Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2025-2026

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Foreword

“As the Chief Nursing Officer and Executive Director of Infection Prevention and Control, I would like to take this opportunity to say thank you to all the staff, colleagues, and partners for welcoming me to the organisation. Infection Prevention and Control is pivotal in ensuring that our patients and citizens receive safe and high-quality care, and it is everyone’s responsibility.

Resetting our focus and raising the importance of fundamentals of care, has been a real focus for us here at The Worcestershire Acute Hospital Trust (WAHT). As the Trust’s Executive Director of Infection Prevention and Control I am proud to be able to present this Annual Infection Prevention and Control Report for 2025/26, which has been developed in collaboration with the Director of Infection Prevention and Control and the Infection Prevention and Control (IPC) Team. This report outlines the activities relating to infection prevention and control for the year from April 2025 to the end of March 2026, presenting the arrangements the Trust has in place to reduce the spread of infections. It outlines our accountability arrangements, policies and procedures relating to infection prevention and control, audits, and the education necessary to support the prevention and control of infections.

Our focus on cleanliness, antimicrobial prescribing and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care from us.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to *Putting Patients First.* The Quality Governance Committee continued to scrutinise our infection prevention progress quarterly on behalf of the Board throughout 2024-25.

Our key achievements for 2025/26 include:

- The Trust reported below threshold for our *Clostridioides difficile* cases.
- The trust reduced the MSSA blood stream infections from 2024-25.
- NHSE rating reduced from requires intensive scrutiny and monitoring to enhanced monitoring and support.
- Mandatory Infection Prevention and Control training completed by 86.90% of clinical staff.
- 95.4% of non-clinical staff up to date with Infection Prevention and Control (IPC) e-learning.
- Recruitment to the mattress store and Fit mask testing teams.
- IPC promotional activities included IPC week and World Health Organisation Clean Your Hands Day.

Looking forward to 2026/27, the IPC team and all WAHT staff will continue to work towards the prevention of all healthcare acquired infections. This will be guided by our overarching IPC annual programme of work and strengthening our relationships with our system partners."

I trust you will find this report informative.

Hayley Flavell,

Chief Nursing Officer and Executive Director of Infection Prevention and Control (DIPC

Definitions/ Glossary

ACP	Advanced Care Practitioner
AE	Authorising Engineers
AER	Automated Endoscope Reprocessor. A specialised machine for washing and disinfecting endoscopes
AHP	Allied Health Professional
AmpC beta lactamases producing Enterobacteriaceae	Produce enzymes which mediate resistance to a wide variety of B-lactam antibiotics e.g., amoxicillin
ALEX	Alexandra Hospital Redditch
AMS	Antimicrobial Stewardship
ANTT	ANTT® / Aseptic Non-Touch Technique: A specific type of aseptic technique with a unique theory and practice framework (NICE 2012).
ASG	Antimicrobial Stewardship Group
AP	Authorised Persons
Bacteraemia	A bloodstream infection
BSI	Bloodstream Infection
CDI	*Clostridioides difficile infection. Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
CMT	Certified Medication Technician
CNO	Chief Nursing Officer
COHA	Community Onset Healthcare Acquired
COIA	Community Onset Indeterminate Association
COVID-19	Coronavirus disease
CPA/ UKAS	*Clinical Pathology Accreditation (CPA* UK) is a subsidiary of United Kingdom Accreditation Service *(UKAS)*
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
D&V	Diarrhoea and vomiting
Datix	Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DDD	Defined Daily Doses. The DDD is a standardized measure used to determine the average daily dose of a medication used for its main indication in adults.
DH	Department of Health

DIPC	Director of Infection Prevention & Control
E. coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ED	Emergency Department
EDIPC	Executive Director for Infection Prevention and Control
EOLAS	Eolas streamlines access to knowledge for use at the point of care, ensuring all healthcare professionals can make the right decision for every patient, every time
EPMA	Electronic Prescribing and Medicines Administration
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
EPP	Exposure Prone Procedure
EPR	Electronic Patient Record
ESR	Electronic Staff Record
GAP	WAHT Audit Tool
GNBSI	Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas.
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HOHA	Hospital Onset Healthcare Associated
HPV	The ProXcide® System uses innovative hydrogen peroxide vapour (HPV) technology for a rapid decontamination process tailored to each room's requirements, ensuring log-6 kill efficacy on all surfaces
HSDU	Healthcare Sterilisation Decontamination Unit
HSE	Health and Safety Executive
HTM	Health Technical Manual. These documents give comprehensive advice and guidance on the legal requirements, design implications, maintenance, and operation in healthcare premises providing acute care.
ICB	Integrated Care Board replaced Clinical Commissioning Boards July 2022
IC NET	IPC Surveillance software and database
ICS	Integrated Care System
IGAS	Invasive Group A Strep
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPCT	IPC Team
IQPR	Integrated Quality Performance Report
IV	Intravenous
KPI	Key Performance Indicator
KTC	Kidderminster Treatment Centre

LHE	Local Health Economy
MD	Managing Director
MDT	Multi-disciplinary Team
MHRA	Medicines and Healthcare Products Regulatory Agency
MICAD	MICAD Trust Audit Reporting System
MPOX	Mpox, previously known as monkeypox, is a viral illness caused by the monkeypox virus, a species of the genus Orthopoxvirus
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g., inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NED	Non-Executive Director
NEWS 2	The latest version of the National Early Warning Score (NEWS), which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NNU	Neonatal Unit
Norovirus	Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults.
OH	Occupational Health
Outbreak	One or more persons with the same signs, symptoms in time place and space.
OPAT	Out-patient parenteral antimicrobial therapy
OPD	Outpatients Department
PCR	A polymerase chain reaction (PCR) test detects genetic material from a pathogen or abnormal cell sample
PEWS	Paediatric Early Warning Score
PFI	Private Finance Initiative
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment e.g., gloves, aprons, and goggles
PPS	Point Prevalence Survey
PSIRF	The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety
PVD	Peripheral Vascular Device
QGC	Quality Governance Committee
RAG RATING	Red, Amber, Green rating system
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RSV	Respiratory Syncytial Virus (RSV) is a common viral infection that primarily affects the respiratory tract, particularly in infants and older adults, and can lead to severe respiratory illnesses
SARS-CoV-2	COVID-19
SCSD	Specialised Clinical and Services Division

