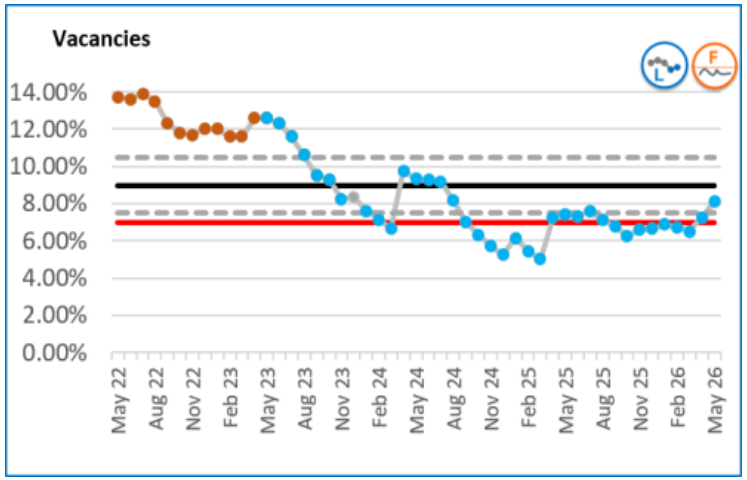
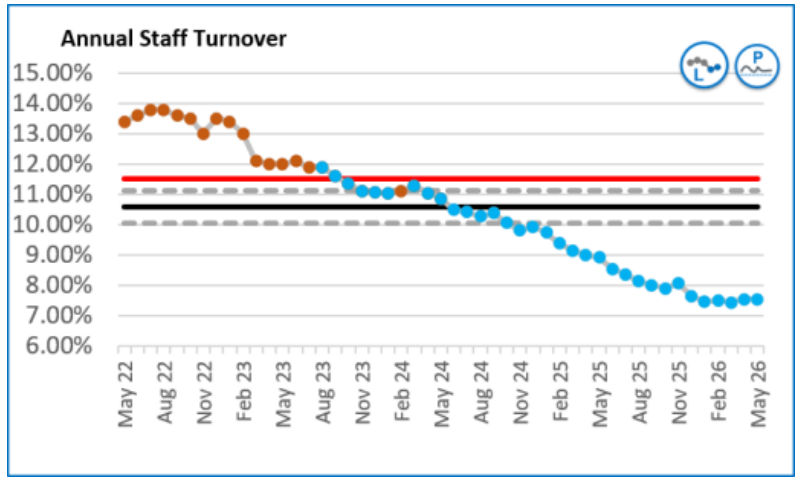
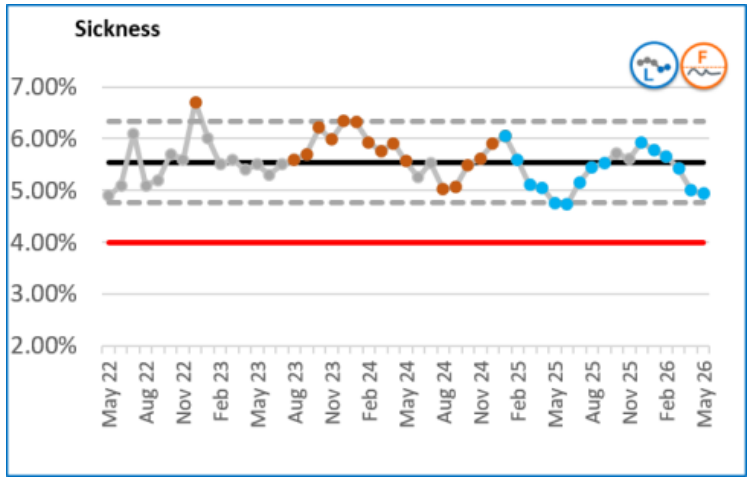
OUR WORKFORCE PERFORMANCE – VACANCIES, TURNOVER AND SICKNESS

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 1.55 wte to 7213.63 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 has increased to 8.09%, against a target of 6.5% primarily due to increased establishment. Medicine have the highest clinical vacancy rate at 11.43% directly related to a 67.67 wte increase in establishment this month on top of increase at budget setting.
- **Starters and Leavers** - We have only 1 more starter than leavers this month. We have processed 67 new starters in month (headcount) and 66 leavers.
- **Annual Staff Turnover** continues to comfortably meet our 11.5% target at 7.54% which is 1.38% better than the same period last year and benchmarks well against the Group.
- **Monthly sickness absence** has reduced by 0.06% to 4.94% which is 0.19% higher than last year. There has been reduced sickness absence in most divisions except Corporate, Medicine and SCSD. Estates and Facilities are outliers with 7.08% (unchanged). This KPI continuously fails to reach the target and is showing common cause variation.
- **Healthcare Support Workers Vacancy rate** is 12.77% (155.61 wte vacancies).

Actions (SMART)

- **Attendance Programme** 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. Total starters in non clinical divisions do not exceed leavers and a MARS scheme has been launched aimed at reducing non-clinical headcount.

Risks

Performance to 26/27 Plan - We are 82.19 wte ahead of plan overall. However, this does not account for the increased establishment as our plan was showing a reduced establishment of 7713.54 for March 2026, and a further reduction to 7214.62 by March 2027.

Medicine and Surgery continue to use more wte than their establishment (33 wte and 82 wte respectively). Increases are likely to be due to continued level 4 escalation and covering vacancies for newly established posts in Medicine.

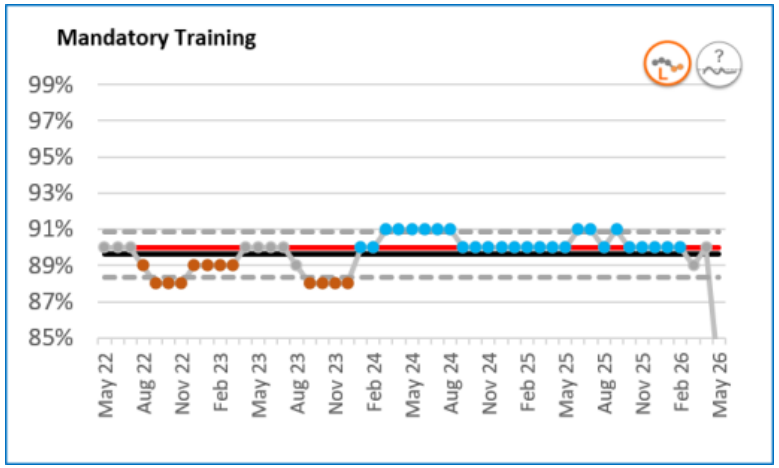
Sickness for Estates and Ancillary Staff Group continues to be very high at 7.70%. This staff group has historically higher sickness across the NHS and we are in Quartile 4 on Model Hospital (September 2025 data). HCA sickness is also high at 6.72%. All other groups with the exception of Registered Nurses and Midwives meet the 4% Group target.

