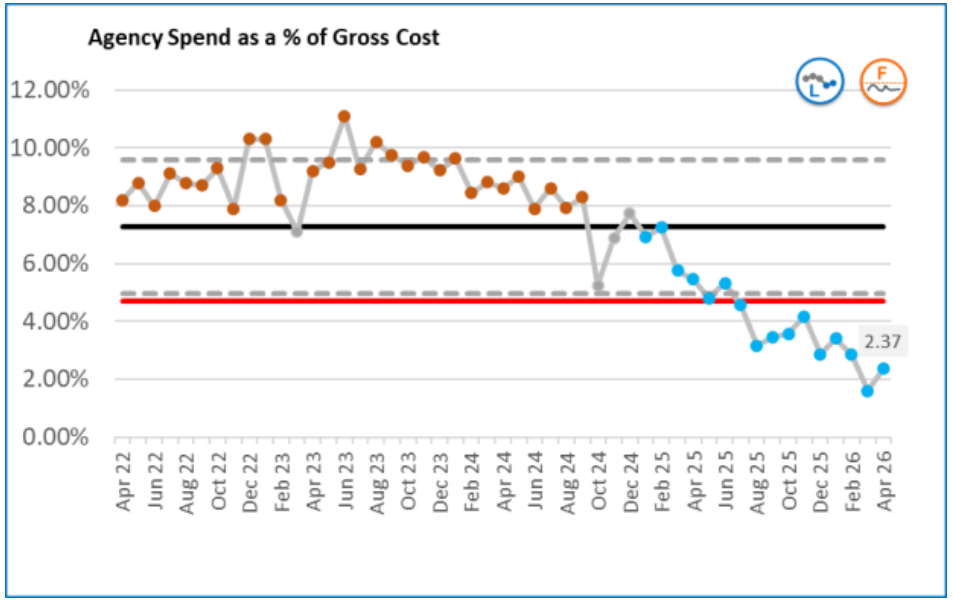
Job Planning

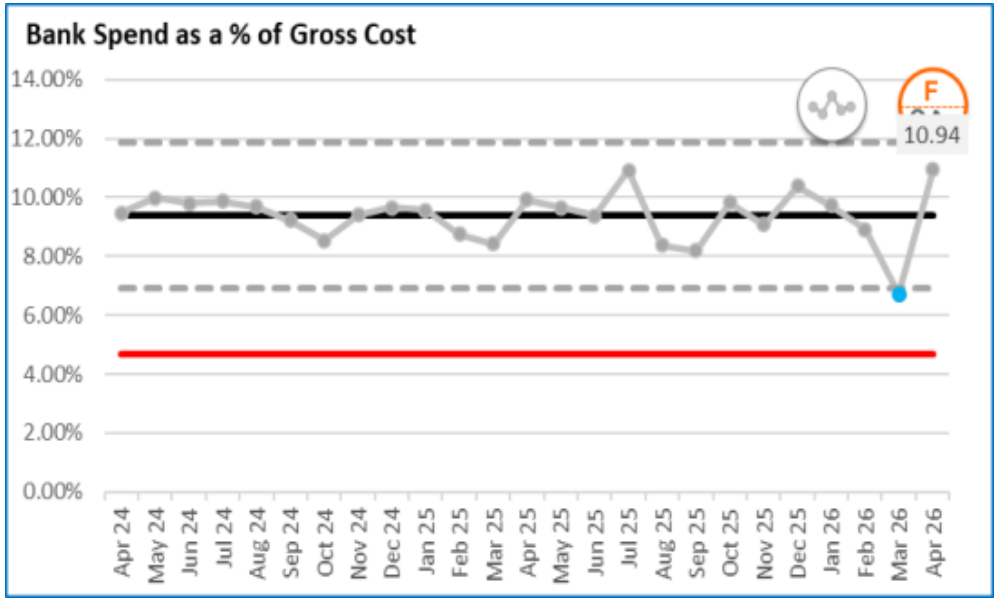
Consultant Job Planning has improved by 1% to 85% against target of 95%. SCSD are the only division to meet the target. Medicine are outliers despite a further 8% improvement to 75%.

OUR WORKFORCE PERFORMANCE – REDUCTION OF AGENCY SPEND

We are driving this measure because

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





Understanding the performance

There has been an increase in Agency spend in April to 2.37% of gross cost which meets target. This remains significantly better than last year when agency costs were 6.55% of gross cost. Work needs to continue to focus on reducing bank usage although this has increased to 10.94% this month.

Usage of HCA agency (NHSE mandate) continues to be low and is being closely monitored for impact and safety.

We continue to see a downward trend for agency usage, there now needs to be more focus on bank usage/spend as our M1 usage means that we are 91.54 wte adrift of our 26/27 plan for bank, although ahead of plan overall.

Actions

- We are developing a Trustwide CPIP scheme for 26/27 to capture and monitor all of the programmes of work to reduce bank and agency usage/costs.
- Continuing to identify long standing agency workers to migrate to trust or NHSP to support trust cost reduction targets.

Risks

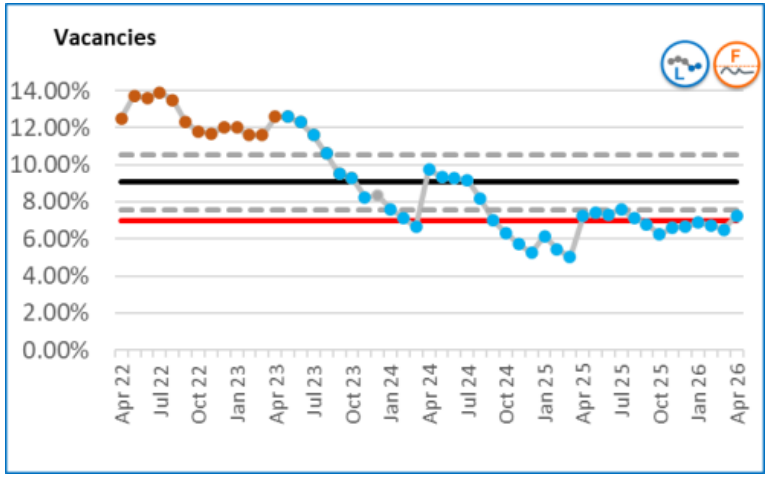
Retrospective agency bookings leading to inaccurate reporting on agency usage and spend.

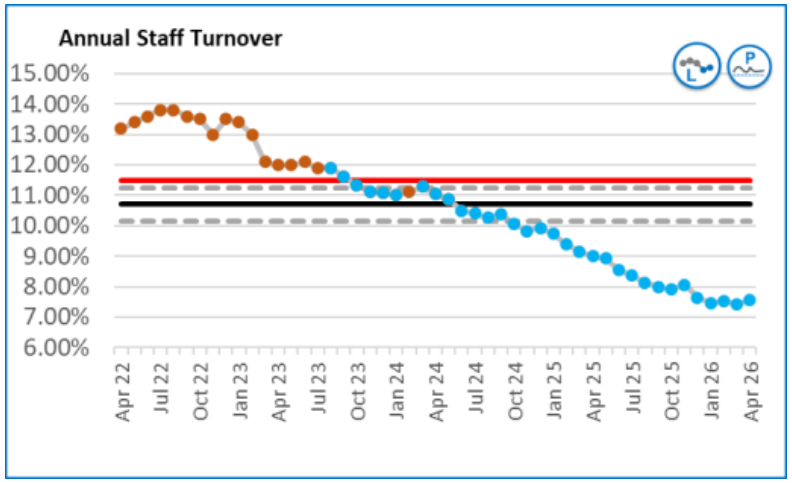
Ongoing risk to financial performance and compliance with the annual plan to reduce temporary staff by 40%.

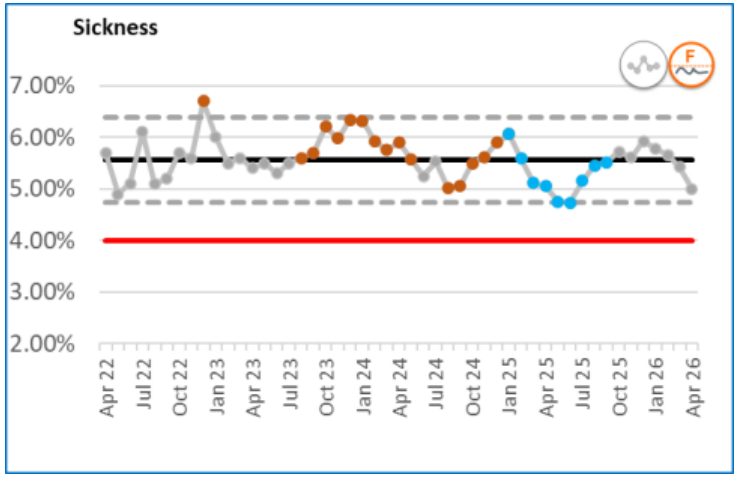
OUR WORKFORCE PERFORMANCE – VACANCIES, TURNOVER AND SICKNESS

We are driving this measure because

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







Understanding the performance

- **Trust-wide Vacancies -** Staff in Post has reduced by 3.50 wte to 7215.18 wte. *(NB. SIP will include staff who terminated on the last day of month who will not appear in the next months leavers, as well as changes in hours).* Our vacancy rate which has increased to 7.25%, against a target of 6.5%. Medicine have the highest clinical vacancy rate at 9.17% directly related to the increase in establishment. Digital has the highest vacancy rate with 10.51% which is due to a 6.64 wte increase in establishment at budget setting.
- **Starters and Leavers** - We have 33 more starters than leavers this month. We have processed 81 new starters in month (headcount) and 48 leavers.
- **Annual Staff Turnover** continues to comfortably meets our 11.5% target at 7.55% which is 1.45% better than the same period last year and benchmarks well against the Group.
- **Monthly sickness absence** has reduced by 0.42% to 5.00% which is 0.05% lower than last year. There has been reduced sickness absence in all divisions except Digital which is a small division with very low sickness. Estates and Facilities are outliers with 7.08% (reduced). This KPI continuously fails to reach the target and is showing common cause variation.
- **Healthcare Support Workers Vacancy rate** is 10.49% (123.31 wte vacancies).

Actions (SMART)

- An **Attendance Programme Board** is being set up to more closely review sickness absence management.
- **Continued Support** is being offered to staff through Occupational Health, Staff Support, Employee Assistance Programme (EAP) and Wellbeing interventions.
- **Targeted intervention meetings** implemented with managers in areas of highest sickness absence levels, with support from the HR Advisory team. Identifying hotspot areas and getting back to basics to ensure processes are in place to manage absence effectively within a timely manner as well as providing drop-in sessions for managers.
- **Trigger reports** have been discussed at divisional meetings to drive compliance with policy and ensure sickness is appropriately addressed
- **Our recruitment should be slowing** down to align with annual plan. Starters in Corporate areas do not exceed leavers and a MARS scheme has been launched aimed at reducing non-clinical headcount.