SEPSIS	A potentially life-threatening condition caused by the body's response to an infection.
SOP	Standard Operating Procedure
SSI	Surgical Site Surveillance
SSISS	Surgical site Infections Surveillance Service
SWFT	South Warwickshire University NHS Foundation Trust
TB	Tuberculosis
The Source	Staff Intranet Site
TIPCC	Trust Infection Prevention and Control Committee
TOR	Terms of Reference
UK HSA	UK Health Security Agency formally Public Health England (UK HSA)
UVc	Ultra-V Connect™ discreetly emits high-intensity UV-C light for efficient routine surface decontamination.
WAHT	Worcester Acute Hospitals NHS Trust
WHO	World Health Organisation
WREN	Worcestershire Reporting System for audit
WRH	Worcester Royal Hospital
WSG	Water Safety Group
WSP	Water safety Plan
WTE	Whole Time Equivalent
WVT	Wye Valley NHS Trust

SECTION ONE: INTRODUCTION

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.

Liz Watkins.
Associate Chief Nursing Officer/ Director of Infection Prevention & Control (DIPC)

Table 1

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

Infection Prevention and Control is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers (WHO) it is essential to ensure that the safety and quality of care for our patients can be provided. At Worcester Acute Hospitals NHS Trust (WAHT) infection prevention and control is a key priority.

Our Trust is committed to delivering the highest infection prevention and control standards to prevent avoidable harm to patients, visitors, and staff from healthcare associated infection. It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times.

The infection prevention and control agenda faces many challenges including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing

service development in addition to national thresholds and outcomes. The Trust Infection Prevention and Control Team experienced several changes in personnel over the last year and recruitment into the team has been challenging. This has resulted in periods of reduced staffing levels and reduction in the service provided to clinical teams.

The Board of Directors and ultimately the Managing Director, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year, the 2025/26 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia and *Clostridioides difficile* infection (CDI) as areas for improvement. Within Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm of the Outcomes Framework reducing all HCAIs remained a priority.

As previously reported, the extension to the mandatory surveillance to include Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Escherichia coli (E. coli) Bacteraemia infections since 2011 together with the MRSA Bacteraemia and CDI national reduction thresholds set for Integrated Care Systems (ICS) reflects the zero-tolerance approach for all avoidable HCAIs.

This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2025 -31 March 2026 by WAHT. The report is aligned to the 2025/26 IPC Programme, informing progress against the objectives set and outlines performance of WAHT against the MRSA Bacteraemia and CDI reduction thresholds.

In addition, the report aims to reassure the public that reducing the risk of infection through robust infection prevention and control practice is a key priority for WAHT and supports the provision of high-quality services for patients and a safe working environment for staff.

SECTION TWO: Who are we, our duties, arrangements, and assurance

2.1 Who are we?

As a Trust, the Worcester Acute hospitals provide health services to around 450,000 people in Worcestershire. These include three hospital sites, Worcester Acute, the Alexander Hospital in Redditch and Kidderminster Hospital and Treatment Centre as well as some community-based services.

We provide a wide range of services to a **population of over 603,000** people in Worcestershire as well as caring for patients from surrounding counties and further afield.

In a year we…

Over the last year, we provided care for:

- **600,296** outpatients (face-to-face appointments)
- **122,952** outpatients (video or phone appointments)
- **145,819** inpatients
- **109,634** walk-in patients in A&E
- **44,639** patients arriving by ambulance
- **4,581** births

We also carried out:

- **18,897** elective operations
- **3,162** emergency operations
- **2,040** trauma operations
- **202,275** plain film x-rays
- **84,699** CT scans
- **28,249** MRI scans
- **73,009** non-obstetric ultrasound scans
- **24,402** endoscopies

We employ over 8,000 people and **over 300 local people volunteer** with us. We have an annual **turnover of nearly £600 million**.

WAHT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC team utilises both a reactive and proactive approach with the emphasis on being visible so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e., being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems.

Looking forward, it is critical that WAHT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations, commissioning

Integrated Care Board (ICB), and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England.

2.2 Our Duties & Arrangements

Infection Prevention and Control Service:

- Executive Director of Infection Prevention and Control (Chief Nursing Officer)
- Associate Chief Nursing Officer/ Director of Infection Prevention and Control
- Infectious Diseases Doctors / Consultant Microbiologists
- Antimicrobial Pharmacist
- Infection Prevention and Control Nurse Specialists
- Infection Prevention and Control Nurses
- Fit mask testing Team
- Infection Prevention and Control Team Admin support
- Mattress cleaning teams

The Executive Director of Infection Prevention and Control (EDIPC) is a role required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008, updated 2022). The EDIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable HCAIs at all levels within the organisation.

The EDIPC is the public face of IPC and is responsible for the Trust's annual report, providing details on the organisation's IPC programme and publication of HCAI data for the organisation.

The EDIPC leads the commitment to quality and patient safety, effective communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users, and visitors. Additional support is provided by the antimicrobial pharmacists, IPC Doctor/ Consultant Microbiologist, and Director of Infection Prevention and Control (DIPC). All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Hygiene Code.

At WAHT, the Chief Nurse holds the role of EDIPC supported by the DIPC who has the responsibility of providing expert advice and day to day operational management of the service reporting to the Chief Nursing Officer (CNO).