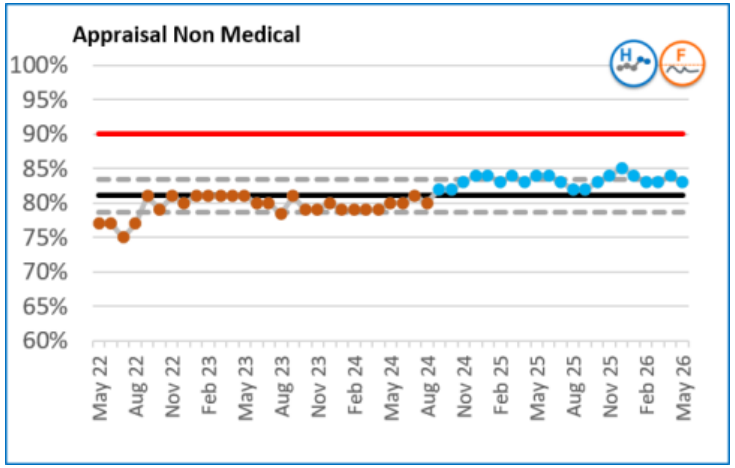
Absence due to stress remains high and increased this month. Women and Children's are significant outliers with 52.07% of all sickness attributable to stress (increased).

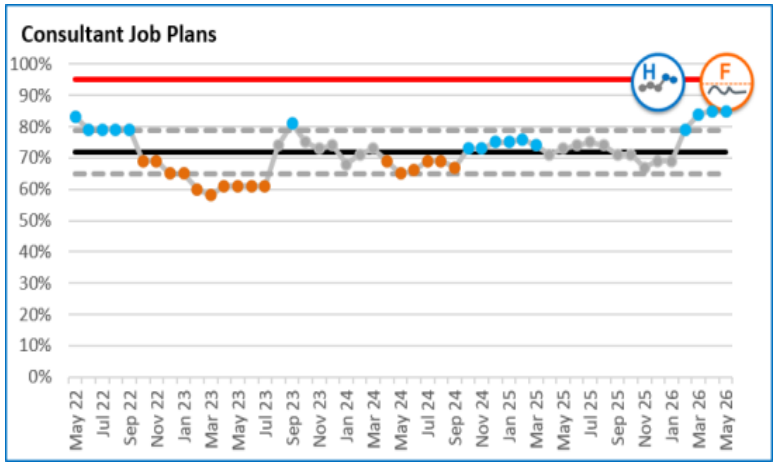
OUR WORKFORCE COMPLIANCE – MANDATORY TRAINING, APPRAISAL & JOB PLANNING

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 dropped significantly from 90% to 83%. This was anticipated due to changes to the Safeguarding Adults (SGA) Level 3 training and eligibility due to the updated Safeguarding Intercollegiate Document. All staff with a registration (M&D, N&M) are now required to complete Level 3 which increased our eligible numbers from 258 to 3532. Those staff completing SGA Level 3 and Level 2 are now required to complete all lower levels as no specified renewal. As L3 training is face to face the Safeguarding Team will need to increase the number of courses available.

Appraisal Rate has dropped to 84% against a target of 90% which is 1% lower than last year. Corporate are outliers at 68% (unchanged) followed by Estates and Facilities at 75%. Medical appraisal rates are good and improved to 93%.

Consultant Job Planning is unchanged at 85% against target of 95%. SCSD are the only division to meet the target. Women and Children's have dropped to 88%. Medicine are outliers at 78%.

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 66% (12% drop). Registered Nurses and Midwives, HCAs and Professional Scientific and Technical have all dropped below target. 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% (unchanged).

Consultant Job Plans are unchanged at 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). The plan has been updated at M2 for the increase to income and to pay costs as a result of the agreed pay award.

Income & Expenditure – Our reported position for M2 is a **£7.3m YTD deficit against a £5.6m YTD deficit plan, an adverse variance of £1.7m** driven primarily by costs of Industrial Action and under achievement of CPIP requirement partially offset by an underspend against the growth reserve.

The Month 2 pay run rate remains broadly consistent with Month 1 despite the absence of industrial action. Around £0.2m relates to retrospective medical bank and agency expenditure within Surgery, which is being reviewed to determine whether any cost was avoidable. Temporary nursing expenditure has also increased modestly, primarily due to calendar-day related factors. The financial benefit from elective activity has reduced due to higher non-clinical supplies and drug costs. Whilst emergency activity has increased year on year, no additional emergency income has been assumed as lower case mix and tariff are expected to offset volume growth. The current phasing of the elective plan is supporting the in-year position, although this benefit is expected to unwind later in the year.

Key Variances:

- **Income is £1m favourable to plan YTD** – key favourable variances include: £1m overperformance against the activity plan; £0.3m on pass through drugs and devices. This is partially offset by other small adverse variances. **At this point we have assumed continued receipt of Deficit Support Funding despite being off plan at M2.**
- **Employee expenses are £1.7m adverse YTD -** adverse variances include: £1.3m of undelivered CPIP; £0.4m Industrial Action costs, £0.2m additional costs of covering sickness, specialling and maternity above 2025/26 outturn, £0.1m of enhancements phasing difference, partially offset by £0.3m of uncommitted other growth reserve.
- **Operating expenses excluding Employee Expenses are £0.8m adverse to plan YTD at M2 -** adverse variances include: £0.4m of pass-through drugs and devices; £0.4m of tariff drugs driven by prescribing patterns and activity. This is partially offset by the favourable variance of £0.2m on utilities and £0.2m on depreciation.

Departments reporting adverse financial positions are required to actively manage financial risk through clear, owner-led mitigation plans. These plans should set out the actions, milestones and escalation routes needed to return budgets to balance, including appraisal of options to reduce lower-value spend and prioritise safety, productivity and patient-facing care. This approach was shared at Trust Leadership Brief and should support delivery of the financial plan, strengthens grip on cost control and ensures that risks are mitigated rather than simply reported.

Capital – The YTD capital spend at Month 2 is £648k, the majority of which has been on the ALEX Fire Scheme (£478k) and the HPV Lease extension (£107k). The capital plan for 26/27 is set at £40,489k but has increased to £41,722k in M2, including £16,818k of internal funds, £21,904k of PDC funding and £3,000k for IFRIC 12. Plans and profiling for schemes is under review to maximise delivery of the available resources within the year.

Cash – The Trust cash position at the end of Month 2 was £15.216m. Included in this balance is DSF funding for June (£3.5m), prior year funding from ICB (£3.2m) and £978k CNST Maternity from 2025/26 which increased the balance from plan. Despite the level of cash in May 2026, creditor payment runs were reduced to ensure that payroll and associated costs can be met in June, with the predicted closing balance for June being £2m. This adversely impacted the prompt payment performance. An application for revenue support in July has been submitted and an outcome is awaited.

Clinical Coding – May coding is at 100% on the 11th working day. Total of FCE's for May was 15,797 compared to 15,224 in April.