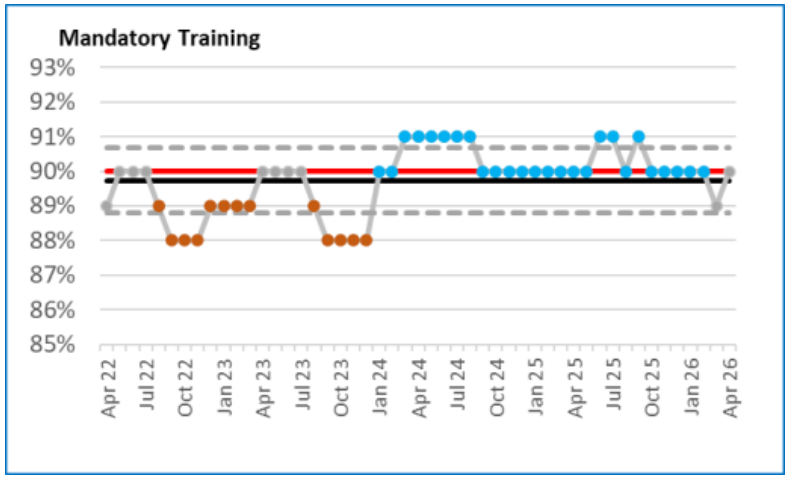
Risks

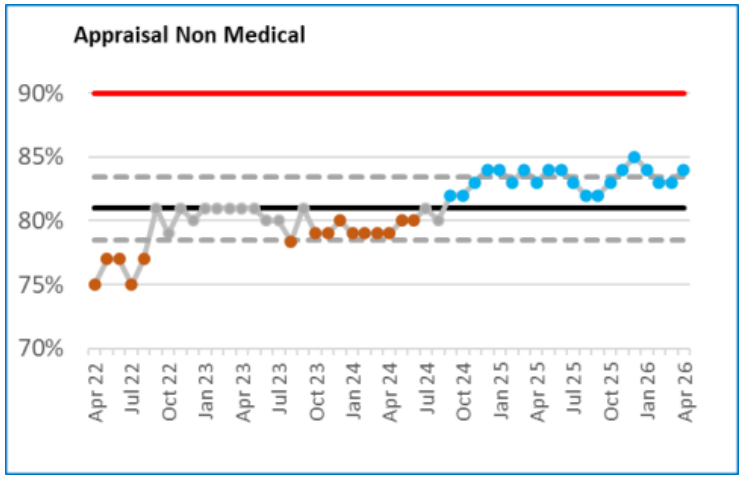
Performance to Plan Our new 2026/27 plan has been submitted. We are 94.08 wte ahead of plan overall. Although improved, Medicine and Surgery continue to use more wte than their establishment (98 wte and 77 wte respectively). Increases are likely to be due to continued level 4 escalation and covering vacancies for newly established posts in Medicine.
Sickness for Estates and Ancillary Staff Group continues to be very high despite reduction to 7.37%. This staff group has historically higher sickness across the NHS and we are in Quartile 4 on Model Hospital (September 2025 data). HCA sickness is also high at 6.52%. Prof and Tech, AHPs and Medical and Dental are the only staff groups to meet the 4% Group target.
Absence due to stress remains high although reduced this month. Women and Children's are significant outliers with 40.48% of all sickness attributable to stress (reduced).

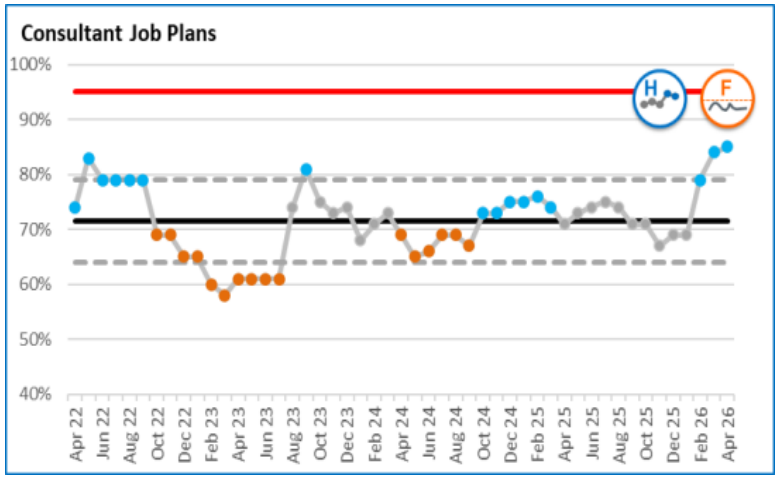
OUR WORKFORCE COMPLIANCE – MANDATORY TRAINING, APPRAISAL & JOB PLANNING

We are driving this measure because

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







Understanding the performance

Overall Mandatory Training has improved to 90%. This is against a Model Hospital average of 91.6% (revised 2024/25 rates). We are Quartile 2 (good) on Model Hospital. Women and Children's Division are outliers at 86% (unchanged for the second month running). Surgery and Medicine are also below target. All other divisions meet the target of 90%.

Appraisal Rate has improved to 84% against a target of 90% which is 1% higher than last year. Corporate are outliers although improved to 68%, followed by Women and Children's at 81%. Corporate, Digital and Medicine have improved by 2%, but Estates and Facilities have dropped by 2% to 84%. Medical appraisal rates are good although dropped to 92%.

Consultant Job Planning has increased to 85% against target of 95%. SCSD are the only division to meet the target. Women and Children's have dropped to 89%. Medicine are outliers at 75%. This KPI failed to reach the target but is showing special cause of improving nature.

Actions (SMART)

Compliance against the NHSE national **job plan target of 95%** is reported via the Provider Workforce Return on a monthly basis.

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

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

Risks

Medical and Dental are outliers for Mandatory Training at 78% (unchanged). All other Staff groups meet the 90% Trust target

Poor Appraisal rates raises concerns that some staff are not meeting regularly with their manager.

Corporate remain **outliers** for Appraisal with 68% (improved by 2%).

Consultant Job Plans have improved to 85% against the NHSE monitored target of 95%. Poor or irregular job planning may mean that clinic and theatre capacity is not fully utilised.

OUR FINANCIAL PERFORMANCE

Katie Osmond

Interim Chief Finance Officer

Financial Plan 2026/27

A balanced plan was submitted for 2026/27, this included Non-Recurrent System Deficit Support funding of £42.2m and £57.1m of Cost Improvement (CPIP) (6.8% of Operating expenditure).

Income & Expenditure – Our reported position for M1 is a **£2.7m deficit against a £2.1m deficit plan, an adverse variance of £0.6m** driven primarily by costs of Industrial Action and under achievement of CPIP requirement partially offset by an underspend against the growth reserve.

- **Income is £1.1m favourable to plan for M1** – key favourable variances include: £0.6m impact of higher pay award than plan offsetting pay costs below; £0.3m overperformance against the activity plan; £0.2m on pass through drugs and devices. This is partially offset by unachieved CPIP (£0.1m). **At this point we have assumed continued receipt of Deficit Support Funding despite being off plan in M1.**

- **Employee expenses are £2.0m adverse to plan for M1 -** adverse variances include: £0.4m of undelivered CPIP (including £0.3m of elective growth reserve); £0.6m impact of higher pay award than plan offset by Income above; £0.4m Industrial Action costs. This is partially offset by £0.3m of unspent other growth reserve (noting that the M1 allocation of the growth reserve cannot be spent to deliver future months activity).

- **Operating expenses excluding Employee Expenses are £0.3m favourable to plan for M1 -** adverse variances include: £0.1m of pass-through drugs and devices; £0.4m of tariff drugs driven by prescribing patterns and activity; and the remainder due to increased non pay costs of other activity across multiple Divisions. This is partially offset by the favourable variance of £0.2m CPIP over delivery (including £0.3m of growth reserve which cannot be spent to deliver future months activity); £0.3m of growth reserve.

Capital – The YTD capital spend at Month 1 is £49k, the majority of which has been on the ALEX Fire Scheme (£66k), and equipment purchases (£60k) offset by VAT Credits in the year (£137k). The capital plan for 26/27 is set at £40,489k, including £16,818 of internal funds, £23,314k of PDC funding and £357k for IFRIC 12.

Cash – The Trust cash position at the end of Month 1 was £4.479m. As at 31 March 2026, the Trust held £12.200m of PDC capital funding, of which £7.4m had been utilised to settle revenue creditors. A further £5.758m was paid in April, with the remaining £6.442m scheduled for payment in May and June 2026. Revenue creditor payments were reduced in April to facilitate these payments and will continue to be reduced in May and June. Due to the timing of the final plan submission, the Deficit Support Funding of £42.194m was not received in April, the Trust has had notification that April and May's DSF will be received in May (£7.032m). **Cashflow modelling indicates cash support will be required in June**. There is a risk of reduced access to Deficit Support Funding which would further challenge cash availability and is being closely monitored.

Clinical Coding – April coding is at 100% on the 10th working day. Total of FCE's for April was 15,224 compared to 16325 in March.

FINANCE HEADLINES

M1 deficit **£2.7m** against a £2.1m deficit plan

Agency spend for M1 **£1m** against £1.2m planned spend

Bank spend for M1 **£4.8m** against £3.7m planned spend

Capital spend **£49k** in M1

CPIP **£2m** delivered against £2.6m target

Deficit support funding of £3.5m included in M1 position

Productivity Cost per unit of clinical output (WAU) **improvement of 1.0%** on last yr

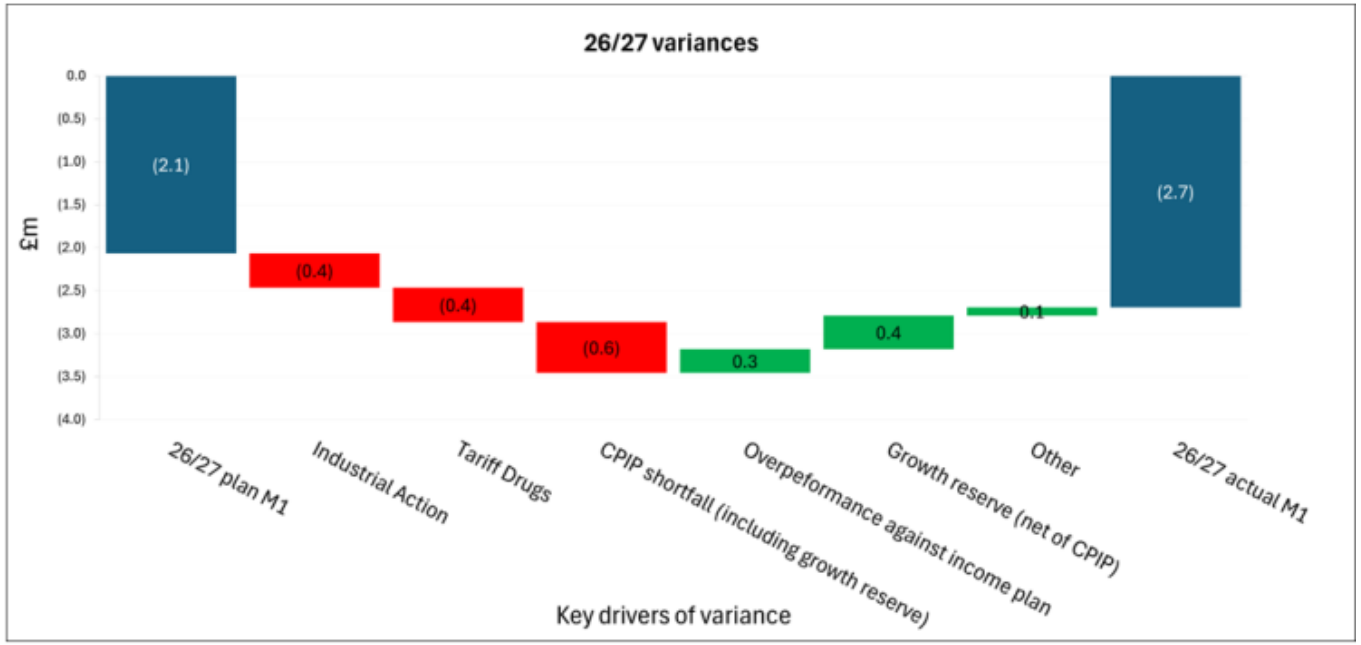
BPPC – Invoices Paid < 30 days (% volume) April: **60%** against 95% target

BEST USE OF RESOURCES – INCOME & EXPENDITURE

We are driving this measure because

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

Statement of comprehensive income	Apr-26 Plan £'000	Apr-26 Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Income from Patient Care Activities	64,083	65,197	1,114
Other Operating Income	3,238	3,248	10
Employee Expenses	(42,280)	(44,255)	(1,975)
Operating Expenses exc Employee Expenses	(24,919)	(24,615)	304
OPERATING SURPLUS / (DEFICIT)	**121**	**(426)**	**(547)**
FINANCE COSTS			
Finance Income	129	134	5
Finance Expenses	(792)	(819)	(27)
PDC dividends payable/refundable	(519)	(520)	(1)
NET FINANCE COSTS	**(1,182)**	**(1,205)**	**(23)**
Other Gains and (Losses)	0	(9)	(9)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(1,061)**	**(1,640)**	**(579)**
Add back all I&E impairments/(reversals)	0	0	0
Surplus/(deficit) before impairments and transfers	**(1,061)**	**(1,640)**	**(579)**
Remove capital donations/grants/peppercorn lease I&E impact	17	19	2
Remove PFI revenue costs on an IFRS 16 basis	3,071	3,536	465
Add back PFI revenue costs on a UK GAAP basis	(4,092)	(4,610)	(518)
Adjusted financial performance surplus/(deficit)	**(2,065)**	**(2,695)**	**(630)**



*£0.5 of growth reserve has been allocated to CPIP reducing the adverse reported CPIP variance to £0.6m

Understanding the performance

In M1 we report a £2.7m deficit against a £2.1m deficit plan, an adverse variance of £0.6m against plan.