2.3 The Infection Prevention and Control Team

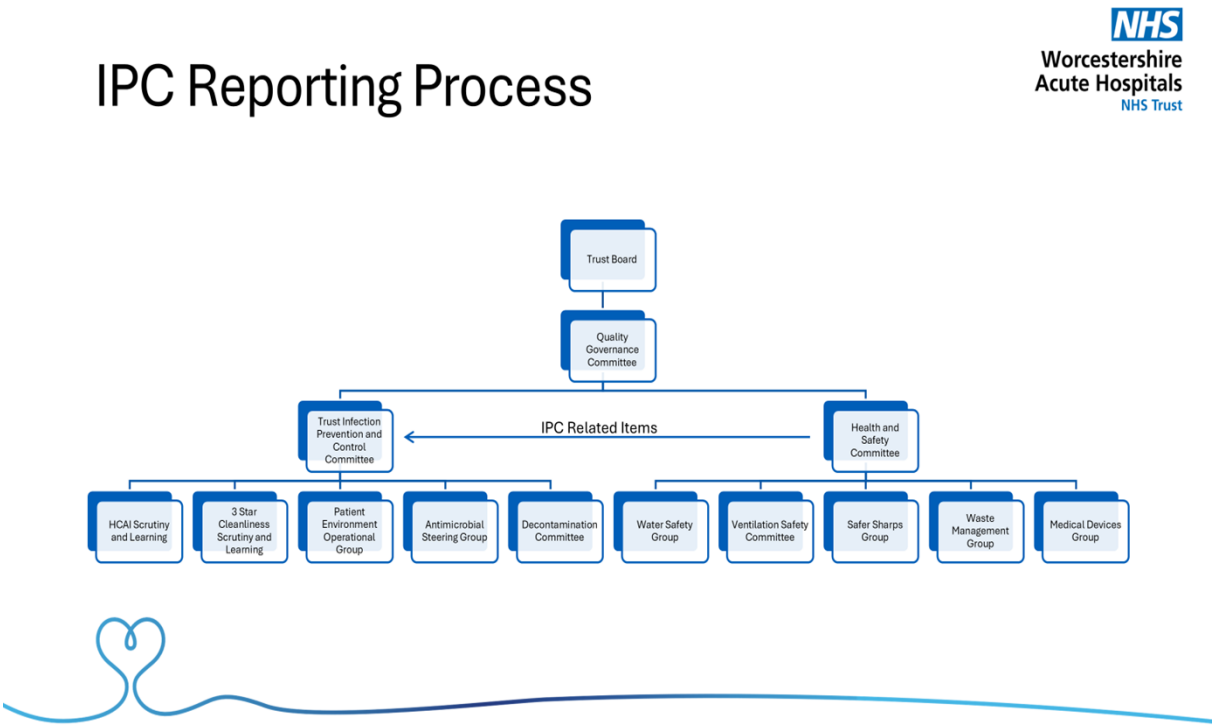
The DIPC has overall responsibility for the IPC Team. The IPC Team works collaboratively alongside clinical leaders at the Trust.

The IPC Team is led day to day by the DIPC for IPC and is supported by Infection Prevention and Control Nurse Specialists, Infection Prevention and Control Nurses, Fit mask testers, Mattress decontamination team, IPC Team Admin support.

The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development.

The IPC team devises and implements a robust Annual Programme of Work to reduce HCAIs. This is achieved by working in collaboration with all WAHT services and staff. The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

2.4 Committee Structures and Reporting Processes



Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Managing Director has overall accountability for the control of infection at WAHT, and any IPC matters across the trust.

WAHT's performance against National and local thresholds are included in the Integrated Quality Performance Report (IQPR) and TIPCC Reports which are presented at WAHT Quality Governance Committee

Quality Governance Committee

Quarterly IPC reports, the IPC Board Assurance Framework and the IPC Annual report are presented to the Quality Governance Committee (QGC) meetings. The QGC is chaired by a Non - Executive Director (NED), it is a delegated committee of the Trust Board which meets

monthly. The purpose of the QGC is to provide oversight and scrutiny of infection prevention and control standards and practices and seeking assurance that IPC Standards are being met. The QGC will provide assurance to the Trust Board around WAHT's arrangements for protecting and improving the quality and safety of patient-centered healthcare, thus improving the experience for all people that encounter the services at WAHT.

Trust Infection Prevention and Control Committee (TIPCC)

The membership is multi-disciplinary and includes representation from the divisions, operations and quality directorates, estates department, antimicrobial pharmacists, and Consultant Microbiologist. Additional members are representatives from UK HSA, ICB and Private Finance Initiative (PFI) partners and patient representatives. The meeting is chaired by the EDIPC and meet quarterly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation and they are reviewed and approved by the QGC. The IPC BAF is also presented, discussed, and adopted at TIPCC before being presented to the QGC and the Trust Public Board. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

The purpose of this meeting is to oversee compliance against the Health and Social Care Act (2008, updated 2022) and to provide assurance that risks are appropriately managed and that appropriate arrangements are in place to provide safe, clinical environments for patients, visitors, and staff.

The IPC Governance Meeting is chaired by the EDIPC and is responsible for:

- Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.
- Reviewing, developing, and adopting relevant policies, procedures, care pathways and guidelines and standard operating procedures.
- Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.
- Ensuring, through the EDIPC, the associated Committees and the Trust Board are informed of any significant infection prevention and control concerns.
- To receive, review and endorse the publication of the Infection Prevention and Control Annual Report.
- To ensure that the wider aspects of maintaining IPC are reported and reviewed within the IPC group these include Health and Safety, Estates and Facilities, Water Safety, Antimicrobial stewardship, and occupational health.
- Effective management of IPC related outbreaks and concerns

Water Safety Strategic and Operational Groups

The Trust has two water safety groups, strategic and operational. The membership is multi-disciplinary and has representatives from the Trust, PFI Partners and Authorising Engineers. The Groups continue to monitor water risk assessments especially around *Legionella*, *Pseudomonas*, flushing regimens, annual disinfection, Automated Endoscope Reprocessor

(AER) and capital developments. The groups review and develop the Trusts water safety policy and water safety plan.

Decontamination Safety Group

This group is chaired by the DIPC. The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The group monitors, challenges, reviews, and where appropriate acts in response to presented assurances to ensure that the trust is demonstrating compliance against regulatory standards. The aim of the group is to identify any risk factors in relation to decontamination, to identify any trust strategies for the safe decontamination of medical devices in accordance with national and local guidelines with particular reference to HTM 01-01 and 01-06, Decontamination policies, Health, and Social Care Act 2008 (updated 2022), MHRA guidelines, NICE IPG 196 Guidance – replaced with IPG 666 2020, ISO 13485 and Care Quality Commission (CQC). The group receives reports from Endoscopy services, Outpatients and Specialist Surgery, Sterile Services (HSDU), theatres, renal service, and Imaging with the group meeting quarterly. A Terms of Reference and Governance structure was developed and is reviewed by the Decontamination Safety Group annually. The Group reports to the TIPCC Meeting.