FINANCE HEADLINES

M2 deficit **£4.6m (£7.3m YTD)** against a £3.5m (£5.6m YTD) deficit plan

CPIP **£3.8m** delivered YTD against £5.2m target

Agency spend for M2 **£1.2m (£2.2m YTD)** against £1.1m (£2.3m YTD) planned spend

Deficit support funding of £7m included in M2 position in line with plan

Bank spend for M2 **£4.7m (£9.5m YTD)** against £3.7m (£7.3m YTD) planned spend

Productivity Cost per unit of clinical output (WAU) YTD **0.4% higher** than 25/26

Capital spend **£648k YTD** in M2 against £7.3m planned spend

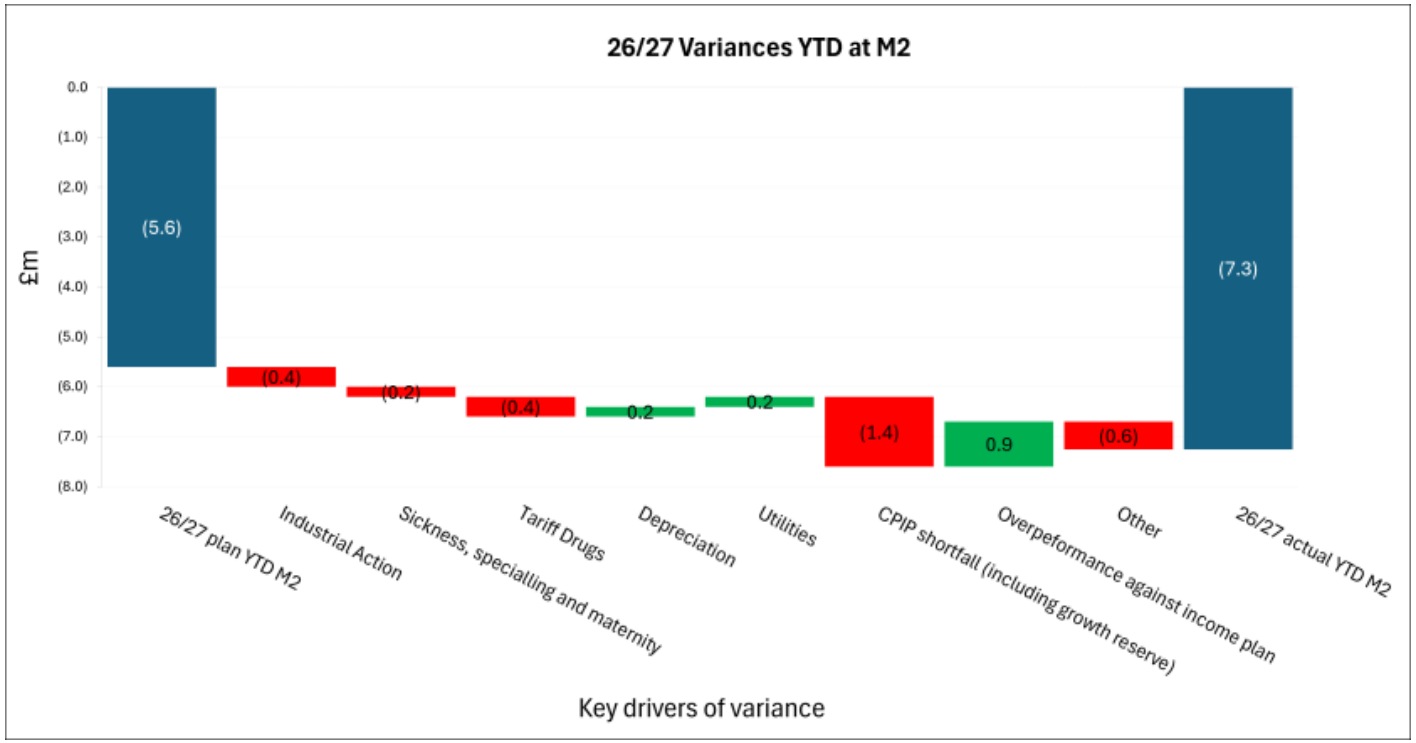
BPPC – Invoices Paid < 30 days (% volume) May: **47%** against 95% target

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	Year to Date Plan £'000	Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Income from Patient Care Activities	127,797	128,724	927
Other Operating Income	6,475	6,525	50
Employee Expenses	(86,645)	(88,353)	(1,708)
Operating Expenses exc Employee Expenses	(48,842)	(49,657)	(815)
OPERATING SURPLUS / (DEFICIT)	**(1,214)**	**(2,760)**	**(1,546)**
FINANCE COSTS			
Finance Income	244	256	11
Finance Expenses	(1,584)	(1,593)	(9)
PDC dividends payable/refundable	(1,038)	(1,040)	(2)
NET FINANCE COSTS	**(2,378)**	**(2,377)**	**0**
Other Gains and (Losses)	0	(9)	(9)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(3,592)**	**(5,147)**	**(1,555)**
Add back all I&E impairments/(reversals)	0	0	0
Surplus/(deficit) before impairments and transfers	**(3,592)**	**(5,147)**	**(1,555)**
Remove capital donations/grants/peppercorn lease I&E impact	34	39	5
Remove PFI revenue costs on an IFRS 16 basis	6,142	7,037	895
Add back PFI revenue costs on a UK GAAP basis	(8,184)	(9,186)	(1,002)
Adjusted financial performance surplus/(deficit)	**(5,600)**	**(7,258)**	**(1,658)**



Understanding the performance

In M2 we report a YTD £7.3m deficit against a YTD £5.6m deficit plan, an adverse variance of £1.7m 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 will strengthen financial improvement delivery through a revised taskforce model that preserves divisional ownership of CPIP while increasing executive grip, accountability and capacity for high-value cross-divisional and transformational schemes. Simplified governance, named leads and clear escalation routes will improve visibility of delivery confidence, recurrent impact and emerging risks, with benefits only banked where supported by robust operational evidence. Benchmarking, targeted deep dives and focused improvement, PMO, external and Group support will prioritise the opportunities with greatest value, providing the Board with assurance that recovery is underpinned by clear ownership, stronger delivery discipline and a sustained focus on recurrent improvement.