Adverse variances driven primarily by costs of Industrial Action and under achievement of CPIP requirement partially offset by an underspend against the growth reserve.

Actions (SMART)

The Trust is currently mobilising a Financial Improvement Taskforce to deliver sustainable financial improvement at pace and strengthen financial leadership and accountability. During May the Taskforce will identify membership of the group, agree scope, define governance structures and streamline the CPIP process. Once this process is complete the Taskforce will move on to prioritising opportunities from benchmarking data and resource planning to deliver against those opportunities.

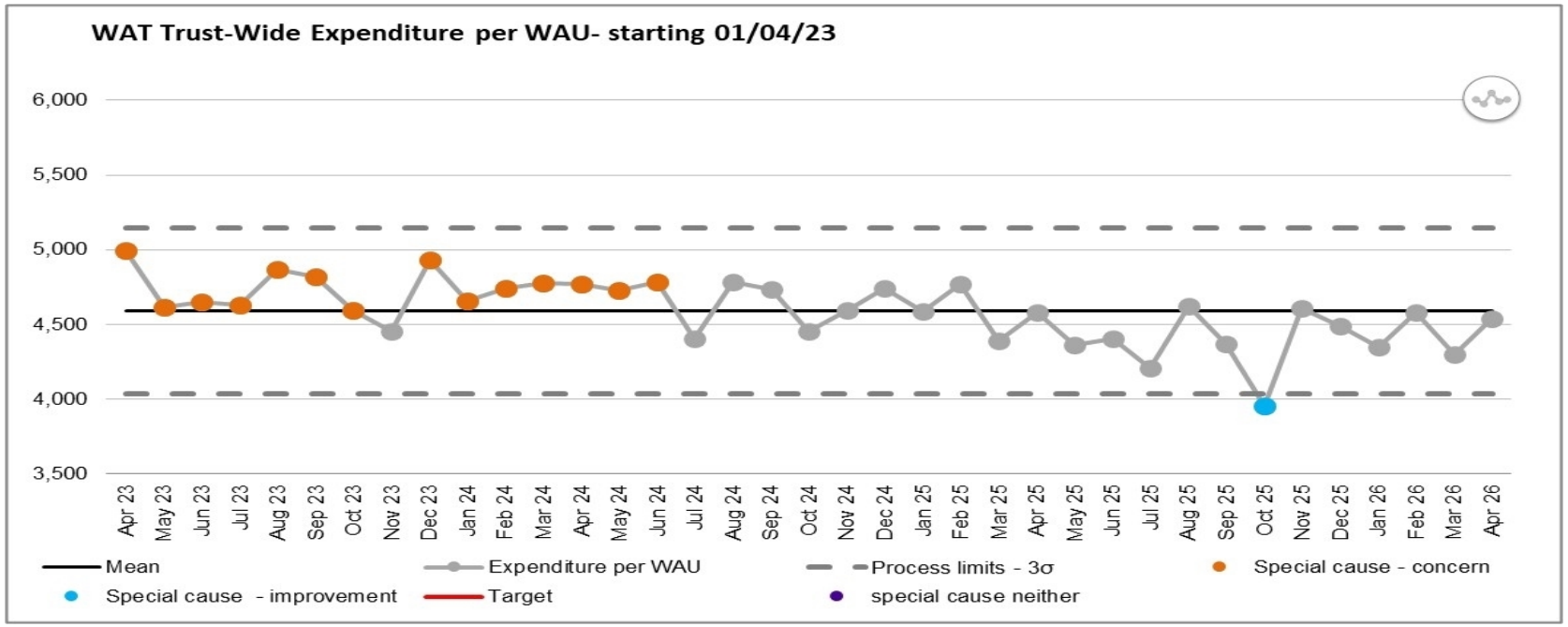
Risks

At this point we have assumed continued receipt of Deficit Support Funding despite being off plan in M1, should this be removed the deficit would increase by £3.5m in month.

BEST USE OF RESOURCES – ADJUSTED EXPENDITURE PRODUCTIVITY TREND

We are driving this measure because

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



Monthly Movement

	Mar - Apr	Adjusted for Working Days
Exp per WAU	5.4%	-0.8%
Expenditure	-1.9%	-1.9%
WAU	-7.0%	-1.1%

YTD Movement compared to 2025/26

Exp per WAU	-1.0%
Expenditure	2.2%
WAU	3.2%

Costing Team Update

- Updated chart to April 2023. this allows better comparison to more recent years

Understanding the performance

For April, our **cost per WAU is 5.4% higher than March, though driven by decreased days.** It's 0.8% lower when allowing for working days. This is driven by decrease in all Elective, down by 8-10% in line with volume of working days.

Compared to 25/26 the expenditure per weighted activity is 1% lower. Indicating that productivity has increased year on year. This is driven by increased ED (up 12%) , Elective Inpatients (up 12%) and a more complex mix of procedures, Emergency inpatients (up 4%) and Outpatients (up 4%). This is delivered while expenditure has increased after adjustment for inflation.

Actions (SMART)

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

Risks

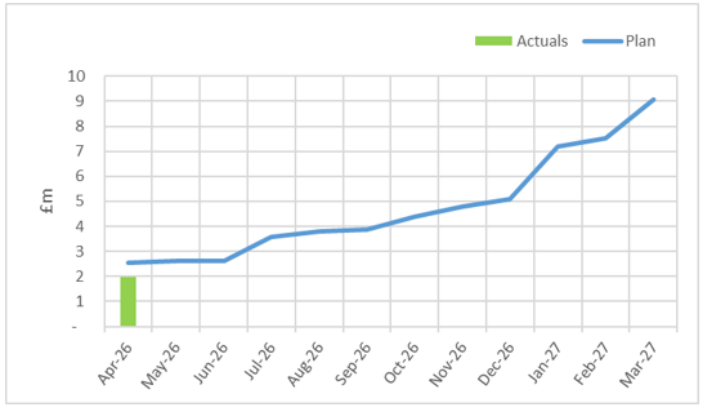
Risks are that unless the trust can reduce expenditure whilst also increasing activity levels than financial and performance targets will be missed.

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

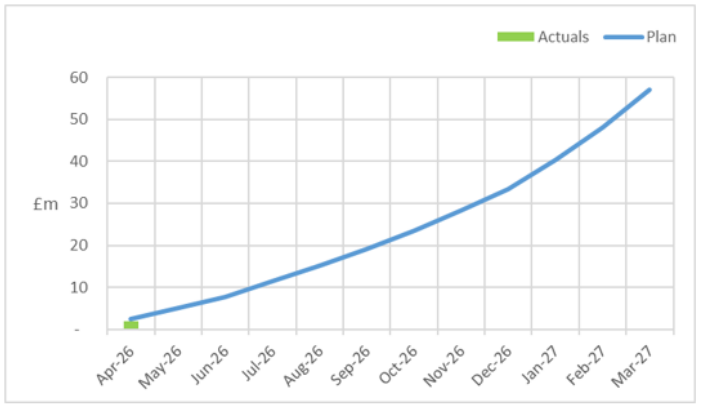
We are driving this measure because

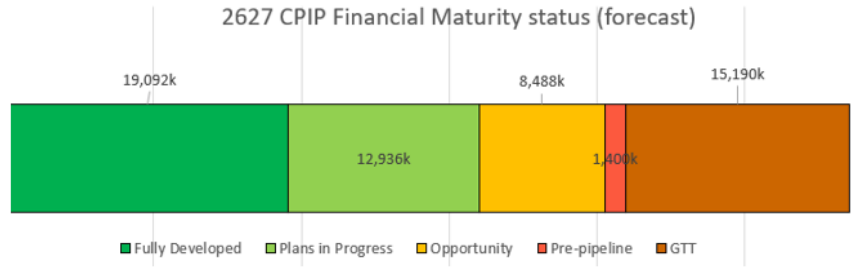
If the Trust fails to identify recurrent Cost and Productivity Improvement Plans (CPIP) and put in place sufficient resources and governance arrangements to drive delivery, then it will not achieve financial sustainability.

YTD CPIP achieved
vs plan target (£57.106m) month



YTD CPIP achieved
vs plan target (£57.106m) cumulative





Understanding the performance

M1 delivered actuals of £1.970m against a plan of £2.560m, an under delivery of £0.590m.

M1 actuals comprised £1.847m recurrent and £0.123m non-recurrent.

Actions (SMART)

The Trust is continuing to identify and develop CPIPs for delivery in 26/27 to mitigate the unidentified (GTT in the illustration above) which is currently £15.190m. A number of scheme opportunities have been identified and will be progressed to improve the overall position.

The Trust CPIP performance is subject to weekly reporting to NHSE.

Risks

Delivery of the 26/27 target is challenging, as evidenced by the performance in M1. Work is continuing to develop existing schemes as well as identifying further cost saving which is being carried out in collaboration with Trust Executives

BEST USE OF RESOURCES – CAPITAL

We are driving this measure because

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

Trust Capital Position at M1 – Actuals vs Available Funding

Workstream	Scheme	YTD Actual
Digital	Additional Digitial Schemes	-7,784.62
Digital	CAP2425 Cardiac PACS	35,883.17
Digital	Cyber Improvement PDC	0.00
Digital	Digital rev to cap transfer	0.00
Digital	Externally Funded Constitutional Schemes	217.32
Digital	Frontline Digital	0.00
Digital	LIMS	0.00
Digital	LIMS Pathology	-7,980.14
Equipment	Equipment Schemes	-5,367.21
Equipment	Externally Funded Constitutional Schemes	0.00
Equipment	LINACS WRH Replacement	483.60
Other	Contingency Shcheme	13,116.53
Other	Donated Equipment Schemes	157.24
Other	IFRIC 12 and other contingency	9,856.19
Other	P&W Scheme Funded by Charity	614.04
P&W	2025/26 P&W Scheme	-51,489.65
P&W	Externally Funded Constitutional Schemes	1,039.49
P&W	Internally funded Fire Scheme	6,477.59
P&W	National Funding Fire Scheme	66,314.00
P&W	P&W Backlog Maintenance	8,091.79
Strategic	2025/26 Strategic Scheme	-3,069.84
Strategic	Acute Service Review	505.22
Strategic	B/F Strategic Scheme	427.95
Strategic	Externally Funded Constitutional Schemes	-54,957.19
Strategic	National Diagnostics - Cath lab	733.60
Total		**48,529.08**

Understanding the performance

The 2026/27 Capital spend in M1 is £49k.

With a lot of spend originally planned for early 26/27 being brought forward and spent at the end of the 25/26 financial year, initial spend in the new financial year has been slow.

There have been a number of VAT Credits included which has reduced net spend in month worth £137k.

Spend in month relates to the Fire scheme (£66k) and Equipment purchases (£60k) offset by the VAT Credits as noted.

Actions (SMART)

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

Risks

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

BEST USE OF RESOURCES – CASH

We are driving this measure because

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

The Trust cash position at the end of Month 1 was £4.479m.

As at 31 March 2026, the Trust held £12.2m of PDC capital funding, of which £7.4m had been utilised to settle revenue creditors. A further £5.758m was paid in April, with the remaining £6.442m scheduled for payment in May and June 2026. Revenue creditor payments were reduced in April to facilitate these payments and will continue to be reduced in May and June.

Following the final submission of the 2026/27 plan, the Trust will be in receipt of £42.194m Deficit Support Funding. Due to the timing of the final plan submission, the Deficit Support Funding of £42.194m was not received in April, the Trust has had notification that April and May's DSF will be received in May (£7.032m).