Ventilation Group Meeting

The membership is multi-disciplinary and has representatives from the Trust, PFI Partners and an Authorising Engineer. The Group continues to monitor ventilation risk assessments and arising issues especially around air handling units, air extraction, and capital developments.

2.5 Roles contributing to IPC service

DIPC and Consultant Microbiologist

The DIPC, and Consultant Microbiologist meet weekly to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

Infection Prevention and Control Link workers

The aim of our IPC link worker is to enhance the IPC knowledge of healthcare professionals working within WAHT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. Our IPC link workers are responsible for arranging IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues. Quarterly link worker meetings are offered with the expectation that IPC Link workers attend regularly.

Divisional Leads, Matrons, Ward Manager, Sisters, Charge Nurses, and Team Leaders

Divisional leads, Ward Matrons, Sisters, Charge Nurses, and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Monthly cleanliness audits are undertaken with staff. These audits are reported in the Divisional Leads and Estates reports to the TIPCC meeting. The Sisters, Charge Nurses, Matrons and Team Leaders are responsible for ensuring the link workers are supported in performing their role and have appropriate time and resources to do this effectively. Self-audit scores and on-going

work undertaken by the link workers is also included in Managers reports submitted to the TIPCC meeting.

Learning and Development Team

Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Arrangements are in place for staff training to be effectively recorded and maintained in staff records. Alerts inform managers of their staff's non-compliance with mandatory training. Training compliance is reported to TIPCC.

Roles and Responsibilities of all Staff

All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow the standard IPC precautions at all times and are familiar with IPC policies, procedures, and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and act as appropriate. All IPC policies and procedures are available on the staff intranet site, The Source.

SECTION THREE - Compliance with the Health & Social Care Act (2008); Code of Practice on The Prevention and Control of Infections and Related Guidance (2015)

Statement of compliance - Compliance with the Health & Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance (2015) (updated 2022):

The 'Hygiene Code'

Declaration of Compliance

Following self-assessment against the criteria in the Hygiene Code, the Trust is able to declare our compliance with the Hygiene Code for the year 2024-25.

Further, based upon our self-assessment in 2024-25 we are able to declare our partial compliance with the IPC Board Assurance Framework.

Criterion 1: Systems to manage and monitor the prevention and control of infection.

Criterion 1: Leadership Arrangements

The *Health & Social Care Act (2008) Code of practice on the prevention and control of infections and related guidance (2015)* (Updated 2022) (also known as the Hygiene Code) sets out the arrangements all Trusts should have in place to prevent and manage infections.

An IPC specific Board Assurance Framework was introduced, most recently updated in February 2026. Regular self-assessment of compliance has been completed, with scrutiny via the Trust Infection Prevention Committee (TIPCC), then progressing along the

governance structure to the QGC on behalf of the Trust Board. This has enabled the Trust to report a high level of assurance that we comply with the IPC BAF, as well as the Hygiene Code.

NHS England increased the Trust to requiring Intensive surveillance and monitoring in January 2025 due to due to the breach in the HCAI alert organisms, following an NHSE visit in May 2025 the monitoring level remained the same. . It should be noted this is a regional and national position with many Trusts exceeding the set Trajectories. This should not detract from the work that has been carried out to address the high infections rates. The level of scrutiny was reduced to requiring Enhanced surveillance and monitoring following a repeat visit to the Trust in September 2025 and evidence of sustained improvement in the Trust in infection prevention and control.

The Trust Board remains committed to the prevention of infection as a priority, ensuring quarterly scrutiny by the Quality Governance Committee on behalf of the Board. The CNO is the executive lead for IPC and the DIPC supports the strategic delivery of the IPC program.

WAHT has a multi-disciplinary Infection Prevention Team led by the DIPC. The team has dedicated resources available to support its work and received support for implementation of several measures during the year to support the response to HCAI cases and outbreaks.

The Trust's Clinical Microbiologists support the team in all aspects of infection prevention including outbreak management, surveillance for and management of healthcare associated infections and policy development. This support is led by the Infection Control Doctor, a role currently shared between two Consultant Microbiologists. In addition, the Trust's clinical microbiology laboratory facilitates screening for and detection of key infections (known as alert organisms) both from clinical and environmental samples.

Consultant Microbiologists and the Infection Prevention Team continue to support improved use of antibiotics as part of our antimicrobial stewardship work. The trust has an Antimicrobial Stewardship (AMS) Pharmacist and there are AMS leads within divisions.

Divisional Leaders remain committed to providing strong and visible leadership in relation to the prevention of infection. The responsibility of all staff to ensure they adhere to expected standards of infection prevention practice is set out in Trust job descriptions and has been reinforced on a regular basis throughout the year via a range of communications. Awareness of individual and managerial responsibilities has increased significantly.

Criterion 1: Governance and Assurance

The DIPC reports to the CNO (EDIPC), the Managing Director and onwards to the Board on all matters relating to infection prevention and control.

The TIPCC business meeting, chaired by the CNO, is held once every 3 months, and TIPCC Scrutiny and Learning meetings take place in each of the intervening months and are chaired by the DIPC. TIPCC has formally established terms of reference and a cycle of business, in line with requirements in the Hygiene Code. It reports to the Quality Governance Committee, and onwards to the Trust Management Executive, which scrutinises performance and actions being taken on behalf of the Board.

The TIPCC Scrutiny and Learning Meetings provide an opportunity for detailed scrutiny of patients with HCAI's resulting in shared learning across the Trust and enables focus on the key issues needed to achieve improvement.

Divisions and key services such as Estates and Facilities report to TIPCC on the actions they are taking to reduce infections and improve standards. The reporting framework ensures Divisions review and understands variations in practice and hotspots requiring focused action.