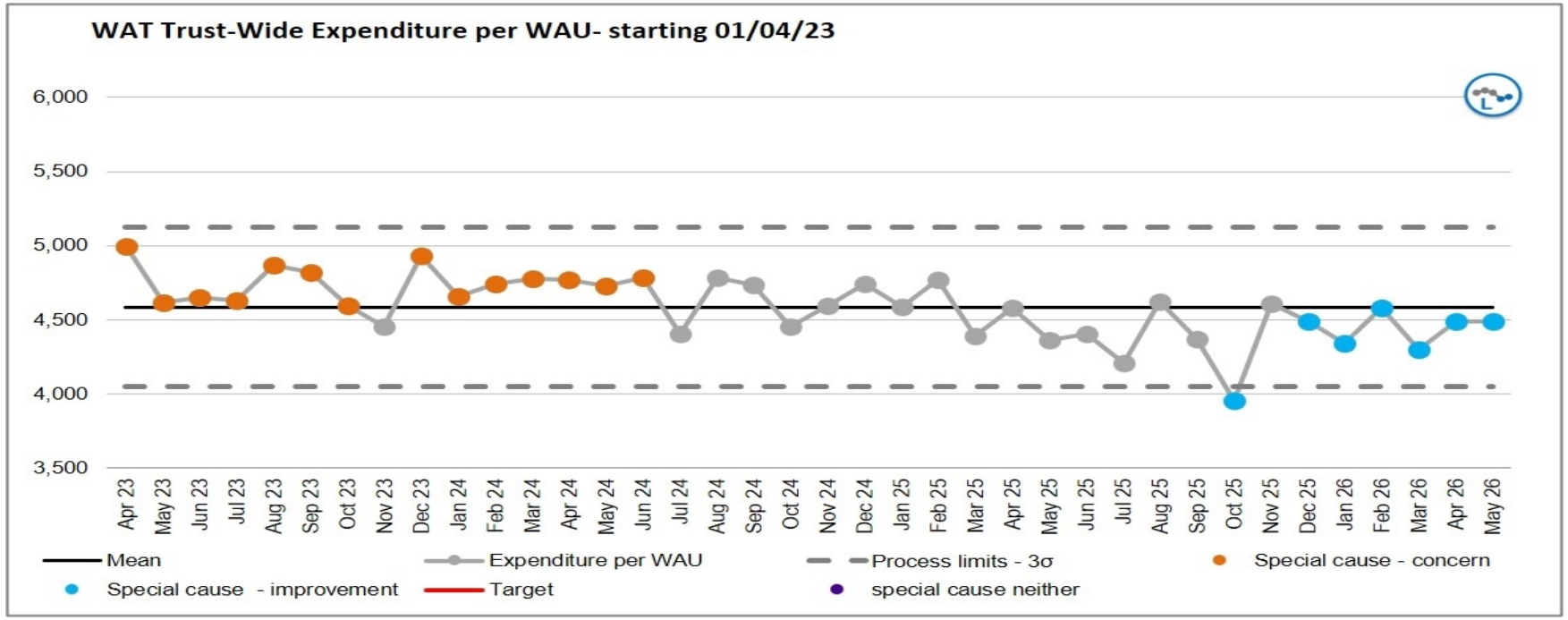
Risks

At this point we have assumed continued receipt of Deficit Support Funding despite being off plan YTD at M2, should this be removed the deficit would increase by £7m.

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

	Apr - May	Adjusted for Working Days
Exp per WAU	-0.0%	-0.4%
Expenditure	0.4%	0.4%
WAU	0.4%	0.8%

YTD Movement compared to 2025/26

Exp per WAU	0.4%
Expenditure	2.8%
WAU	2.4%

Costing Team Update

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

Understanding the performance

For May, our **cost per WAU is the same as April, and that's with lesser working days. Its 0.4% lower when allowing for working days.** This is due to reductions in Outpatient activity offset by increased emergency activity.

Compared to 25/26 the expenditure per weighted activity is 0.4% higher. So fractionally reduced productivity year on year. This is just comparing April to May so a small range. This is driven by activity volumes delivered at similar levels with increased cost after inflation adjustment.

Actions (SMART)

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

Risks

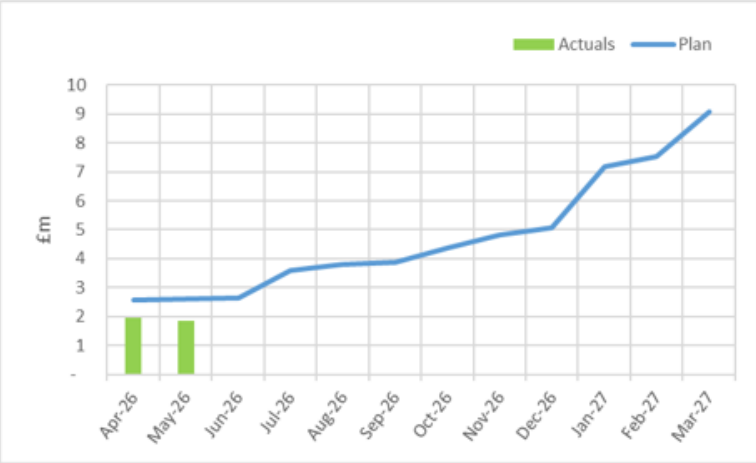
Risks are that unless the trust can reduce expenditure whilst also increasing activity levels than financial and performance targets will be missed.

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

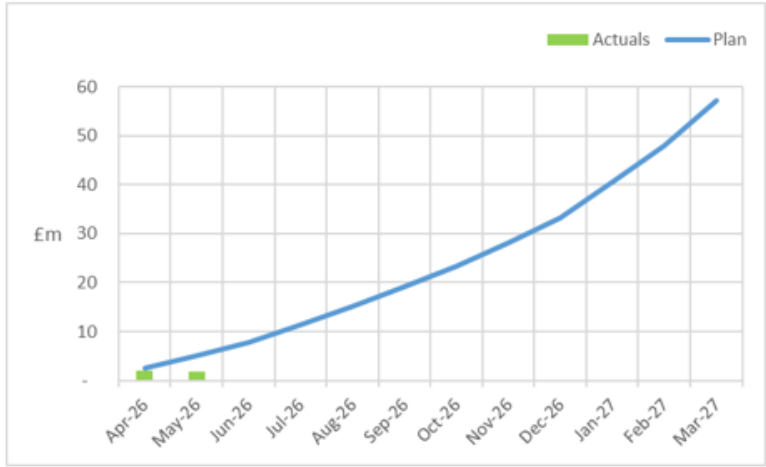
We are driving this measure because

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.

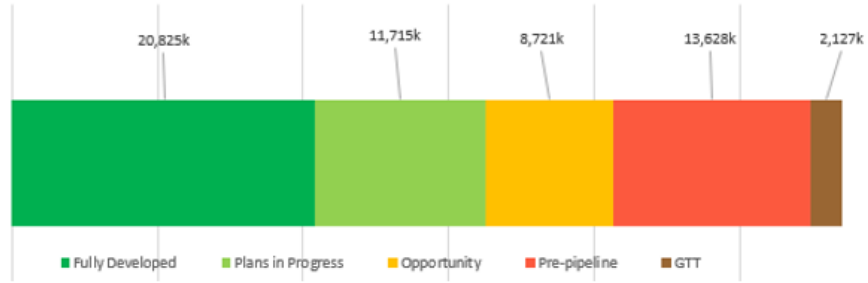
YTD CPIP achieved
vs plan target (£57.106m) month



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



2627 CPIP Financial Maturity status (forecast)



Understanding the performance

M2 delivered actuals of £1.835m against a plan of £2.603m, an under delivery of £0.768m.

M2 actuals comprised £1.634m recurrent and £0.201m 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) and to progress schemes which are currently within Pre-pipeline, Opportunity and Plans in Progress.