Understanding the performance	Actions (SMART)	Risks
The Trust cash position at the end of Month 1 was £4.479m. The cash position is monitored daily, which includes the agreed debtors and creditors to ensure payroll costs are prioritised.	The Trust had initially applied for £15.5m of Provider Revenue Support for March; however following discussions with the ICB and the Regional finance leads the application was withdrawn and DSF was received for £11.8m for Q4 2025/26. The remaining cash shortfall of £3.7m will be managed through existing tight controls of our supplier payments to ensure sufficient cash is available to cover the payroll c£40m.	The Trust cash flow is based on the final plan submitted on 26 March 2026 and assumes the CPIP programme is delivered from month 1, April 2026 and the Deficit Support Funding of £42.2m will be received in full for 2026/27. Suppliers may put the Trust on stop if payments terms are not adhered to, which in turn will jeopardise supplies and services to the Trust for patient care. To ensure that the Trust meets it payroll obligations and continues to pay its creditors within their payment terms, it will need to apply for Provider Revenue Support if the CPIP programme is not delivered as noted above. We anticipate needing to make an application for support in June.

Worcestershire Acute Hospitals NHS Trust

Trust Key Performance Indicators (KPIs) - up to Apr-26 data

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

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

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

Example

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

NHS Worcestershire Acute Hospitals NHS Trust

Quality of care, access and outcomes		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Latest Month Numerator	Latest Month Denominator	Year to Date (v Standard if available)	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Cancer	% of patients told their cancer diagnosis outcome within 28 days (all routes) ***NHSE NOF***	Chief Operating Officer	**80%**	74.6%	70.0%	75.4%	77.2%	75.9%	74.0%	80.1%	80.4%	75.8%	63.7%	77.2%	72.2%		2,047	2,836	74.7%		79.4%	Mar-26			
	% of patients receiving their first or subsequent treatment for cancer within 31 days of decision to treat / earliest clinically appropriate date (all routes)	Chief Operating Officer	**96%**	87.4%	84.7%	84.4%	79.6%	83.3%	80.8%	83.3%	85.8%	87.3%	82.9%	89.1%	83.1%		443	533	84.2%		92.8%				
	% of patients receiving their first definitive treatment for cancer within 62 days of referral (all routes) ***NHSE NOF***	Chief Operating Officer	**75%**	64.5%	57.4%	58.5%	57.3%	65.1%	54.5%	60.2%	61.1%	66.5%	58.4%	57.3%	57.2%		192	336	59.8%		72.8%				
	% of suspected cancer referrals waiting >62 days	Chief Operating Officer	**Plan**	8.6%	10.3%	9.8%	9.8%	11.5%	9.1%	10.4%	9.3%	12.1%	12.2%	11.8%	10.9%	11.1%									
Urgent and emergency care	% of ambulance handovers within 45 minutes	Chief Operating Officer		65.9%	71.7%	80.8%	84.2%	81.4%	65.8%	65.2%	74.8%	72.7%	59.6%	75.1%	83.4%	87.1%	3,219	3,859	73.2%						
	% of patients seen within 4 hours (any type) ***NHSE NOF***	Chief Operating Officer	**76%**	60.9%	65.1%	66.1%	66.5%	64.5%	63.0%	62.4%	62.7%	59.9%	62.9%	67.1%	71.5%	69.6%	6,134	20,167	69.6%		76.9%	Apr-26			
	% of patients seen within 4 hours (type 1)	Chief Operating Officer		44.5%	49.3%	50.9%	50.8%	49.5%	47.7%	48.0%	49.1%	47.1%	49.4%	54.8%	59.6%	56.6%	8,541	14,331	49.9%		63.8%				
	% of patients spending more than 12 hours in A&E ***NHSE NOF***	Chief Operating Officer	-	13.0%	10.8%	10.1%	8.9%	10.3%	12.3%	12.9%	11.9%	12.3%	13.2%	10.7%	7.5%	11.6%	1,641	20,497	13.2%		12.2%				
Elective care	Referral to Treatment - % of open pathways waiting < 18 weeks ***NHSE NOF***	Chief Operating Officer	**92%**	59.3%	59.8%	59.9%	59.1%	58.5%	59.3%	58.9%	57.5%	57.9%	57.3%	58.7%	62.6%	62.3%	35,648	57,248			62.5%				
	Referral to Treatment - % of non-admitted pathways waiting < 18 weeks for their first outpatient appointment	Chief Operating Officer		63.1%	63.1%	62.2%	59.1%	58.5%	58.8%	58.4%	57.4%	57.5%	58.8%	60.7%	65.6%	67.6%	-	-			-	Apr-26			
	Referral to Treatment - % of open pathways waiting > 52 weeks ***NHSE NOF***	Chief Operating Officer		1.65%	1.66%	1.72%	1.66%	1.57%	1.49%	1.51%	1.34%	1.24%	1.32%	1.42%	1.37%	1.45%	818	57,248			1.7%				
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	21	24	22	18	18	25	47	22	5	4	4	6	5					6,726				
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	104%	105%	105%	100%	95%	100%	97%	106%	98%	107%	104%	117%	103%	21,499	20,791	53%						
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	107%	106%	105%	103%	97%	102%	100%	105%	97%	107%	102%	113%	106%	63,457	59,876	6%						
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	106%	108%	98%	98%	98%	96%	97%	100%	95%	101%	97%	104%	102%	7,913	7,747	52.35%						
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	83%	84%	84%	83%	83%	83%	82%	84%	81%	84%	85%	85%	87%			87%		81%	Feb-26			
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)	Chief Operating Officer	-	40	37	55	50	21	46	32	36	50	40	61	42	44			44		21,456	Q3 25/26			
	Waiting Times - Diagnostic Waits >6 weeks ***NHSE NOF***	Chief Operating Officer	**<15%**	16.8%	16.2%	21.0%	24.9%	26.4%	24.9%	28.1%	27.4%	29.6%	27.6%	21.7%	24.5%	27.6%	4,291	15,540			21.2%	Mar-26			
Maternity	% of women who have been booked to see a midwife by 9 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	37%	37%	42%	47%	42%	49%	54%	55%	56%	50%	66%	65%	64%	277	433	64%						
	Maternity Activity (Deliveries)	Chief Nursing Officer		384	403	420	432	419	450	441	373	402	372	388	383	374			374						
Outpatient transformation	Missed outpatient appointments (DNAs) rate	Chief Operating Officer	**<4%**	4.5%	4.7%	5.0%	5.2%	4.9%	5.1%	5.2%	4.8%	5.0%	5.1%	4.6%	4.5%	4.6%	2,972	65,237	4.6%		6.5%	Mar-26			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	89%	90%	90%	89%	89%	89%	89%	90%	88%	88%	90%	90%	90%	4,106	40,181	90%						
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	109%	108%	105%	105%	98%	103%	102%	104%	97%	107%	101%	111%	107%	41,958	39,085	55.07%						
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	18%	18%	17%	17%	18%	18%	18%	18%	19%	19%	18%	18%	18%	11,557	63,516	18%		18%	Mar-26			

Prevention long term conditions	Maternity - Women who were smokers at time of delivery (SATOD)	Chief Nursing Officer	-	3.9%	6.5%	5.7%	4.4%	5.0%	4.4%	4.1%	4.0%	3.2%	3.5%	2.1%	2.3%	4.5%	17	374	4.5%							
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	96%	96%	95%	94%	93%	94%	94.5%	94.6%	93.4%	96.3%	95.5%	95.3%	95.0%	788	827	95%		95%	Mar-26				
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	55	62	46	60	52	55	53	56	61	58	38	64	50			660		4,549	Mar-26				
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	7.3	7.4	7.3	7.0	6.7	7.1	7.24	6.92	6.58	6.88	7.52	7.8	7.85	22412	2856	7.9		4.4	Feb to Jan				
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	3.1	3.1	3.3	2.5	3.6	3.4	3.16	3.7	3.63	3.29	3.84	3.4	3.96	1792	452	3.96		3.1					
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	12%	14%	16%	15%	15%	12%	12%	12%	11%	14%	16%	16%	15%	116	790	15%		23.1%	Dec				
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	4.65%	4.87%	4.62%	4.73%	4.67%	4.69%	4.44%	4.84%	4.86%	5.01%	4.84%	6.73%	7.32%	660	9021	4.9%		7.5%	Jan to Dec				
	Mortality SHMI - Rolling 12 months ***NHSE NOF***	Chief Medical Officer	**100**	110.71	110.55	111.77	111.51	111.51	112.19	111.00	110.04	107.99								As expected						
	MRSA Bacteraemia ***NHSE NOF***	Chief Nursing Officer	**0**	1	0	0	1	1	2	0	0	0	0	0	0	0			5							
	Number of external reportable >AD+1 clostridium difficule cases ***NHSE NOF***	Chief Nursing Officer	**78**	4	8	11	10	11	14	12	8	13	5	10	8	9			114							
	Number of falls with moderate harm and above	Chief Nursing Officer		3	4	4	4	3	4	1	1	1	2	5	4	4			36							
	VTE Risk Assessments	Chief Medical Officer	**95%**	91%	91%	91%	91%	92%	93%	93%	91%	92%	93%	94%	94%	93%	11,024	11,906	93%							
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	**80%**	47.5%	57.1%	57.9%	65.2%	67.3%	77.8%	62.5%	68.7%	66.7%	79.0%	68.3%	48.1%	81.1%	43	53	81%							
	Complaints resolved within policy timeframe	Chief Nursing Officer	**85%**	64%	69%	78%	54%	79%	67%	63%	65%	64%	56%	64%	63%	57%	32	56	67%							
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	**95%**	84%	81%	85%	84%	80%	80%	82%	81%	82%	84%	93%	89%	85%	2,304	2,723	84%		80%					
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	**95%**	96%	96%	96%	96%	95%	96%	97%	95%	95%	96%	94%	94%	94%	5,905	6,267	95%		95%	Mar-26				
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	**95%**	98%	93%	96%	97%	96%	97%	94%	94%	95%	97%	95%	97%	96%	75	78	96%		92%					
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**20%**	13%	25%	16%	24%	19%	18%	16%	15%	12%	17%	16%	21%	18%	2,723	15,318	84%							
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	32%	36%	35%	36%	31%	31%	38%	33%	32%	23%	37%	55%	53%	6,276	11,822	36%							
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	26%	21%	11%	23%	18%	14%	14%	17%	10%	11%	18%	18%	10%	78	828	15.0%							

People		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Latest Month		Year to Date	Latest Available Monthly Position		SPCs		DQ Mark
																	Numerator	Denominator		Latest month v benchmark	National or Regional	Pass/ Fail	Trend Variation	
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6%**	6.6%	4.8%	5.3%	4.6%	3.2%	4.6%	3.6%	4.1%	2.9%	3.4%	2.9%	1.6%	2.4%			2.4%					
	Appraisals - Non-medical	Chief People Officer	**90%**	83.0%	84.0%	84.0%	83.0%	82.0%	82.0%	83.0%	84.0%	85.0%	84.0%	83.0%	83.0%	83.0%	5,498	6,584	83.0%					
	Appraisals - Medical	Chief People Officer	**90%**	96.0%	96.0%	94.0%	94.0%	94.0%	93.0%	96.0%	95.0%	96.0%	94.0%	94.0%	94.0%	96.0%	591	640	96.0%					
	Mandatory Training	Chief People Officer	**90%**	90.0%	90.0%	91.0%	91.0%	90.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	89.0%	90.0%	80,862	90,290	90.0%					
	Overall Sickness	Chief People Officer	**4$%**	5.1%	4.8%	4.7%	5.2%	5.5%	5.5%	5.7%	5.6%	5.9%	5.8%	5.7%	5.4%	5.0%	10,799	216,067	5.0%					
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**12%**	9.0%	8.9%	8.6%	8.4%	8.1%	8.0%	7.9%	8.1%	7.7%	7.5%	7.5%	7.4%	7.6%	492	6,513	7.6%					
	Vacancy Rate	Chief People Officer	**8%**	7.2%	7.4%	7.3%	7.6%	7.1%	6.8%	6.2%	6.6%	6.6%	6.9%	6.7%	6.5%	7.3%	564	7,215	7.3%					