Criterion 1: Systems to manage and monitor the prevention and control of infection.
• Leadership and governance arrangements are in place in line with Health and Social Care Act 2008 ~ (updated 2022) requirements. • There are robust Governance processes in place and the risk management system is used to support decision making and ensure the correct mitigations are in place. • A multi-disciplinary Infection Prevention & Control Team is in place, including nursing, administration along with data support and microbiology. • Patient representatives attend Trust infection prevention and control committee. • Trust data is uploaded to the UK HAS data capture system • CDI HCAI trajectory was achieved following an extensive work programme to address the key themes and trends. • Executive Director for IPC sits on the Trust board. • A range of actions were taken during the year to identify and implement key improvements needed so that we can achieve the infection reductions needed. • Our *Fundamentals of Infection Prevention and Control* are a core part of our programme. • Continued working with system partners to review and reduce HCAIs including CDI. • Continued working with partners to ensure smooth transfer of care between organisations and systems. • Information on our Fundamental of IPC are displayed across the Trust. This includes wards displaying their achievement of the standards required. • Our internet page contains key information for our patients and visitors, and the Trust use social media to share key messages to the public regarding infections including Norovirus, Influenza etc. • Fluid resistant surgical face masks are available at Trust sites to ensure patients and visitors have the option to wear a face mask. • Daily outbreak reports continue and are shared with our systems partners. • The Trust EPR system has an IPC risk assessment in place to ensure correct placement of patients. • TIPCC meeting TOR and membership reviewed annually. • DIPC has provided quarterly reports to Quality Governance Committee including thresholds, risks, and progress against objectives. • The Annual IPC Report is produced and presented to the public board. • The Annual IPC Report is made available for public viewing via the Trust website. • IPC BAF was developed, updated as required and presented to the TIPCC, QGC and the Public Board • Risks associated with infection have been entered on the Trust risk register and are reviewed monthly and quarterly via the Executive Risk Management Committee. • The IPC team continued to identify IPC risks and areas of weakness in policy and practice though audit and surveillance. • CQC Provider Compliance Assessments completed and regular meetings with our CQC representatives. • Information shared with external agencies and partners when requested. • IPC Team has worked alongside clinical staff in the hospitals as a mechanism to deliver teaching and education to staff.

- Weekly HCAI surveillance meeting with IPC Team , consultant microbiologist , AMR pharmacists, and ICB to identify outbreaks,
- All infection outbreaks reviewed, and service improvement plans developed so that relevant learning was appropriately communicated and acted upon.
- Strengthened link worker training with clear roles and responsibilities
- Case reviews were completed for all patients who developed CDI.
- New electronic patient record alerts have been developed to reflect emerging infections supported by informatics.
- Alerts are added to patients' EPR to highlight risk of infection.
- IPC audit tools adapted in 2011/12 from the Department of Health (DH) /Infection Prevention Society Quality Improvement Tools and DH Saving Lives care bundles have been revised and updated to incorporate new guidance. These are reviewed and updated annually.
- High Impact Intervention audits are completed by the wards.
- IPC training is delivered via a mixture of face to face, bespoke and via a Heath Education E-learning package.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

- Our deep cleaning teams remain an embedded part of our cleaning programme; they remain responsive to the request for deep cleans.
- The use of HPV and UVc systems continue,
- Clinical areas continue to use Rediar instant air purification devices.
- The Trust has continued to monitor our cleaning standards using the national MICAD system and ensured results are available for all staff on the trust electronic quality reporting system.
- All areas have a functional risk assessment in line with the National Standards of Healthcare Cleanliness 2021
- A robust system of environmental audits is in place.
- All areas have a star rating displayed and reviewed annually as a minimum.
- Star ratings are reviewed if there are two consecutive audit failures as well as two consecutive improvements and adjusted accordingly.
- There is still improvement required on how audits are responded to however the IPC team has introduced an audit escalation plan.
- IPC database in place to ensure action pans are in place
- Weekly walkarounds with MDT.
- Monthly Cleanliness Scrutiny meeting in place to review all scores of 3* or less.
- The Trust has scrutiny processes in place where concerns about cleanliness are identified.
- IPC audits also review levels of cleanliness and escalate concerns.
- Cleanliness scores reported to TIPCC.
- Annual PLACE assessments undertaken.
- Regular IPC site reviews with external partners

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

- Antimicrobial stewardship (AMS) made good progress with antimicrobial ward rounds.
- The Trust has an antimicrobial pharmacist .
- New electronic prescribing system is in place.
- All Divisions have Divisional Board approved action plans to improve AMS and have improved their assurance levels during 2025-2026.

- Improvements are required to increase medical engagement in AMS.
- Trust Antimicrobial Treatment Guidelines are published on The Source.
- Participate in World Antimicrobial Resistance Awareness Week in November
- Trust has AMS meetings.
- Trust attends system AMS group meetings
- Work has taken place to implement the new electronic patient Record (EPR) for medications which was implemented in 2025.
- Sepsis training is available for staff.
- NEWS and PEWS are used widely throughout the Trust.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

- Information on our *Fundamental of IPC* are displayed across the Trust. This includes wards displaying their achievement of the standards required.
- Our internet contains key information for our patients and visitors, and we have used social media to share key messages to the public.
- Masks are available to ensure patients and visitors have the option to wear a face mask.
- Daily outbreak reports continue and are shared with our systems partners.
- The EPR system contains an IPC risk assessment in place to ensure correct placement of patients.
- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.
- Communication boards are located across the Trust providing patients and visitors of key communication.
- The IPC Team have a page on the Trust intranet page which provides information to staff.
- The external Trust website also has key messages relating to infection prevention and control.
- The Trust Intranet, The Source, promotes infection prevention issues and guides users to information on specific alert organisms such as MRSA and *Clostridioides difficile* as well as key organisms that may be of particular concern seasonally
- The IPC Team produce a monthly IC newsletter circulated to staff and placed on the IPC page on The Source.
- IPC produced an annual report covering the organisation's approach to prevention and control of infections for publication on the Trust's website.
- Hand hygiene is included in patient/visitor/volunteer/staff/agency staff information leaflets.
- Strategically placed hand hygiene products available with information on their use.
- Continued encouragement for patient and public involvement in hand hygiene and cleanliness campaigns and services' Quality Review process, satisfaction surveys, and PLACE inspections.
- Polices related to specific organisms and care pathways remind staff of the need to give affected patients and relatives leaflets about the infection.
- The IPC team continue to respond to ad hoc requests for information related to IPC under the Freedom of Information Act.
- IPC requirements are included in the health economy transfer/discharge form.
- IPC team share infection rates and outbreak information with appropriate services based upon local, regional, and national surveillance.
- Surgical Site surveillance data is submitted externally.