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

Risks

Delivery of the 26/27 target is challenging, as evidenced by the in month and YTD performance. 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 maintenance requirements and urgent replacement schemes.

Trust Capital Position at M2 – Actuals vs Available Funding

Workstream	Scheme	YTD Budget	YTD Actual	YTD Variance
Digital	2026/27 Digital Scheme	300,000.00	0.00	-300,000.00
Digital	Additional Digitial Schemes	0.00	15,817.33	15,817.33
Digital	CAP2425 Cardiac PACS	0.00	7,848.40	7,848.40
Digital	Digital rev to cap transfer	0.00	0.00	0.00
Digital	Externally Funded Constitutional Schemes	366,000.00	-12,088.20	-378,088.20
Digital	LIMS	0.00	0.00	0.00
Digital	LIMS Pathology	0.00	-7,980.14	-7,980.14
Equipment	Equipment Schemes	384,000.00	18,153.12	-365,846.88
Equipment	Externally Funded Constitutional Schemes	0.00	0.00	0.00
Equipment	LINACS WRH Replacement	248,000.00	2,759.64	-245,240.36
Other	Contingency Shcheme	0.00	23,649.00	23,649.00
Other	Donated Equipment Schemes	0.00	157.24	157.24
Other	IFRIC 12 and other contingency	302,000.00	19,712.38	-282,287.62
Other	Lease Additions	0.00	106,520.00	106,520.00
Other	Lease Modifications	256,000.00	0.00	-256,000.00
Other	P&W Scheme Funded by Charity	0.00	1,228.27	1,228.27
P&W	2025/26 P&W Scheme	126,000.00	76,714.68	-49,285.32
P&W	2026/27 P&W Scheme	42,000.00	6,161.26	-35,838.74
P&W	Externally Funded Constitutional Schemes	0.00	24,527.29	24,527.29
P&W	Internally funded Fire Scheme	0.00	27,467.39	27,467.39
P&W	National Funding Fire Scheme	584,000.00	451,147.48	-132,852.52
P&W	P&W Backlog Maintenance	33,000.00	-8,741.92	-41,741.92
Strategic	2025/26 Strategic Scheme	918,000.00	9,097.60	-908,902.40
Strategic	Acute Service Review	578,000.00	2,925.35	-575,074.65
Strategic	B/F Strategic Scheme	200,000.00	316.25	-199,683.75
Strategic	Externally Funded Constitutional Schemes	2,406,000.00	-118,718.63	-2,524,718.63
Strategic	National Diagnostics - Cath lab	580,000.00	1,547.14	-578,452.86
Total		**7,323,000.00**	**648,220.93**	**-6,674,779.07**

Understanding the performance

The 2026/27 Capital spend in M2 is £648k.

Spend in month mostly relates to the Fire scheme (£478k) and the HPV Lease extension (£107k).

In M2, the IFRIC forecast has increased by £2,643k as the Trust has received updated forecast for PFI replacements in 2026/27.

The Trust has also received notification in M2 that the available Estates Safety Funding for 2026/27 has increased by £150k which has been allocated into the revised external forecast.

Budgets have been set based on the plan submission less the external funding that is not currently available for drawdown (i.e. if the Trust has not received the MOU yet).

Plans and profiling for schemes is under review to maximise delivery of the available resources within the year.

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 2 was £15.216m.

Included in this balance is DSF funding for June (£3.5m), prior year funding from ICB (£3.2m) and £978k CNST Maternity from 2025/26 which increased the balance from plan. Despite the level of cash in May 2026, creditor payment runs were reduced to ensure that payroll and associated costs can be met in June, with the predicted closing balance for June being £2m. This adversely impacted the prompt payment performance.

Understanding the performance	Actions (SMART)	Risks
The Trust cash position at the end of Month 2 was £15.216m. The cash position is monitored daily, which includes the agreed debtors and creditors to ensure payroll costs are prioritised.	A £25m revenue support application has been submitted for Quarter 2, and the outcome is awaited. The request is partly driven by assumed reductions in Deficit Support Funding, reflecting the risk that the funding may be reduced following the £12m adverse variance to plan in 2025/26, alongside the potential withholding of Quarter 2 2026/27 support due to current financial performance. The Finance team will respond promptly to any queries arising from the application and will update the Board once the outcome is confirmed.	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. An application has been submitted for Provider Revenue Support for quarter 2 which is now with NHS England for approval.

Quality Governance Committee
28 May 2026 at 9:30am
Via Microsoft Teams

Required Attendees			
Dame Julie Moore, Non-Executive Director (Chair)	JM	Simon Murphy, Non-Executive Director/Deputy Chair	SM
Sue Sinclair, Associate Non-Executive Director	SSi	Michelle Lynch, Associate Non-Executive Director	ML
Hayley Flavell, Chief Nursing Officer	HF	Jules Walton, Chief Medical Officer	JW
Justine Jeffery, Director of Midwifery	JJ	Rosemary Smart, Public Patient Forum	RS
Chris Byrne, Healthwatch	CB	Liz Watkins, Associate Chief of Nursing/Director IPC	LW
Attending			
Tracy Pearson, Deputy Chief Operating Officer	TP		
Guests			
Helen Harris, Associate Director of Nursing & Quality ICB	HH	Karen Apps, Head of Patient Safety & Complaints	KA
Nikki O'Brien, Deputy Chief Information & Performance Officer	NO	Anna Sterckx, Head of Patient, Carer & Public Engagement	AS
Amy Gray, Healthcare Standards Lead	AG		
Apologies			
Rebecca Brown, Chief Digital Information Officer	RB	Mike Cornes, Deputy Divisional Director of SCSD	MC
Chris Douglas, Chief Operating Officer	CD	Gwenny Scott, Company Secretary	GS
Catherine Driscoll, Associate Non-Executive Director	CDr	Jo Wells, Deputy Company Secretary	JWe

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

JM welcomed all present at the meeting.

JM noted that the meeting was being recorded in the absence of a minute taker.

Ref	Item	Lead	Purpose	Format
2	Minutes and Actions Arising	JM	Approval	Report 1

The minutes of the meeting held on 30 April 2026 were approved as an accurate record.
The action log was reviewed an updated.

Ref	Item	Lead	Purpose	Format
2.1	Update on Theatres	TP	Information	Report 2

TP presented a paper on theatre key performance indicators covering the past two years with national benchmarking comparisons. The overall picture was described as mixed.

Late starts had improved year on year, with the strongest gains at the Alex Hospital. Worcester Royal retained the greatest opportunity for further improvement. Early finishes had improved slightly, largely driven by Worcester Royal. Capture utilisation had risen from 82% to 84% at Trust level. Kidderminster Treatment Centre showed the most scope for improvement, with unused and reuse sessions a continuing concern.

The Committee discussed the timeliness of data, noting that some metrics were nine months out of date. A BI theatre dashboard was now available to provide more live data. Capture of dropped theatre sessions required further development as this remained a manual process.