Finance and Use of Resources		Responsible Director	Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Latest Month		Year to Date	Latest Available Monthly Position		SPCs		DQ Mark
																	Numerator	Denominator		Latest month v benchmark	National or Regional	Pass/ Fail	Trend Variation	
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	**≥0**	-£3,631	-£3,063	-£2,149	-£339	-£2,292	-£745	£2,773	-£4,741	-£2,037	-£6,266	£3,417	£7,056	£2,695			£2,695					
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	-5.7%	-4.8%	-3.3%	-0.5%	-3.6%	-1.1%	-5.7%	-7.2%	-3.0%	-9.9%	4.8%	7.0%	-3.9%			-3.9%					
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£221	-£68	£141	£199	-£40	£23	-£12	-£6,148	-£3,559	-£8,366	£1,725	£4,310	£630			£630					
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	6.0%	2.0%	-6.0%	-38.0%	2.0%	-3.0%	0.0%	-437.0%	-234.0%	-398.0%	102.0%	157.0%	31.0%			31.0%					
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£593	£147	-£152	-£563	-£2,833	-£489	£2,346	-£4,574	-£4,190	-£4,411	-£2,654	£1,404	£591			£591					
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	-£2,294	-£1,983	-£2,215	-£1,988	-£1,275	-£1,404	-£1,501	-£1,825	-£1,234	-£1,460	-£1,186	£1,186	£1,043			£1,043					
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	5.5%	4.8%	5.3%	4.6%	3.2%	3.4%	3.6%	4.2%	2.9%	3.4%	2.8%	1.6%	2.4%			2.4%					
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£664	£328	-£378	£1,420	£11	£1,489	-£1,204	-£2,069	-£2,122	-£1,544	-£991	£4,866	-£4			-					
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£21.887m	£21.443m	£17.673m	£18.698m	£15.859m	£6.160m	£6.39m	£4.638m	£4.478m	£10.678m	£10.143m	£7.388m	£4			-					
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	92%	94%	94%	92%	90%	91%	90%	98%	90%	82%	75%	72%	79%			-					
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	91%	94%	91%	82%	90%	92%	94%	96%	89%	83%	71%	67%	60%			-					

Escalation and Assurance Report

Report from: Quality Governance Committee
Date of meeting: 30 April 2026
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Urgent and Emergency Care (UEC) Quality and Safety Report**
Rating rationale	Improvement work commenced in January at WRH and there were early indications of a positive impact on flow, crowding, patient experience and ownership of care. There had been an associated improvement in FFT scores and reduction in complaints and PALS contacts. Incident reporting indicated a strong safety culture and IPC standards compliance was positive. Pressures remained high, however, and there were 7 extreme risks (score of 15+), including two new risks both relating to the Alexandra Hospital Emergency Department (ED). Ambulance handover times had much improved but were difficult to sustain during times of high pressure. A UEC Recovery Programme Board was now in place with non-executive membership. There were clear differences between performance at the two sites and work was needed to understand the drivers of this and to share learning, particularly about flow between ED and SDEC.
Outcome	The Committee remained concerned about the high risks associated with the service but welcomed the early signs of improvement.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Perinatal Incident Report Q4 2025/26**
Rating rationale	One PSII had been completed resulting in a Trust-wide medicines management action plan. There were six incidents involving moderate harm or above. Duty of Candour was being completed in each case. Learning had been shared more widely in relation to four incidents. There were five stillbirths and four neonatal deaths. Reviews had been undertaken to identify any immediate actions required ahead of the PMRT process. The 12-month rolling mortality rate was within expected parameters. A new national Maternity Outcomes Signal System (MOSS) issued a Level 1 signal to the Trust on 31.3.26, which indicated a potential safety issue in the intrapartum service at WRH. This required a Trust self-assessment in response, which was rated amber due to known issues of delay in Triage and the induction of labour pathway. The report was shared with the ICB and NHSE. The Committee considered how this triangulated with staff feedback and noted a key current concern regarding the number of midwives on maternity leave. The MOSS report would be considered at a meeting of the maternity and neonatal safety champions.
Outcome	The Committee was assured that learning was being shared in relation to perinatal incidents and there were effective governance processes in place. **Actions:** • Include more quantitative information and analysis as well as data in future reports. • Provide a single, comprehensive report at a future meeting summarising the recent and pending external reports and developments about perinatal services.
Item/Topic	**Midwifery Safe Staffing Report March 2026**
Rating rationale	All workforce KPIs were green, except sickness which was above target for both midwives and midwifery support staff. Turnover was good and vacancies were low but maternity leave was high. Staff were regularly deployed to the intrapartum area when required, to maintain safety No red flags were reported. There had been a positive shift in culture on taking breaks and not staying beyond end of shift.
Outcome	The Committee was assured that there were robust processes in place to monitor midwifery staffing levels and that appropriate actions are taken to mitigate risk when staffing gaps occur. **Action:** Obstetrics Clinical Lead to be invited to attend Board meetings alongside the Director of Midwifery to present the perinatal safety report.

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

Escalation and Assurance Report

Report from: Quality Governance Committee
Date of meeting: 30 April 2026
Report to: Trust Board

Item/Topic	Nursing Safe Staffing Report March 2026
Rating rationale	Staffing on neonatal and all adult inpatient areas was maintained at safe levels throughout the month. In Paediatrics, 100% BAPM levels were not achieved but staffing was assessed as safe. All KPIs had improved. Vacancies were low for registered nurses (RN). There was a focus on the student pipeline. Agency usage had reduced to 2.2% of nurse staffing costs. The biannual staffing review would take place in May. 77 red flags were raised (compared with 78 in February), all of which were deemed insignificant or minor, with no patient harm. Over the coming months, at the Chief Nurse's request, an independent NHSE review would be undertaken of the Trust's use of the Safer Nursing Care Tool.
Outcome	The Committee was assured that there were robust processes in place to monitor nurse staffing levels and that appropriate actions are taken to mitigate risk when staffing gaps occur.
Item/Topic	**Integrated Performance Report (IPR) February 2026**
Rating rationale	The Committee noted the following points from the Quality section of the IPR: • Falls and pressure ulcers were below the national benchmark. • Numbers of reportable C-difficile infections were below the threshold for the first time in many months. • The Martha's Rule second opinion process was launched at the Alexandra Hospital and would launch at WRH next week. • The EPR sepsis module had been launched.
Outcome	Noted

Assure: Including assurance items rated green	
Item/Topic	**Safety Leadership Walkarounds Quarterly Report**
Rating rationale	The process had been conducted monthly since October 2024 across all Trust sites to strengthen visibility and reinforce the safety culture. Walkarounds involved executive and non-executive directors and other senior leaders. Actions identified were monitored until closure. In the last quarter, areas visited were Acute Medical Unit at WRH and Ophthalmology at KTC. Themes were estates constraints, staff facilities and environment. Going forward the walkarounds would include a focus on temporary escalation spaces. The Committee recognised the additional benefit of leadership ward visits to elicit anecdotal evidence about low-risk issues or improvement ideas that did not have a formal reporting route.
Outcome	The Committee was assured that the walkaround programme and process remained an effective mechanism alongside quality assurance visits and executive rounding to enhance leadership visibility, strengthen relationships between leadership and clinical teams and promote a culture of openness.
Item/Topic	**Quality Dashboard Development Progress**
Rating rationale	The updated safety and quality information dashboard, SQuID2 had been released and was now in use, enabling data analysis and reporting to a number of Quality sub-committees and the Finance and Performance Executive. Further planned developments included the addition of safer staffing metrics and a suite of metrics comparable across divisions and incorporation of the 2026/27 quality priorities. In future, data would be incorporated into the IPR.
Outcome	The Committee was assured by the continued development of the refreshed system. **Action:** Provide a quality dashboard snapshot at each meeting going forward.
Item/Topic	**Safety Alerts Report Q4 2025/26**
Rating rationale	Of all alerts received during the period (19), 100% were acknowledged by the deadline. Three earlier alerts remained open and were scheduled for closure in 2026.
Outcome	The Committee was assured that the safety alert governance process was robust.

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: Quality Governance Committee
Date of meeting: 30 April 2026
Report to: Trust Board

Item/Topic	GIRFT Report Q4 2025/26
Rating rationale	The report, which had been reviewed by the Clinical Effectiveness and Assurance Committee, provided an update on progress in delivering the GIRFT programme. There was a current focus on theatres productivity, where the key challenges were in T&O and Urology. There were plans to integrate GIRFT and model hospital data in the work of divisions.
Outcome	The Committee was assured by the progress demonstrated.
Item/Topic	**Clinical Effectiveness Annual Report**
Rating rationale	There had been issues of non-participation in some national audits, which were important for benchmarking, which was resolved. The process for management of key documents was changing, to shift ownership from individuals to relevant committees. This would be subject to an internal audit this year.
Outcome	The report was accepted.
Item/Topic	**Improving Safety Action Group (ISAG)**
Rating rationale	Red-rated areas: Medical device training governance and strategy Amber areas requiring escalation: Medicines safety practices and policies.
Outcome	The report was accepted.

To Note: Items received for information or approval	
Item/Topic	**Complaints Process Report**
Summary	A new complaints process was now in place to better manage the sustained increase in volume and complexity of complaints.
Outcome	Noted.
Item/Topic	**Regulatory reviews**
Summary	• JAG accreditation of Endoscopy Accreditation was awarded, with all standards achieved. • National stroke team visit Overall, feedback was positive, noting improvements since the last visit. Peer reviews and a self-assessment were in progress ahead of another visit in summer.
Outcome	Noted
Item/Topic	**Chief Nurse Escalations**
Summary	• Inquest outcome This related to an incident in May 2025, which was a PSII reported to the Committee in October 2025. A Regulation 28 letter were issued to the Trust regarding the staffing establishment in ED. This would be fully resolved in May.
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.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT

Report to:	**Trust Board**
Date of Meeting:	**09/06/2025**
Title of Report:	Quality Account 2025/26
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amy Gray, Healthcare Standards Lead Effie Gridley, Healthcare & Quality Standards Officer
Reporting Route:	ISAG → TMB → QGC → Trust Board
Appendices included with this report:	Appendix 1. Draft Quality Account 2025/26 Appendix 2. Draft Summary Quality Account 2025/26 Appendix 3. Draft Quality Priorities House 2026/27
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

Worcestershire Acute Hospitals NHS Trust is required to publish an annual Quality Account, as outlined in the Health Act 2009. The Quality Account must include the Trust's quality indicators, in accordance with the Health and Social Care Act 2012. The Trust is required to submit the Quality Account by uploading it to the public website and forwarding the link to NHS England by 30th June 2025.

As in previous years, the Quality Account is a working document and may be subject to change as data is ratified and additional narrative is added.

This report provides a summary of the sections of the Quality Account, as well as the process for governance approval.

The Quality Account has been reviewed by the Quality Governance Committee (QGC) and amendments based on the Committee's comments are summarised below.

Recommended Actions required by Board or Committee

The Trust Board is asked to:

- Review and approve the draft of the Quality Account and Summary Quality Account 2025/26, noting the two sections requiring finalisation before publication at the end of June.
- Receive the draft Quality Priority Indicators for 2026/27.

Executive Summary

Key Sections of the Quality Account

A Quality Account is a report about the quality of services offered by a provider. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

We have prepared the content of the Quality Account in line with current Quality Account requirements, which remain unchanged since 2023/24 This year's Quality Account is structured as follows:

- Welcome and Introduction
- Our Commitment to Quality, including developments to support Staff Culture, Trust Complaints Process, Care Excellence Accreditation, Freedom to Speak Up, registration with CQC and Digital
- A Look back at our Quality Priorities for 2025/26
- Setting our Quality Priorities for 2026/27, including the Big Quality Conversation & Results
- Statement of Directors Responsibilities
- Showcasing our Quality Improvement
- Quality Dashboard - NHS Outcomes Framework
- Participation in Clinical Research
- Commissioning for Quality Innovation (CQuINS)
- Appendices, including Clinical Audit Participation, CQC Ratings
- External Opinions from stakeholders

Review of our Quality Priorities for last year 2025/26 has been undertaken and supported by Corporate and Specialist leads, who reviewed the data provided for our key indicators by the Information team for Narrative included an overview of performance and what the data tells us, showcases and celebrations, focus areas for the future, outlining throughout what the significance of these quality priorities are for our patients.