- Alert organism surveillance is undertaken by the IPC team.
- IPC policies and procedures are available on the IPC page on the Source.
- MRSA screening compliance shared.
- IPC team promoted Clean Your Hands Day, Infection Prevention and Control Week and Antimicrobial Awareness Week.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

- Assessment tools for infection risks are in use for patients on admission and throughout the in-patient stay. This includes diarrhoea and vomiting as well respiratory risk assessment tool.
- EPR has been adapted to ensure the correct information is recorded to enable the correct level of reporting from the system. Work continues to improve education and compliance.
- Our Infection Prevention and Control Team provide a service to advise and support clinical staff on all infection-related queries.
- COVID testing moved to symptomatic testing only, there is a daily symptom checker in place that is in line with the National guidance for COVID symptom, this also covers the possibility of influenza.
- Outbreaks and infection-related incidents have been effectively dealt with in 2025-26. These are listed in Appendix 1.
- Responsibilities of groups and staff included in IPC policies.
- Support provided by IPC team included visits and telephone contact.
- Continued to develop link staff and support their role.
- Continued to audit compliance with IPC polices and care pathways.
- IPC team has access to IC NET Laboratory IT system.
- IPC team reported outbreaks and incidents of infection to the ICB, UK HSA and NHSE.
- Outbreak of infection meeting are held with external partners and agencies to ensure transparency and that any lessons learnt are disseminated throughout the organisation.
- IPC received notification of outbreaks of infection within the local health economy.
- IPC specific organism policies available on the Source.
- Patients are screened for MRSA on admission.
- Antibiotic policy available to all clinicians.
- EOLAS prescribing guide app available to all clinicians
- MSSA/ MRSA BSI and CDI investigated using PSIRF approach.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.

- Highly visible senior nursing leadership has been maintained through leadership visits by divisional teams, the DIPC and the Chief Nursing Officers and deputy CNOs.
- Statutory and mandatory training and Trust inductions continue to include infection prevention and control as core requirements.
- At the end of 2025-26, mandatory level 1 training (non-clinical staff) achieved 95% compliance meeting the Trust requirement. Level 2 training (clinical staff) was at 86.9% compliance.

- A significant amount of ward-based training, electronic resources and posters have been put into place to support staff knowledge and awareness as the pandemic continued to devolve and guidance changed during the year.
- We have acted on the learning from our review process for cases of *Clostridioides difficile* infection and HCAI infections. As a result of our reviews, we have a good understanding of the causes of these infections, and quality improvement measures are in place focussed on reducing these infections.
- Alerts are added to Sunrise to highlight risk of infection.
- Worked with EPRR to develop HCID training, programme forming process for dissemination of info
- Compliance with MRSA screening policy audited monthly, and findings shared.
- As appropriate, joint investigations and reviews held between local partners and the acute trust on cases of MRSA Bacteraemia and CDI, to assist staff with managing outbreaks.
- Bespoke IPC Training is delivered if need identified.
- IPC team supported the development of Trust clinical policies/procedures and Standard Operating Procedures (SOPs).
- Infection Prevention and Control Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in The Trust via an IPC in the Built Environment Risk Assessment Form.
- The IPC Team has attended conferences and study days throughout the year.
- NHSE delivered IPC Masterclasses to all three sites.

Criterion 7: Provide or secure adequate isolation facilities.

- The Trust has over 130 single rooms available to support isolation requirements. It should be noted that not all have en-suite facilities.
- Trust policy includes use of cohort facilities to nurse patients with the same infections when numbers exceed the number of single rooms.
- This cohort model has been used extensively, and this model has continued to be utilised for patients with the same infection, being flexed up and down depending upon the number of patients infected.
- Daily reviews with ED to assist with the allocation of siderooms
- Throughout the year we have amended our processes in response to the changing national guidance for the management of infections.
- Measles and Invasive group A Strep (IGAS)and Candidozyma Auris (C. Auris) have been a focus, and pathways have been developed to ensure that all patients and contacts are managed effectively.
- Isolation Risk matrix developed to aid patient placement.
- Risk assessments performed by ward staff with support from the IPC team when insufficient isolation facilities were available to meet demand.
- Cohort approach taken as necessary within the trust during outbreaks of diarrhoea and vomiting.
- All episodes where staff are unable to isolate patients are reported to Risk Management via Datix.
- COVID-19 swabbing has continued throughout the year in line with National Guidance.

Criterion 8: Secure adequate access to laboratory support.

- We have an onsite microbiology laboratory which is accredited by UKAS, confirming it operates an effective and quality-controlled service.
- The laboratory links with regional and national laboratory networks as required to provide a full range of microbiology testing.
- The laboratory provided sufficient capacity for on-site testing for our patients. Specialised samples such as measles PCR were sent to the regional lab.
- There remain staff capacity issues in the department which at times increases the pressure on the clinical teams.
- Weekly meetings are held with the IPC team to review HCAI cases.
- The DIPC and Consultant microbiologists meet weekly.
- The EDIPC, DIPC and Consultant microbiologists meet monthly.
- Out of hours, the on-call duty microbiologists will provide Infection Prevention and Control advice for the Trust.
- Continuation of rapid testing for *Clostridiodes difficile* and use of typing to search for clusters and linked cases.
- Ribotyping used to determine if cases are linked for MRSA etc.
- Continuation of local test for Norovirus to speed up diagnosis and outbreak management of patients with infection.
- Continuation of local test for influenza to speed up diagnosis and outbreak management of patients with infection.
- Local testing for COVID-19 for symptomatic patients
- Point of Care testing available in Emergency Department for COVID-19 and Influenza
- Adequate resources available in laboratory for MRSA screening in line with national guidance.
- Mandatory surveillance also included MSSA, E. coli, *Pseudomonas* Bacteraemia infections.
- Consultant Microbiologist is the IPC Doctor.
- Medical microbiology support provided 24 hours a day 365 days a year.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

- Use of national High Impact Intervention audit tools to monitor compliance, this will be reviewed next year to align to the EPR system. GAP and WREN results are available for all staff to view on our electronic quality reporting system, helping support improvement.
- Our policy review programme has been progressed, with the few outstanding policies in the process of being reviewed.
- Throughout the year we have implemented a wide range of policies and procedures to manage infection and promote prevention, in line with national guidance. We have put the National Infection Control Manual on to the intranet that is available to all.
- All policies refer to the National IPC manual.
- We continue to achieve hand hygiene practice compliance of 98%.
- Published evidence reviewed whenever policies were developed or reviewed on publication of new national guidance to ensure they reflect up to date, evidence based, best practice national guidance.
- New policies developed as need identified.