Hub optimisation weeks at the Alex and Kidderminster had demonstrated positive results during those periods, with late starts better managed and utilisation at the Alex reaching 88%. Work was under way on volunteer-supported pre-operative calling to reduce DNA rates at Kidderminster.

The Committee discussed habitual late starts by individual surgeons and the use of job planning information to address performance. JW confirmed that theatre performance data would be made available at CMO level and would be acted upon. NO confirmed that consultant-level data was shared weekly with operational teams and was included in enhanced consultant appraisals.

SSi observed that underutilisation at Kidderminster, a clean elective site, was not acceptable given the Trust's financial position and that this had been noted for some time.

Action: TP to provide an update on live data capture for theatre performance and progress on improving late starts and session utilisation at a future meeting.

Committee noted the report.

3	Declarations of Interest	JM	Information	Verbal
No noted declarations of interest.				
4	Escalations for Items Outside of Standard Reports / Not on the Agenda	HF/JW/JJ	Information	Verbal Update

NMC Registration and Revalidation Process Concerns

HF informed the Committee of a national issue identified by the NMC regarding its registration and revalidation processes. Over the previous 12 years, character and health assessment policies had not been applied rigorously at the point of registration and re-entry to the register. Approximately 18,000 registrants had been identified where policy had not been followed. Of these, 421 would be contacted by the NMC to provide further information. An embargoed briefing had been provided to CNOs; communications had been issued to Trust staff. It was not yet known whether any Trust staff were among those recalled. Staff contacted by the NMC were advised to inform their employer; this expectation had been included in the Trust's staff communications.

Measles Outbreak

Since the beginning of May 2026, seven positive cases of measles had been confirmed, described as unprecedented for the Trust. An outbreak had occurred involving two staff members on a higher risk ward, and cases spanned a range of ages with none over 55. Contact tracing was under way for three current cases, with two further possible cases awaiting swab results. Three patients had received Human Normal Immunoglobulin (HNIG), including a pregnant woman and two patients with solid organ transplants. Staff who were unvaccinated and had been exposed to measles had been required to isolate for up to 21 days.

Issues had been identified in occupational health processes, including a lack of robust information flow to managers regarding staff vaccination status and limitations in the occupational health database. A look-back exercise was under way across the Trust's approximately 8,500 staff.

JM expressed concern about the lack of a robust process for monitoring and recording staff vaccination status, particularly for staff working in high risk areas, and raised the patient safety implications of unvaccinated clinical staff. The Committee discussed the risk assessment approach required to protect patients and the need for managers, occupational health and HR to have clear oversight. HF confirmed that a review of processes was under way and that a stronger professional link between the CNO and occupational health was being established.

SM requested that data on the proportion of unvaccinated staff be reported to the Committee once the look-back exercise had been completed.

Action: HF to bring an update on occupational health vaccination assurance and processes to the August 2026 meeting.

Maternity Outcomes Signal System (MOSS) – Second Level 1 Alert

JJ updated the Committee on the second MOSS alert, which related to a further intrauterine death. A woman had attended a routine 38-week antenatal appointment at which the community midwife was unable to detect a fetal heartbeat. No concerns regarding fetal movements had been reported prior to that appointment. The case would be reviewed through the Perinatal Mortality Review Tool (PMRT) process in June 2026 and was not MNSI reportable. JJ confirmed that no further MOSS alerts had been triggered in May 2026.

Analysis by the informatics team indicated that the Trust would need approximately four months without a term stillbirth or neonatal death before the alert threshold would no longer be triggered, and this was not anticipated to be a concern going forward.

JM requested that the Committee be provided with a summary overview of all external reporting requirements, inspections and inquiry frameworks applicable to maternity services, to support clarity of oversight.

Surgical Skin Preparation Product – Potential Licensing Issue
JW informed the Committee that the surgical skin preparation product currently in use may not hold the appropriate licence from its supplier for the specific use to which it was being applied. The product was NICE compliant and contained all required ingredients; no clinical risk was believed to present, as supported by surgical site infection data which showed no adverse trends. However, a regulatory concern remained. A formal stakeholder meeting had been arranged for the following day to agree a resolution and to understand how the situation had arisen, including a review of procurement processes.

Committee noted the updates.

5	QUALITY & SAFETY			
5.1	Annual Infection Prevention and Control Report	LW	Assurance	Report 3

LW presented the Annual Infection Prevention and Control Report, required for compliance with the Health and Social Care Act, covering the 12-month period.

The C. difficile target had been met for the first time in several years, with 114 cases reported against a threshold of 129. NHS England had informed the Trust that the threshold would be reduced by approximately 10% for 2026–27.

All other infection thresholds had been exceeded, consistent with the national picture. Work was planned in collaboration with the antimicrobial pharmacist and the nutrition and hydration team to address gram negative organisms, particularly E. coli and Klebsiella, focusing on hydration, UTI diagnosis and treatment, and antimicrobial prescribing.

The Committee commended the work of the IPC team and clinical divisions in achieving the C. difficile target and noted the positive shift in the collaborative working relationship between the IPC team and clinical teams.

Committee noted the report and agreed for it to be presented to Public Board.

5.2	IPC Board Assurance Framework 2026–27	LW	Assurance	Report 4

LW presented the updated IPC Board Assurance Framework for 2026–27. There were no red areas and three areas were fully assured. The Trust remained at an enhanced NHS inspection monitoring level. Following an anticipated inspection visit in July or August 2026, the Trust hoped to move to routine monitoring. The framework had been developed in collaboration with pharmacy, estates and facilities colleagues.

Committee noted the report.

5.3	IPC Quarter 4 Report	LW	Assurance	Report 5

LW presented the IPC Quarter 4 Report. C. difficile remained below threshold. An outbreak of Citrobacter had occurred in the neonatal unit in January 2026; no further cases had been identified, screening would continue for three further months and drain treatment would cease at the end of May. Two Group A streptococcus cases with associated deaths had been followed up through the PSIRG with no further cases identified.

Emerging infectious disease threats included: measles (discussed earlier in the meeting); hantavirus (a regional patient who had been on a cruise to Argentina was currently isolating at Arrow Park Hospital; the Trust had policies and procedures in place); and Ebola (cases in the Democratic Republic of Congo and Uganda, with query cases in Italy; the Trust had Ebola policies and HCID training in place and was working with the Learning and Development team to cascade training).

JM asked about the relationship between sink use and gram negative organisms. LW confirmed the Trust was monitoring this, referenced work in other trusts on water-light approaches in high risk areas, and noted the implementation of a compass system through the water safety group to improve flushing compliance.

The Committee agreed that LW would provide a brief monthly IPC cover sheet, including emerging threats or concerns, rather than relying solely on quarterly reporting. A nil return would be acceptable where nothing had changed.

Committee noted the report.

5.4	Perinatal Services Safety Report Q4	JJ	Assurance	Report 6

JJ presented the Perinatal Services Safety Report for Quarter 4. Note: the agenda contained an error referencing Quarter 1; this was the Quarter 4 report.