The Quality Account outlines our quality priorities for 2026/27, introduced by a summary of findings from our Big Quality Conversation, our annual survey of patient and carer engagement. Several existing priorities continue this year and a number of quality indicators have been rolled on or updated in line with national targets.

Continuing from last year's production of the Quality Account, we have maintained our use of Microsoft's accessibility tools to guide the wording of the document, ensuring that the content provided by Specialist Leads is presented with a readability score of 12 where possible. This supports the accessibility of the language for the majority of our patients, their relatives, and carers.

The Healthcare Standards Team reviewed all proposed Quality Indicators to ensure appropriate reporting is available to measure KPIs as well as reviewing the baseline figures at the end of 2025/26. This has supported teams to better understand the context of proposed reduction/increases and the trajectories for improvement required in the coming year. This work has been undertaken in collaboration with colleagues from our Information teams to ensure data accuracy and consistency.

Key amendments following QGC

Following the review of the draft Quality Account by QGC and in line with the continuous quality assurance of the document a key amendment has been made to the end-of-life data and narrative:

Reframed reporting to clearly show:

- % of patients dying with an ILDOL in place
- % of patients with a URP who also had an ILDOL

This provides a clearer link between advance care planning and the delivery of personalised end-of-life care, and ensures the narrative aligns with currently available dashboard metrics and external stakeholder review. The quality priority KPI has been revised to focus on increasing the use of ILDOL plans, without setting a fixed percentage target. This reflects previous feedback and sector-wide learning regarding the sensitivity and appropriateness of setting numerical targets related to patients at the end of life, while still supporting continuous improvement through benchmarking and use of dashboard data.

In addition to the above, and ahead of receipt of the External Opinion from the Patient Public Forum (PPF), the PPF Chair shared several informal comments. Relevant Trust colleagues have reviewed and responded to the PPF Chair's comments to strengthen narrative and included additional opportunities to showcase. We want to give our thanks to the PPF for their continued engagement in our Quality Accounting.

Summary Quality Account

Last year, the Trust was commended by External Stakeholders for the production of its first Summary Quality Account. Selecting key information from the full account in an accessible way for the public. We have continued with this approach to ensure we are continuing to be responsive to our stakeholders and improving the accessibility of key messages relating to quality.

The Summary Account has been drafted (appendix 2) and includes:

- Trust Communications including the 'About our Trust' and 'Year in Numbers' graphics
- Welcome message from our Chief Executive and Chair.
- A summary of Trust quality assurance processes
- A high-level account of our Quality Priorities 2025/26
- The summary of results of our Big Quality Conversation 2025/26
- Quality indicators we are taking forward for 2026/27

Quality Account Governance

The production of the Quality Account is managed by the Healthcare Standards Team, under the direction of the Chief Nursing Officer and Deputy Chief Nursing Officers. The governance process for the Quality Account is as follows:

- **5th May**: Improving Safety Action Group
- **20th May**: Trust Management Board
- **28th May**: Quality Governance Committee
- **9th June**: Trust Board

Sections currently in progress and will be included as the Quality Account is developed:

Element	Timescale	Status
Continuous quality assurance of the Quality Account document	April to June 2025	In progress
Final data for Quality Priorities, Data Quality, NHS Outcomes Framework and CQuINS	May to June 2026	On track and anticipated in line with national publications.
Finalisation of Quality Priority indicators for 2026/27	April to May 2026	Complete
A welcome message from our Chief Executive	May 2026	Complete
A Year in Numbers Graphic	May 2026	Complete
Showcases for Quality Improvement	May 2026	Complete
External Opinions from HOSC, PPF, Healthwatch, and ICB	May 2026	Complete
Glossary of terms	May to June 2026	In progress
Production of the Summary Quality Account	May to June 2026	Complete
Publication	**30 June 2026**	On track

Executive Director Opinion[1]
The Quality Account for 2025/26 is in draft form with some final sections to be completed and is on track through the governance processes to be submitted as the final approved Quality Account to NHSE by 30th June 2026. The Quality Account reflects our commitment to excellence and our strategic quality priorities. Our commitment to ongoing improvements is showcased throughout the quality account to achieve the best possible outcomes for our patients and stakeholders. In line with its submission to ISAG, the draft Quality Account was shared with our stakeholders to provide an opportunity for them to review and comment on the content. Stakeholders were provided with a 4-week period to review and provide their comments. The feedback received from External Stakeholders has been collated into the draft Quality Account.

[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

WORCESTER ACUTE HOSPITALS NHS TRUST COVERING REPORT

Report to:	**Public Board**
Date of Meeting:	**09/06/2026**
Title of Report:	Response to Maternity Oversight Signal System
Lead Executive Director:	**Chief Nursing Officer**
Author:	Justine Jeffery - Director of Midwifery Susie Smith - Maternity & Neonatal Governance Lead
Reporting Route:	Quality Governance Committee
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Maternity Outcomes Signal System (MOSS) was developed by NHS England in response to the East Kent Reading the signals report. The report recommended the development of a safety signal system capable of monitoring routinely collected maternity and neonatal outcomes to detect potential declines in safe care in a timely way. MOSS operates at trust site level. It is a near-real time safety signal system that supports early detection and rapid responses to potential safety issues in intrapartum care service delivery.

Safety signal systems are widely used in healthcare and other high-risk industries to monitor outcomes and processes to prompt rapid safety checks and initiate early interventions when unusual patterns occur. Examples include children's cardiac services and paediatric intensive care, which use cumulative sum control chart methodology (CUSUM) – a statistical analysis used to detect trends in rare but serious events to improve mortality and morbidity outcomes. MOSS applies this approach to maternity with a specific focus on intrapartum care safety.

MOSS is not a performance management or investigation tool; it is part of a wider critical safety management system (CSMS). Together, these systems are essential tools that help organisations deliver consistently safe care.

Signals do not necessarily mean that a service is unsafe but prompt a service-led critical safety check: providing early insights into potential intrapartum care safety issues and enabling rapid intervention to reduce harm. MOSS operates within the perinatal quality oversight model (PQOM), ensuring consistent monitoring, support, and escalation across trusts, ICBs, regions, and nationally.

On 31st March 2026 the Maternity Outcomes Signal System (MOSS) generated a **level 1 signal** for Worcestershire Royal Hospital, Worcestershire Acute Hospitals NHS Trust. This means that there could be a potential safety issue with the intrapartum service at Worcestershire Royal Hospital.

A review was undertaken by the Maternity Directorate Team, Director of Midwifery, Chief Nursing Officer and Medical Director that identified some anomalies with the data however the summary of the local self-assessment

agreed that the service was currently rated as AMBER – 'There is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned'.

This is because there are a number of well reported challenging areas in our local maternity service such as Triage and IOL pathway where delays are often recorded and are impacting on patient experience and a perception of safety however following a number of interventions improvements have been noted although there is more to do. The Triage times will continue to be monitored at Board via the safety report.

For transparency there is a new emerging theme (highlighted at the critical safety huddles) around the categorisation of cesarean section – the directorate teams are already working together to try to improve some of the more challenging behaviours and improve the understanding of how each service operates and improve the working relationship of the maternity and theatre team.

The final report was returned to the ICB and NHS England within the 8 working day mandated timeframe. At the time of writing this report no feedback has been received.

Further work will be undertaken to ensure that there is a locally agreed governance process to support the receipt, review, Board oversight and return of such signals.

Recommended Actions required by Board or Committee

It is recommended that the Board accept the signal response rating and note the plans for future reporting following the receipt of a signal.

Executive Director Opinion[1]

This report provides assurance to the Board that following the receipt of an AMBER MOSS alert; a critical safety check was completed and following self-assessment the service was rated as AMBER.

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

Annex 1: Critical safety check - WAHT

The **critical safety check** is a rapid, structured review of intrapartum care operations led by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the Trust Board (see responsibilities below). It is not designed to replace comprehensive audits, investigations or case reviews.

Objective: To conclude whether an intrapartum service has a safety issue that needs to be addressed.

Areas of focus: Improvement timelines from known safety themes, leadership and culture, time-limited safety care pathways, risk assessment and escalation processes and safe staffing.

Responsibilities: Completed by the perinatal leadership team and approved by an accountable Trust Board executive (i.e. Chief Nurse, Chief Medical Officer or executive Trust Board Safety Champion) within 8 working days from a signal (including external peer review in level 2 signals). If a signal is received over the weekend, the timeline starts from the next working day. The check should be agreed/approved face to face or virtually where possible.

After completion and approval: Share with ICBs and regions for oversight and support where a safety issue is identified. ICBs/regions can stand down if a check does not conclude there is a safety issue.

Assumed knowledge/processes in place: The perinatal leadership team should have the below information available prior to the critical safety check:

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable Trust Board executives
Have an early understanding of the causes of death for events over the past 3 months	Cause of death identified for three of the six cases listed but no modifiable factors identified thus far.
Commissioned formal investigations where appropriate	Out of the six listed cases, three have been recently referred to MNSI including the case from the 03/26.

Publication reference: PRN02098_ii

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable Trust Board executives
Involved families in the investigation process where appropriate and listened to their insights and feedback	All families involved have been informed of the relevant review process for their baby and their care and have been sent the MBRRACE parental engagement information and feedback forms. To date no formal feedback has been received from any of the cases yet. However, informally BCH have shared via their Paedicrid process that the family felt their concerns about their baby were dismissed - the baby died of Non-Ketotic Hyperglycinaemia. They have been invited to submit feedback directly as per the process above.

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable Trust Board executives
Emerging and known safety themes with any timelines of action plans to address	Please see spreadsheet attached highlighting the learning from all cases where the investigation has been completed and/or local actions have been identified following the completion of an IIR. We have had no previous MOSS critical safety checks at the Trust. Our most recent MNSI themes report (received in October 2025) identified our themes for 2025/2026 (based on one report only) as clinical assessment, fetal monitoring and documentation. Quarterly NHSR claims scorecard reviews are completed and presented in both Divisional meetings and to the Safety Champions. They are also included in the Perinatal Safety report submissions. The most recent review was Q3 and identified no significant changes in themes from previous reviews – our term admission rate is stable, as is our PPH rate (>1500ml). 'Delays' are an ongoing theme seen previously in patient feedback, and is under further review as part of our Q4 review – though we do acknowledge over Q2 and Q3 we had sustained increased acuity and birth numbers. 'Fail/delay in treatment' is our most common cause for both open and closed claims in the low value/high volume (blue) part of the scorecard but the reasons are varied though the most expensive relate to three claims for bladder damage/inappropriate management of bladder care. A large piece of work was undertaken around 2020/2021 which including improving the bladder care guidance, increasing awareness and training all staff. Further incidents, complaints or feedback seen regarding bladder care have not been noted since. The Trust's Patient Safety Incident Report Plan (PSIRP) was published in June 2024 and is currently undergoing review. In the current publication, there are no specific maternity or neonatal themes identified though we are working with the Patient Safety team to ensure that maternity and neonates is fully captured in the new version. The MBRRACE-UK real time data monitoring tool identifies that there are peaks and troughs in terms of occurrences which is reassuring in that we do not have a sustained level of incidents occurring frequently. Our 2024 perinatal mortality figures identify that our stabilised and adjusted perinatal mortality rate is 3.97 per 1000 total births. This is around the average for similar Trusts and Health Boards. Our crude rolling perinatal mortality rate from 1.04.2025 – 31.03.2026 for stillbirths is 2.02 per 1000 births and 1.21 per 1000 for neonatal deaths which is under the national stabilised and adjusted 2023 rate of 3.22 and 1.63 respectively.

Advice for completing the check:

- Do not share patient identifiable information on this form with anyone who does not have a lawful basis to see it – redact first.
- Section 2 does not need to be completed if the service has completed this in relation to a previous signal in the past 3 months.
- The completed and approved check needs to be shared with ICBs and regions within 8 working days even if not all questions can be completed.
- Italicised text should be deleted before completing.