- In collaboration with Pharmacy commenced work to implement the relevant recommendations of the Tackling Antimicrobial Resistance 2024-2029, the UK's five-year national action plan.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

- Our Occupational Health Service along with Human Resources Team (Health, Wellbeing and Flexible working) supports the health and wellbeing of our staff, as well as the staff of our PFI partners.
- A health monitoring and vaccination programme is in place.
- The Trust met our staff influenza vaccination target.
- PGD's and written instructions are available for prophylaxis treatment

SECTION 4 – Infection Performance

Respiratory Viral Infections

There remains a significant shift in focus and Living with COVID was promoted by UK HSA and NHS England. This was based on the lower impact of the current variants on mortality and admission to hospital. However, COVID has still impacted on the Trust's position as we continued to see patients admitted with COVID and acquire COVID whilst an inpatient. There are many variables to the acquisition.

The screening requirement is for symptomatic patients only. At times, these symptoms can be interpreted as other issues and a screen not taken as the symptom checker describes very broad signs of infection. The full respiratory panel was introduced as the Influenza season was declared. This enables multiple respiratory viruses to be detected.

This year Respiratory Syncytial Virus (RSV) in adults and children was challenging as there was a requirement to recommend isolation for these patients. RSV is usually a very low-level infection with only minor symptoms, however this year the impact was greater on patients who were sicker and more symptomatic.

Due to the number of influenza cases requiring isolation, a risk assessment was completed to reduce the isolation time for influenza patient contacts (patients who were contacts of influenza positive patients) to prioritise the side room use for those with active infections. The isolation of flu contacts is custom and practice and not based on any Acute NHSE/UK HSA guidance. The reduction in flu contact times has not resulted in acquisition of influenza.

The IPC Team assisted in the delivery of influenza national in patients' vaccination programme vaccinations for in patients who were unable to obtain vaccinations for from their community source.

This section of the report focuses on a summary of the actions we have taken to protect staff and patients from infection, as well as reporting information on hospital-acquired infection and outbreaks.

COVID-19 is reported to have an incubation period (the time between catching the infection and showing symptoms) between 1-11 days. This means someone can be admitted to hospital with no symptoms and test negative for COVID-19, despite having already caught the infection. National guidance sets out the following definitions for categorising COVID-19 infections which are detected during admission to hospital:

Community acquired	Onset day 0-2
Hospital onset – indeterminate acquisition	Onset Day 3-7
Hospital onset – probable hospital acquired.	Onset day 8-14
Hospital onset – definite hospital acquired.	Onset day 15 onwards

*The day of admission is Day Zero.
This has remained the same guidance and is unlikely to change in the foreseeable future.

During the year 2025/26 we cared for 594 patients with COVID-19 infection.
This is a decrease of 43% when compared to the number of patients treated in 2024/25

Of these 181 were determined to be probably or definitely acquired in hospital.
This is 32% of all COVID patients treated in 2025/26 and represents a fall from the 41% of hospital acquired COVID infections in 2024/25
This should be caveated with the screening standard as only symptomatic patients are screened on admission.

Some symptoms may be low level, and the patient may not be considered symptomatic, so not swabbed.

Category	Category description	Total
1. Community-Onset	Positive specimen date <=2 days after admission to Trust	261
2. Hospital-Onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after admission to Trust	122
3. Hospital-Onset Probable Healthcare-Associated	Positive specimen date 8-14 days after admission to Trust	88
4. Hospital-Onset Definite Healthcare-Associated	Positive specimen date 15 or more days after admission to Trust	93
Total		**564**

Outbreaks of COVID-19 Infection
Despite our efforts, in line with many other trusts, we were unable to fully contain this highly transmissible virus and reported fifty-eight ward outbreaks during 2025/26. Each outbreak was reported and managed in line with national requirements.

Review and Learning
There are quarterly COVID outbreak meetings and there is a review of all outbreaks for the quarter. The Divisional Governance teams present cases and the learning that has happened at Divisional level to enable wider dissemination of learning.

Measures Taken to Protect Patients from Hospital-Acquired RESPIRATORY virus.

Throughout the year there have been steps put in place to ensure that the appropriate risk assessment and safe patient placement occurs. The Trusts EPR system has enabled staff to have access to a respiratory risk assessment tool. Where patients with a confirmed or suspected respiratory virus are placed is regularly reviewed, by both the ward and IPC team to ensure patients are separated as far as possible from those who do not have a respiratory virus.

- Hand hygiene messages are reinforced regularly to encourage staff and patients to clean their hands more often than normal.
- Alcohol hand gel is readily available in all areas.
- There is a risk assessment in place to determine when there is a requirement for universal mask wearing. This is based on number of cases, staff sickness, and community prevalence.
- Respiratory Virus Winter Management Plan in place to aid clinical decision making.
- Access to masks for patients/visitors is available.
- The Trust continues to clean with disinfectant products that are effective against respiratory viruses.
- Special air scrubbers continued to be used in key areas to help to reduce the risk of airborne transmission of COVID-19.
- We swab patients in line with guidance to identify anyone who presents with respiratory and wider symptoms.
- The Infection Prevention and Control Nurses visit our wards regularly to support staff and check standards.
- The Trust takes take rapid action if an outbreak is identified to stop further spread of infection. This includes deep cleaning the ward and swabbing patients in the affected area.

Carbapenemase-Producing Enterobacterales (CPE)

CPE has been an endemic problem at the Worcester site for approx. 5years where CPE was identified following an outbreak in the Laurels wards and zonal kitchen.

There is a continued surveillance program that requires patients to have an admission and then then weekly screens. This checks for any ongoing acquisition of the organism that results in colonisation that may lead to an infection.

During 2025/26 there was one outbreak of CPE in the ITU at Worcester Royal Hospital, a total of 2 patients were found to be colonised, The Outbreak was closed on the 16.9.25 (declared as PII on 1.8.25 escalated to Outbreak on the 15.8.26). Actions included drain treatment, contact management, extended screening, deep cleaning, sink and drain survey, audit, Outbreak meeting. Both patients were discharged.