Booking by 10 weeks was showing consistent improvement towards the locally set stretch target of 85%. CNST training compliance was on track; JJ noted for the record that compliance for 3 June 2026 would need to exceed 90% in all groups to meet the new CNST scheme requirements, which now comprised six safety actions.

Five stillbirths and four neonatal deaths had occurred in Q4; however, the perinatal mortality rate remained below the national average and in line with comparative groups. No term losses had been reported in May 2026. An MNSI report had been received for one neonatal death and an action plan would be brought to the Committee as an appendix to the perinatal incident report in Q1.

A foetal medicine lead vacancy was anticipated; the job advertisement was being prepared for immediate issue on receipt of the resignation, to avoid any delay.

Freedom to Speak Up feedback had identified concerns around toxic culture, perceived favouritism and racism. Each concern had been investigated with context provided. A deep dive had been undertaken by CNO and CPO and a meeting with the division was planned.

Kindness interaction training was being extended across triage and postnatal areas in response to patient experience feedback. The 2025 CQC patient survey showed limited overall change; a co-produced action plan was in place with the MMVP.

The Trust was now in the blue zone on the regional CNST heat map, placing it in the top 10 organisations in the Midlands. External validation had confirmed that the Trust had fully met the Year 7 CNST scheme; funding, including previously unclaimed monies, had been secured. The midwifery vacancy rate was 0%.

SSi raised concerns about community reports of patients attending for caesarean section being advised to bring their own pain relief. JJ acknowledged the concern and confirmed that work was under way to reintroduce drug rounds and progress patient self-administration of medications on the postnatal ward.

Committee noted the report.

5.5	Maternity Safe Staffing	JJ	Assurance	Report 7

Midwifery vacancy rate remained at 0%. The Maternity Care Assistant (MCA) vacancy rate stood at 12%; a recruitment event was planned for June 2026. Improvement had been seen in meeting acuity requirements and a reduction in cross-ward staff moves. No staffing incidents or delays had been reported via the tool.

Sickness and maternity leave continued to present challenges in Meadow Birth Centre and the postnatal ward. A paper was being prepared for Trust Management Board to support substantive recruitment to cover long-term maternity leave, which carried financial as well as quality and safety benefits.

Committee noted the report.

5.6	Nurse Safe Staffing Report	HF	Assurance	Report 8

Agency usage continued to improve. RN numbers had increased due to approved business cases rather than attrition. A Healthcare Support Worker recruitment event had taken place.

Approximately 230 newly qualified nurses would qualify in September 2026; limited vacancies were available and interviews had been offered to approximately 120 candidates. The Chief Nurse for England had issued a public statement acknowledging this national position.

The Safe Care nursing tool was in place to support the upcoming biannual staffing review, which would be presented to Trust Board in October 2026. An external NHS review of the Trust's staffing methodology and processes would also inform the Board paper.

Committee noted the report.

5.7	Quality Account 2025–26	HF/AG	Assurance	Report 9

HF and AG presented the draft Quality Account 2025–26. The report had previously been considered by ISAG and Trust Management Board and was due to be presented to Trust Board on 9 June 2026 for submission ahead of the 30 June 2026 deadline.

Quality priorities for 2025–26 were assessed against agreed targets, with outcomes of met, partially met or not met reported. Quality priorities for 2026–27 were established with clear targets and key actions, to be monitored through ISAG via the SQUID 2 dashboard. Changes for the coming year included removal of a dedicated HAFD priority, separation of clinical effectiveness priorities into unplanned and planned care, introduction of a new priority for medicines management, and explicit reference to digital optimisation.

KPIs had been agreed with informatics colleagues to ensure measurability and realistic target-setting using baseline data. External stakeholder feedback had been received from Healthwatch, the Patient and Public Forum and ICB colleagues. An easy read summary quality account for the public was also being prepared for Trust Board submission.

The Committee commended the quality of the process and engagement of the team.

Committee noted the report and approved it for presentation to Trust Board.

5.8	Fundamentals of Care	HF	Assurance	Report 10

Areas of good practice included patient experience, patient feedback and catheter care. Key risks included ED overcrowding, corridor care/boarding and critical workforce gaps in dietetics and speech and language therapy.

The Committee discussed the format and volume of the report. JM suggested that future reports should lead with the key issues requiring the Committee's assurance, alert or advice, with full supporting detail available as supplementary material. HF agreed to review the format.

Committee noted the report.

5.9	Blood Transfusion	JW	Assurance	Report 11

JW presented the Blood Transfusion report. A decrease in wrong blood in tube incidents had been seen following the implementation of BloodTrack. Pre-operative iron infusions in the Day Case Unit at the Alex were under review following a previous committee recommendation. JW confirmed that surgical representation at the Blood Transfusion Committee was being progressed.

SSi noted that 92 Major Haemorrhage Protocol activations had taken place over a six-week period and queried whether this figure was appropriate. JW agreed to check and report back.

Action: JW to review the appropriateness of the number of Major Haemorrhage Protocol activations over the reported six-week period and confirm findings to the Committee.
Action: JW to confirm surgical representation at the Blood Transfusion Committee.

Committee noted the report.

5.10	Learning from Deaths Q3	JW	Assurance	Report 12

JW presented an abbreviated update. The full Q3 Learning from Deaths report had not been completed in time and would be brought to a future meeting. The SHMI remained within expected parameters; a slight increase at the Alex Hospital had since stabilised. Committee noted the update.				
5.11	Organ Donation	JW	Assurance	Report 13
JW reported a strong year for organ donation, with an increase in activity over the 12-month period and continued compliance with NHS Blood and Transplant standards. Dr Haynes, the Trust's Lead Clinician for Organ Donation, had stepped down after seven years in the role, having made a significant contribution to advancing the organ donation agenda. Dr Bhardwaj had been appointed as the new Lead Clinician and a formal handover was under way. Committee noted the report.				
5.12	Learning Disabilities and Autism Q4	HF	Assurance	Report 14
Tier 1 training compliance remained above 90%. Discussions regarding Oliver McGowan Level 2 funding were continuing with ICB colleagues. Community engagement with SEND and local community groups was ongoing. Commitment to this agenda had been embedded in the 2026–27 Quality Account. Committee noted the report.				
5.13	Patient Safety, Incidents and Complaints Q4	KA	Assurance	Report 15
Well over 5,000 incidents were reported in the quarter, consistent with previous quarters. One never event was reported and investigated. No Regulation 28 (Prevention of Future Deaths) notices were received in this quarter. A 30% reduction in overdue actions was recorded compared with the same period the prior year. 875 complaints were received during 2025–26. Revised complaint KPIs had been implemented from 1 May 2026 in response to increasing complaint volumes and complexity. A 10% increase in PALS contacts was recorded between Q3 and Q4; almost 90% were closed within two working days. Work continued to strengthen investigation processes using the Being Fair tool and compassionate engagement of staff. Committee noted the report.				
5.14	Patient Experience, Carer and Community Experience Q4	AS	Assurance	Report 16
The AccessAble partnership continued to deliver green assurance; a new five-year contract had been signed. In Q4, 8,741 individual users accessed Trust guides through the platform. Interpreting and translation: the digital and telephone-first approach, live since 2 January 2026, had significantly shifted the service mix. Video bookings increased from 9.1% to 29.7%; face-to-face bookings reduced from approximately 70% to 38.2%. Monthly spend had reduced despite increased booking volumes. The Trust's volunteering programme had received national recognition and had been showcased at the House of Commons. Eight other trusts had contacted the Trust to learn from its volunteer recruitment streamlining approach, which had reduced mobilisation time from six weeks to two. A health literacy hub had been launched with the ICB. Experience of Care and Accessible Information Standards self-assessments were under way, with planned escalation through governance committees. RS queried delayed discharge figures, noting that medication delays accounted for 29% of cases. AS confirmed that weekend pharmacy volunteers had not reduced this figure and agreed to explore the recently published Caring Communities report for further insight. Committee noted the report.				
6	PERFORMANCE REPORTS			
6.1	Integrated Performance Report	TP	Information	Report 17