Section 1 – MOSS pre-completion check

This section provides accountable Trust Board executives with additional context that may explain the signal, whether the pre-requisites for implementing MOSS are in place and if there was a recent signal which allows perinatal leadership teams to skip section 2.

MOSS pre-completion check		
Questions	**Answer**	
	Yes/No	**Description**
Have you identified an issue with the data displayed by MOSS (for example, the event was not at term or care/delivery did not take place at the site displayed)?	Yes	In so much as one of the cases listed (Jan-25) was a demised twin who died at 28 weeks but was born with their surviving twin at term.
Is the trust site that signalled a NICU plus cardiac surgery centre?	No	
Were any of the events in MOSS that occurred over the last 3 months unavoidable? Please state why.	Choose an item.	Without the full information from the post-mortem reports and placental histology results available, it is difficult to state whether any of the deaths were wholly unavoidable as they have occurred over the last 3-4 months. It is not obvious from our initial reviews that any of the 6 deaths reported on the MOSS system were avoidable. We have been open and honest with the family of the baby who died in March 2026 that Mum should have been advised to take aspirin from booking and this was omitted – whether this would have affected the outcome is uncertain.

Are the pre-requisites for implementing MOSS in place (page 5-6 of Standard Operating Procedures)?	Yes	We have in place the following: ➢ Perinatal leadership team (PLT) comprising of Clinical Director for Obstetrics, Clinical Director for Paediatrics and Neonatal Services, Deputy Director of Midwifery, Directorate Manager for Maternity as leaders, and other involved colleagues including Governance Lead for Maternity and Neonates ➢ The PLT are supported and are accountable to the Divisional Leadership Team: Director of Midwifery, Medical Director. Director of Operations and Divisional Director of Nursing. ➢ Accountable trust board executives: • chief nurse • chief medical officer • executive trust board safety champion ➢ Maternity and neonatal voice partnership Strategic lead ➢ Regional chief nurse ➢ Regional chief midwife ➢ Regional chief obstetrician ➢ Regional medical director ➢ ICB executive with responsibility for maternity and neonatal services (Chief Nurse LMNS SRO) ➢ ICB director of quality – Locally LMNS Programme Lead
Have you completed a critical safety check previously for a signal that has occurred within the last 3 months?	No	

Section 2 – Are key safety elements of your intrapartum service in place?

Please complete this section focussing on the activity of your intrapartum service **over the last 3 months**. This section does not need to be completed if you have completed it previously for a signal that occurred within the last 3 months.

Safety culture - conversations with staff and service users		
Questions	**Answer**	
	Yes/No	**Brief description with any action taken** (bulleted only)

<table>
<tr>
<td>1. Are the perinatal leadership team, accountable Trust Board executives and staff (on labour ward, triage and birth centre) working well together?</td>
<td>Yes, this is working well</td>
<td>

The Deputy Director of Midwifery, Clinical Director and Directorate Manager meet weekly as a Triumvirate
The Perinatal Leadership Team (PLT, formerly known as The Quad)) undertake walkarounds of the service including Delivery Suite, Ward areas and NICU to speak with both staff and service users about their experiences
The Chief Nursing Officer (CNO) and a Non-Executive Director (NED) attend Safety Champions meetings. Safety Champion walkarounds are also completed across all sites/services by the Board and Non Exec Safety Champions. There are also Maternity & Neonatal Safety Champions in place.
The DoM attends the Trust Board and Sub board committees to present and report on all maternity items.
The DDoM attends the weekly CNO Production Board and Senior Nurses meeting.

</td>
</tr>
<tr>
<td>2. How do you measure your leadership culture and how frequently is this done? What actions have you taken?</td>
<td></td>
<td>

The PLT undertook the Perinatal Culture and Leadership Programme and are part of the first Cohort for the follow-up Perinatal Equity and Anti-Discrimination Programme
The Team ran a SCORE survey and cross referenced the results with that of the Staff Survey to identify themes, trends and areas of concern – an action plan was agreed and shared at the sub board People & Culture Committee.
SCORE stands for Safety, Communication, Organizational Reliability, and Engagement. The survey is designed to assess the culture and wellbeing of employees. It evaluates teamwork climate, safety climate, work-life balance, burnout, emotional exhaustion, and local leadership
They worked with the team’s HR Business Partner putting together a plan to address any issues raised
A monthly drop- in session is run on Teams hosted by either the DoM or DDoM which can be attended by any staff member who wishes to ask questions or raise concerns.
The Lead PMA and Lead Midwife for Recruitment and Retention provide regular reports to DoM and DDoM providing feedback and statistics on the number and type of meetings held such as exit interviews

</td>
</tr>
<tr>
<td>3. What have service users/MNVP Leads fed back that they feel could be improved?

Wells Jo
03/06/2026 13:31:46</td>
<td></td>
<td>
Service user feedback by theme – positives and areas for improvement
This table summaries triangulated service user feedback drawn from Patient Experience Meetings, MNVP feedback and engagement activity, and CQC Maternity Survey work. It presents both positive feedback and areas identified by women and families as needing improvement, with the primary forum noted for assurance.
<table>
<tr><th>Area / theme</th><th>What people value</th><th>What people say needs improving</th><th>Primary forum(s)</th></tr>
<tr><td>Staff attitudes, compassion and professionalism</td><td>Staff are frequently described as kind, calm, reassuring and</td><td>Women report feeling dismissed or not taken seriously, particularly in</td><td>Patient Experience Meetings; MNVP</td></tr>
</table>
</td>
</tr>
</table>

	compassionate. Emergency, theatre and neonatal staff are particularly praised for professionalism and empathy, even when overall journeys were difficult.	early labour, induction and triage, despite otherwise positive views of staff.	feedback; CQC Maternity Survey
Being listened to and feeling heard	When staff take time to listen and explain, women feel safer, more confident and more trusting of care decisions.	Feeling unheard is a recurring theme, particularly antenatally and during early labour, with concerns not acted on until escalation.	MNVP feedback (including triage survey); Patient Experience Meetings; CQC Maternity Survey
Triage and early labour support	Some women report clear advice and reassurance when triage contact works well.	Barriers include fear of wasting staff time, fear of not being taken seriously, busy phone lines, long waits and feeling missed when attending.	MNVP triage survey; Patient Experience Meetings
Continuity of care and access to a midwife	Individual community midwives are often described as kind, pleasant, and supportive.	Women report lack of continuity, seeing different midwives at each appointment and not knowing who to contact.	MNVP feedback summaries; Patient Experience Meetings
Information, communication and shared decision-making	Clear explanations during labour, birth and emergencies help women feel informed and reassured.	Inconsistent or unclear information about induction, risks and options, and limited involvement in decisions.	CQC Maternity Survey; CQC Action Plan meetings; Patient Experience Meetings
Care during emergencies and operative births	Emergency and operative care is consistently described as calm, well-led and safe, with good communication and partner inclusion.	Earlier delays or dismissal of concerns are sometimes perceived as contributing to escalation to emergency care.	MNVP case narratives; Patient Experience Meetings
Postnatal care – pain relief	When pain relief is timely and staff are responsive, women feel cared for and supported.	Delays in pain relief, inconsistent drug rounds and women feeling forgotten on postnatal wards.	CQC Maternity Survey; CQC Action Plan meetings; MNVP feedback

Infant feeding support	Individual staff who provide feeding support are highly valued.	Feeding support is inconsistent, particularly on postnatal wards, and below national benchmarks.	CQC Maternity Survey; MNVP feedback
Staff availability and ward experience	Calm environments and responsive staff contribute to feelings of safety and dignity.	Long periods without staff contact during induction or postnatally, leading to feelings of neglect.	MNVP feedback; Patient Experience Meetings
Neonatal and NICU care	Neonatal teams receive consistently strong positive feedback for communication, expertise and emotional support.	Initial transitions and communication between maternity wards and neonatal units can be unclear.	MNVP feedback reports; Patient Experience Meetings
Partner involvement and facilities	Partners feel supported and included during birth and theatre care when expectations are clear.	Inconsistent partner-stay rules, unclear information and variable facilities across wards.	MNVP feedback; Patient Experience Meetings
Cultural awareness and personalised care	Women value being asked about their needs and culturally specific engagement through MNVP.	Lack of awareness of cultural and religious needs, limited translated information and assumptions about care.	MNVP community engagement (South Asian, GRT groups)
Mental health support	When mental health needs are recognised, women feel validated and reassured.	Poor experiences of perinatal mental health pathways, including dismissive communication.	CQC Maternity Survey; MNVP feedback
Opportunities to give feedback (MNVP)	Women value opportunities to share experiences through MNVP events, surveys and focus groups.	Some women are unclear how feedback leads to change, highlighting the need for visible “you said, we did” messaging.	MNVP feedback; Patient Experience Meetings

4. From your walkarounds and conversations with staff:		
a) What do staff feel is working well in providing safe care in labour and birth?		• ISH (Immediate Support Huddles) following an incident • Daily SBAR safety huddles • Good team work particularly during obstetric emergencies • Introduction of Physiological CTG interpretation – particularly well embedded with Midwifery staff • Multidisciplinary Training • Opportunities for Restorative Clinical Supervision Sessions with PMAs • Collaborative working with the Matron Team including support from Matrons during challenging cases • Introduction of Teach or Treat RCOG Escalation Toolkit • Timely/early escalation of concerns
b) What do staff feel could be improved to achieve better outcomes?		• Improved communication with the Theatre team – it was noted that having one person from the Theatre team as a point of contact for the DS Coordinator supported clear communication and improved patient flow better than numerous colleagues "chipping in" • A better understanding and appreciation of the differences in the ways of working by the Theatre and Maternity Teams e.g. Maternity staff frustrated by perceived regimented break times of theatre colleagues and lack of flexibility/urgency • Correct categorisation of c/sections e.g. not cancelling an elective c/s, moving it to another day and referring to it as a "Category 3" The categorisation has been described as "fluid" • Involving the Theatre Team in ABC training to aid understanding of impacted fetal head as an Obstetric Emergency • There is a perception that some staff are more approachable than others which has the potential to impact on timely escalation • Less challenge when needing to open a second theatre, particularly at night • Perceived increase in Registrars conducting reviews remotely at night rather than attending DS and undertaking holistic review of the labouring patient
Are you achieving safety timelines for these care pathways?		
5. Is the maternity service achieving a triage of new cases within 15 minutes of presentation?	No - we are putting plans in place to improv	Three months data was reviewed 1 Jan – 31st March 26. There were 2896 attendances- results as follows: <15mins -87% <20mins -90% <25mins -92% <30mins -94%

	e this and are on track	There were 44 attendances that did not appear to be Triaged under 1 hour – the times of attendance are generally between 5-7pm.
6. Is the maternity service achieving commencement of induction of labour (IOL) within 6 hours from point of admission for induction (from home or ward)	No - we are putting plans in place to improv e this and are on track	Currently 89% of women admitted from home for IOL are commenced within 6 hours of arrival. Further review of this data will be undertaken to understand what the reasons for delay are.
7. Is the maternity service achieving **category 1** caesarean sections as soon as possible and usually within 30 minutes of the decision to deliver?	Yes - plans are already in place to maintai n/impro ve this	We audit this metric periodically and have recently completed a further audit – the data has been gathered, and we are currently reviewing the outcomes – it is anticipated this will be presented at Maternity Governance at the end of April 2026. There has been no reported harm because of any delays in either Cat 1 or 2 CS. Our current performance target for the last three months (01.12.2025-28.02.2026) and taken from our published dashboard for Category 1 CS is: Decision to Delivery – 67.9% The number of women whose baby was not born within 30 minutes of the decision totalled 16 across the three months. In all of these cases the baby was born within 40 minutes of the decision. We are assured there has been no harm resulting from the delays.

<table>
<tr>
<td>8. Is the maternity service achieving category 2 caesarean sections as soon as possible and usually within 75 minutes of the decision to deliver?</td>
<td>Yes - plans are already in place to maintain/improve this</td>
<td>We audit this metric periodically and have recently completed a further audit – the data has been gathered, and we are currently reviewing the outcomes – it is anticipated this will be presented at Maternity Governance at the end of April 2026.

Our current performance for the last three months (01.12.2025-28.02.2026) and taken from our published dashboard for Category 2 CS is:

Decision to Delivery – 73.5%

The number of women whose baby was not born within 75 minutes of the decision totalled 28 across the three months. Of those 28, 11 women’s babies were born within 100 minutes of the decision. Of the 17 remaining, the table below demonstrates the reasons for the delay:
<table>
<tr><th>Reason for delay</th><th>Number of women affected</th></tr>
<tr><td>Eaten recently – safe to wait 6 hours</td><td>2</td></tr>
<tr><td>Childcare required</td><td>1</td></tr>
<tr><td>Error in system – unable to change (61 mins DDI)</td><td>1</td></tr>
<tr><td>Obs Theatre busy overnight (unable to open intervention room)</td><td>6</td></tr>
<tr><td>Both Obs theatre and intervention room busy during the day</td><td>5</td></tr>
<tr><td>Delay with spinal efficacy – in theatre 50 mins before birth</td><td>1</td></tr>
<tr><td>Patient did not have procedure at Worcester Royal Hospital – providing postnatal care only therefore unable to remove from review list at present</td><td>1</td></tr>
</table>
Of these 17 cases, 3 should have been a category 3 CS. We are assured however that there has been no harm resulting from the delays as above.</td>
</tr>
<tr>
<td colspan="3">Are you achieving regular multi-disciplinary team (MDT) communication of known and/or emerging risk factors on the labour ward?</td>
</tr>
<tr>
<td>9. Are you achieving at least one MDT huddle every day on the labour</td>
<td>Yes - this is</td>
<td>A twice daily handover/huddle takes place on delivery suite attended by the neonatal nurse in charge, the labour ward shift leader, ward staff and the flow coordinator alongside the obstetrician and anaesthetist.</td>
</tr>
</table>

<table>
<tr><td>ward based on NHSI guidance?</td><td>already in place</td><td>A handover of labour ward is completed first and then a discussion takes place about the wider service challenges and plans made accordingly.</td></tr>
<tr><td>10. Do your huddles always include a consultant obstetrician, anaesthetist, midwifery co-ordinator and member of the neonatal team?</td><td>No/not always - we are putting this in place and are on track</td><td>Various ways of recording presence at huddles have been explored including ‘fingerprint’ scanning as the paper register is not consistently completed.
However, we can evidence from the documentation that we have, that obstetric and midwifery are in attendance at over 90% compliance at both the morning and afternoon huddles. Neonatal staff are in attendance at 93% of the morning huddles and 39% of the afternoon huddles.
Anaesthetic staffing attendance is more challenged with 79% of attendance in the morning and 61% in the afternoon.
Work is ongoing to identify the barriers to attendance from all areas and to support compliance with this metric.</td></tr>
<tr><td>11. Is the maternity service achieving a structured handover process in the labour ward, such as SBAR or an equivalent, that can manage known or emerging risks and involves the MDT?</td><td>No/not always - we are putting this in place and are on track</td><td>Badgernet requires structured documented SBAR handover however we do not consistently use SBAR as part of the verbal handover.

However, the escalation toolkit has now been embedded.</td></tr>
<tr><td colspan="3">Are your teams carrying out appropriate risk assessment and escalation?</td></tr>
<tr><td>12. Is the service achieving compliance with element 4 of the current version of the Saving Babies’ Lives Care Bundle?</td><td>Yes - this is already in place</td><td>Yes, we are 100% compliant with Element 4 of SBLCB v3 – this was approved by the LMNS for Q3 and we will be submitting the same again for Q4.</td></tr>
<tr><td>13. Is the service achieving 90% of attendance in each relevant staff group (as per Maternity Incentive Scheme guidance) at:
• Fetal monitoring training</td><td>Yes - this is already in place</td><td>For Q4 (01.01.2026-31.03.2026), our compliance is as below:
• Fetal monitoring training
<table>
<tr><th>Staff group</th><th>Jan 26</th><th>Feb 26</th><th>Mar 26</th></tr>
<tr><td>Midwives – 5/6/7/8</td><td>99%</td><td>97%</td><td>95%</td></tr>
<tr><td>Obstetric Consultants</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
</td></tr>
</table>

• Multi-professional maternity emergencies training • Neonatal resuscitation training		<table><tr><td>All other obstetric doctors</td><td>100%</td><td>100%</td><td>95%</td></tr></table> • Multi-professional maternity emergencies training (we follow the PROMPT programme)<table><tr><th>Staff group</th><th>Jan 26</th><th>Feb 26</th><th>Mar 26</th></tr><tr><td>Midwives – 5/6/7/8</td><td>95%</td><td>98%</td><td>97%</td></tr><tr><td>MSW and MCA's</td><td>100%</td><td>98%</td><td>98%</td></tr><tr><td>Obstetric Consultants (that contribute to the rota)</td><td>86%</td><td>100%</td><td>100%</td></tr><tr><td>All other obstetric doctors</td><td>78%</td><td>97%</td><td>97%</td></tr><tr><td>Anaesthetic Consultants (that contribute to the rota)</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>All other anaesthetists (that contribute to the rota)</td><td>93%</td><td>60%**</td><td>58%**</td></tr></table>** this is due to the rotation of 18 new anaesthetic resident doctors in February • Annual Neonatal resuscitation training<table><tr><th>Staff group</th><th>Jan 26</th><th>Feb 26</th><th>Mar 26</th></tr><tr><td>Midwives – 5/6/7/8</td><td>95%</td><td>98%</td><td>97%</td></tr><tr><td>Neonatal doctors</td><td>94%</td><td>96%</td><td>96%</td></tr><tr><td>Neonatal Nurses</td><td>97%</td><td>84%**</td><td>88%**</td></tr></table>** this is due to 8 staff members out of date, 4x staff booked for 8th May >90% compliance will be achieved. 4x members are 2x LTS, 1x New starter, 1x Mat Leave. The nursing staff are 97% compliant with the 4 yearly NLS
Is there a stable workforce offering safe and effective care during labour and birth?		
14. Have staff been redeployed or non-clinical midwifery staff (e.g. managers / specialist midwives) utilised to meet minimum **midwifery safe staffing levels** as per your Trust safe staffing policy?	Yes	Staff deployment is reported monthly via the safe staffing report. Both internal and community/continuity deployment recorded. Further funding being sought to substantively fill all maternity leave.

15. Have there been **obstetric staffing shortfalls** impacting on safe care delivery?	Yes	Reported daily via the national sitrep. However, recognising the challenge with middle grades and the impact on timely review in Triage and discharge from the PN ward.
16. Have there been any **anaesthetic staffing shortfalls** as per RCoA guidance impacting on safe care delivery?	No	Reported daily via the national sitrep and no concerns identified by the CD for anaesthetics ot the Obstetric Lead for Anaesthetics. The Obstetric Anaesthetic Lead is satisfied that the above statement is true if we are not defined as a “busier” unit. Unfortunately, there is no specific definition for a busier unit - It’s not necessarily the number of deliveries. Some may argue that the occasional lack of 4th on call (senior registrar) can sometimes delay the opening of a second theatre out of hours. However, if we are not defined as a busier unit, there is no mandate for having a second duty resident anaesthetist dedicated to maternity. The senior registrar rota therefore acts as a supporting mechanism to the less experienced resident anaesthetists who maybe covering CEPOD, Obstetrics or ITU, and is not seen as mandatory for safe delivery of any of those services. The CD for Anaesthetics shared the following: I am not aware of any incidents in the past three months where anaesthetic staffing levels have fallen below those recommended by the Royal College of Anaesthetists or have impacted on the safe delivery of maternity care. Within core hours (Monday–Friday, 08:00–18:00), we roster a minimum of three obstetric-competent anaesthetists in line with RCoA guidance, and this standard has been met consistently. Out of hours, there is always a dedicated resident obstetric anaesthetist on the delivery suite, with consultant support available from home. In addition, a senior trainee (“4th on”) is present for a significant proportion of the time (approximately 50–60%). While this role is not currently mandated under RCoA guidance for units not classified as “busier”, it provides additional resilience during periods of concurrent demand. On this basis, I am satisfied that current staffing arrangements are compliant with RCoA recommendations and continue to support safe service delivery.

Section 3 – Is there any additional information that accountable Trust Board executives should pay attention to?

Please use this section if there is anything not captured above that you feel executives should pay attention to, explaining potential safety issues in your intrapartum service over the last 3 months.

Following a review of the 6 cases identified there are no consistent themes currently identified. All of the cases have been reviewed locally with some investigated by MNSI and via the PMR Tool.

There are a number of well reported challenging areas in maternity such as Triage and IOL pathway where delays are often recorded and are impacting on patient experience and a perception of safety however following a number of interventions improvements have been noted although there is more to do. The Triage times will continue to be monitored at Board via the safety report.

For transparency there is a new emerging theme (highlighted at the critical safety huddles) around the categorization of cesarean section – the directorate teams are already working together to try to improve some of the more challenging behaviours and improve the understanding of how each service operates and improve the working relationship of the maternity and theatre team.

This is why we have graded ourselves as amber as below.

Section 4 – Conclusion from this critical safety check

This section is used to summarise the outcome of the critical safety check for accountable Trust Board executives. If more than one safety issue has been identified and these are being dealt with differently, then overall the perinatal leadership team should select the RAG rating which best describes the safety issue(s) with the highest risk.

Question	Answer
How would you summarise the outcome of this critical safety check?	AMBER - There is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned.

Section 5 – Recommendation from this critical safety check

It is recommended that the below actions are taken following the relevant conclusion of this check from section 4.

Conclusion	Action(s)	Please select
***GREEN** – No safety issues in our intrapartum service have been identified.*	• No action is required other than sharing the completed check with ICB (executive with responsibility for maternity and neonatal services and Director of Quality) and regional colleagues (Regional Chief Nurse, Midwife, Obstetrician and Medical Director) for awareness.	☐
***GREEN**/**AMBER** - There is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • The perinatal leadership team should continue to report to the Trust Board on plans as required. • The Trust Board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed.	☐
***AMBER** - There is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement get plans back on track within 12 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed.	☐
***AMBER**/**RED** - There is at least one known safety issue in our intrapartum service, but a plan of action is not in place.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed.	☐
***RED** – At least one new safety issue in our intrapartum service has been identified which requires a plan of action.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed.	☐

DATE:

AGREED BY MEMBERS OF THE PERINATAL LEADERSHIP TEAM AND TRUST BOARD EXECUTIVE(S) AS FOLLOWS:

NAME(S)	ROLE(S)
Justine Jeffery	Director of Midwifery 14/04/2026
Hayley Flavell	Chief Nursing Officer/ Board Maternity Safety Champion 14/04/2026

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTER ACUTE HOSPITALS NHS TRUST COVERING REPORT

Report to:	**Public Board**
Date of Meeting:	**09/06/2026**
Title of Report:	**Midwifery Safe Staffing Report March 2026**
Lead Executive Director:	**Chief Nursing Officer**
Author:	**Justine Jeffery – Director of Midwifery** **Rebecca Fox - Deputy 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 Board 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:

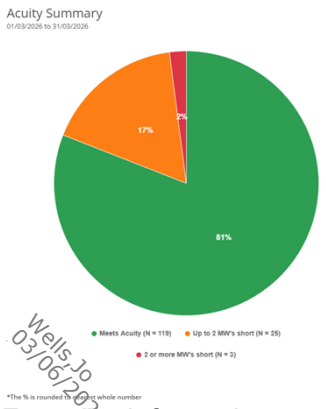
Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	7.29%	6.75%
Turnover rate (rolling)	11.5%	3.3%	12.3%
Vacancy rate (MW)	7%	1%	14%
Maternity Leave	-	5.7%	1.7%
Midwife to birth ratio (in post)	1:24	1:18	N/A
1:1 care in labour	100%	Achieved	N/A
Shift leader SN	100%	Achieved	N/A

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 79% of the expected intervals (higher than last month) and therefore the data presented is not reliable. The diagram below presents when staffing met or did not meet the acuity.



From the information available, the acuity was met in 81% of the time and recorded at 19% when it was not met prior to any actions taken. This is higher than the previous month's performance. Safe staffing levels were maintained on all shifts in March following mitigation.