TP presented key highlights from the Integrated Performance Report.

System-wide EAS was 69.6% in April 2026, a slight decline from 71.5% in March, with the Easter period, industrial action and high admissions over the Easter Bank Holiday weekend noted as contributory factors. The Trust ranked 41st nationally for the week commencing 10 May 2026.

RTT performance was 62.2% in April against a plan of 57.5%; however, waiting list size was a concern with referral volumes above plan. Long waits remained a challenge in ENT, T&O and oral surgery, with plans to eradicate 52-week breaches before September 2026.

Cancer FTS performance was 75.3% in April 2026, improved from March though not yet at target. Breast cancer performance had improved by approximately 20% from March to April. Urology prostate backlogs were being addressed through plans to access the robotic theatre, targeting clearance by August 2026.

Committee noted the report.

6.2	Research and Innovation Q4	JW	Assurance	Report 18

JW reported that the Trust was the highest recruiting acute trust in the West Midlands by the end of March 2026. R&I funding was on target to be maintained at the same level as prior years. A Memorandum of Understanding was being explored with Worcester University and Wye Valley Trust to strengthen collaboration on the research and innovation agenda.

Committee noted the report.

7	GOVERNANCE & RISK			
7.1	Improving Safety Action Group Escalations	HF	Assurance	Report 19

HF presented the ISAG escalations report.

Medical Device Training: a wider workstream was being established within the Chief Operating Officer's portfolio to address inconsistencies in how medical devices were managed across the organisation, covering training, governance and procurement. JW confirmed that all relevant stakeholders including procurement would be involved. JM noted the link between this workstream and procurement process concerns discussed earlier in the meeting.

Corridor Care: work was ongoing to address corridor care and boarding and was being managed through ISAG.

Committee noted the report.

7.2	MBRRACE Report 2024	JJ	Assurance	Report 20

JJ presented the Embrace 2024 report, covering 15 cases reviewed: 10 stillbirths and five neonatal deaths. The Trust's perinatal mortality rate was comparable to its peer group and 5% lower than the comparative group for the year.

One case was rated C and one was rated D. The D-rated case related to an inadequate risk assessment at the onset of labour, which had resulted in a woman commencing her birth journey in the Meadow Birth Centre rather than in the delivery suite where continuous electronic monitoring would have identified deterioration at an earlier stage. Peer review by colleagues at Hereford ensured external validation of case ratings.

JM noted the volume of different reporting frameworks applicable to maternity services and suggested that consideration be given to presenting a consolidated overview to support Committee oversight.

Committee noted the report.

7.3	PSII Summary	HF/JW/KA	Assurance	Report 21

HF presented the PSII summary. Two PSIIs had been approved in May 2026 and key learning from each case was identified.

The Committee discussed concerns arising from one case regarding inconsistent interpretation of the terms 'urgent' and 'emergency' across departments and clinical systems. JM highlighted that differing interpretations across clinical teams, pathology and pharmacy presented a patient safety risk. JW, HF and KA agreed to take forward a piece of work to establish trust-wide standard definitions for urgency categories. Action: JW, HF and KA to develop a trust-wide framework defining urgency categories across all departments and clinical systems and report back to the Committee. Committee noted the report.				
7.4	QGC Terms of Reference	HF	Approval	Report 22
Queries had been received regarding the QGC Terms of Reference. In the absence of GS, it was agreed that queries would be discussed outside the meeting and the Terms of Reference would be brought back to the Committee at the next meeting.				
8	Regulatory and Accreditation Reports			
8.1	Committee Escalations	JM	Approval	Report 22
Report Format and Agenda Management The Committee discussed ways to improve the clarity and management of reports, including spreading annual reports across the year, consolidating maternity reports into an accessible overview, and reviewing font size and layout so that material was readable. JJ confirmed that meetings to progress consolidation of maternity reporting were already planned. **Maternity Safe Staffing Reporting Frequency** JJ proposed that the Maternity Safe Staffing report move to a quarterly cycle, with exceptions reported as required. **Monthly IPC Updates** Confirmed under item 6.3. LW to provide a brief monthly IPC cover sheet to the Committee.				
9	Date of Next Meeting	JM	Information	
To be confirmed.				
10	Any Other Business	JM	Information	

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Public Board
Date of Meeting:	14 July 2026
Title of Report:	Infection Prevention and Control Annual Report 2025/26
Lead Executive Director:	Hayley Flavell
Author:	Liz Watkins DIPC
Reporting Route:	TIPCC Quality governance Committee
Enclosures included with this report:	IPC Annual Report
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The purpose of this report is to provide assurance to The Worcester Acute Hospital NHS Trust (WAHT) Board of Directors, Governors and the public for the reporting period 1 April 2025- 31st March 2026 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (update December 2022) (commonly known as The Hygiene Code) and with regard to appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils the Trusts' statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Updated December 2022), which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual programme which is monitored at the Trust's quarterly Infection Prevention and Control committee (TIPCC) meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase organisational focus and collaborative working to ensure continued compliance and continuous improvement.

The report also reflects the IPC Board Assurance Framework (IPC BAF). It is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework and sets out our priorities and plans to achieve further improvement and reductions in infection during 2026-27 and achievement of the quality priorities.

Recommended Actions required by Board or Committee

Scrutinise the information contained within this report, to ensure it provides sufficient detail for assurance on the range of issues covered and request any additional information necessary.

2. Note the continuing performance in relation to CDI and other key infection targets, the associated impact on patient safety, and measures being progressed to mitigate risks.

3. Approve the report for publication on the Trust website.

Executive Director Opinion[1]
This Annual Infection Prevention and Control (IPC) Report provides moderate to high assurance that the Trust maintains compliance with the Health and Social Care Act (2008) Hygiene Code, supported by a well established governance framework and clear executive oversight. The Trust has demonstrated continued progress during 2025/26, with strengthened leadership, improved system working, and visible organisational focus on IPC as a core component of patient safety and quality.

[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.