Measles

There has been a resurgence of measles in the region, particularly in Birmingham where there has been a high number of cases.

In preparation for potential cases, clinical pathways were devised. A screening tool is used to enable early identification of cases and therefore earlier isolation. Staff were encouraged to seek Occupational Health advice regarding vaccination status.

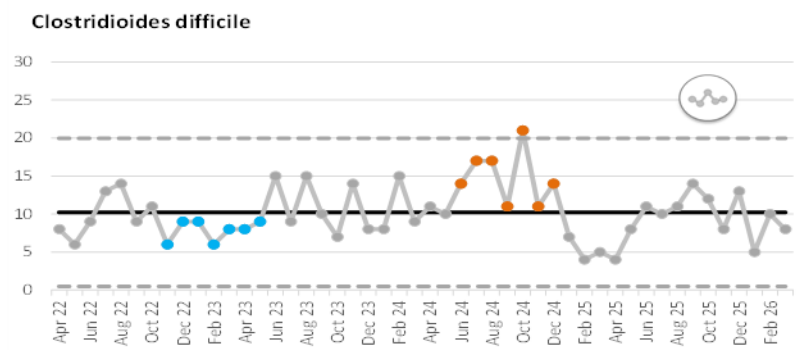
Measles Immunoglobulin pathways developed and shared with ICB.

The Trust has seen very few cases, and the appropriate care and treatment was received by the patients. Contact tracing was completed for patients and staff and actions taken as per the National guidance. There were no transmission events in the Trust to report.

In 2026-26 we achieved the 1 out of the 5 (Clostridiodes difficile) national infection reduction targets. We did not achieve our internal target for MSSA bacteraemia reduction. Nationally there has been an increase of HCAI. We are unsure of the reasoning behind the increase, and this is currently being reviewed by UK HSA and NHS England.

HCAI National Targets 2024/25	Outcome Against Target
Clostridioides difficile infection= 114 Vs 129	
MSSA = 42 Vs 40 (internally set)	
MRSA= 5 infections	
E coli BSI = 120 vs 108	
Klebsiella species= 50 vs 35	
Pseudomonas aeruginosa BSI = 20 vs 9	

***Clostridioides difficile* Infection (CDI)**	**How Are We Doing?** We met our improvement target this year. We reported 114 vs 129 full-year target.



To Reduce These Infections, We Have….

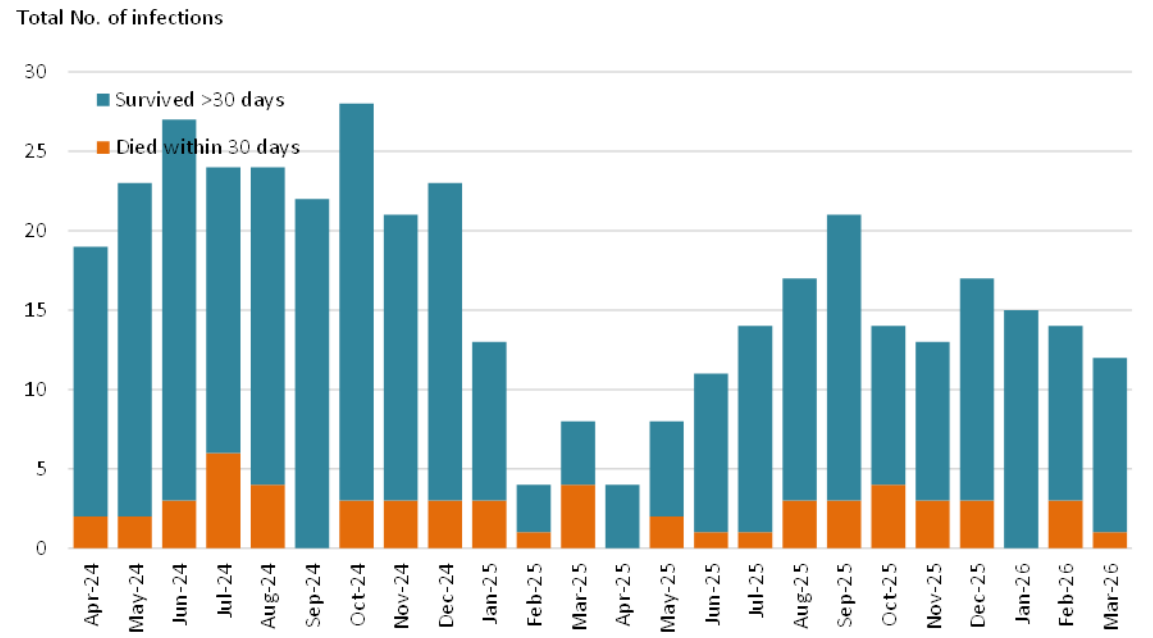
- Aligned case reviews with the PSIRF model which has allowed us to focus on the themes and trends obtained through the MDT case reviews.
- As a result, C. diff related documents are now embedded into the EPR system, cleaning standards and Star ratings are reviewed more frequently, and isolation facilities are easily identified with the implementation of a new daily side room report.
- Antimicrobial prescribing and stewardship (AMS) is well-recognised as a significant factor in the development of CDI. Throughout the year we have had a major focus on AMS, including monthly audits to monitor our compliance with the national *Start Smart Then Focus* principles. We have achieved significant improvements in AMS this year. 2025-26 saw the e re-implementation of an MDT approach to C.diff reviews with the Trusts AMS pharmacist and consultant microbiologist.
- Improved communication and awareness of C.diff between the Trust, positive patients, and GP colleagues by providing C.diff information following discharge in an attempt to prevent relapse and associated complications.
- "Gloves Off" campaign focused on staff use of PPE.
- Equipment trials are in progress to replace bed pan washer disinfectors on the WRH site with macerator systems, to reduce the risks of cross contamination caused by multi patient use items. There are 3 bed pan macerators (3 different suppliers) installed at the WRH site, all received favourably by the clinical teams and so far, no reported issues with drainage-blockages or leaks.
- Patient advice leaflet "Preventing Infections."
- Held drop-in sessions for Hand Hygiene and commode cleaning training and competence.
- Red, amber, Green (RAG) poster was updated and awareness promotion undertaken.
- Bed cleaning video is now part of mandatory training.

***Clostridioides difficile* 30-day all-cause mortality**

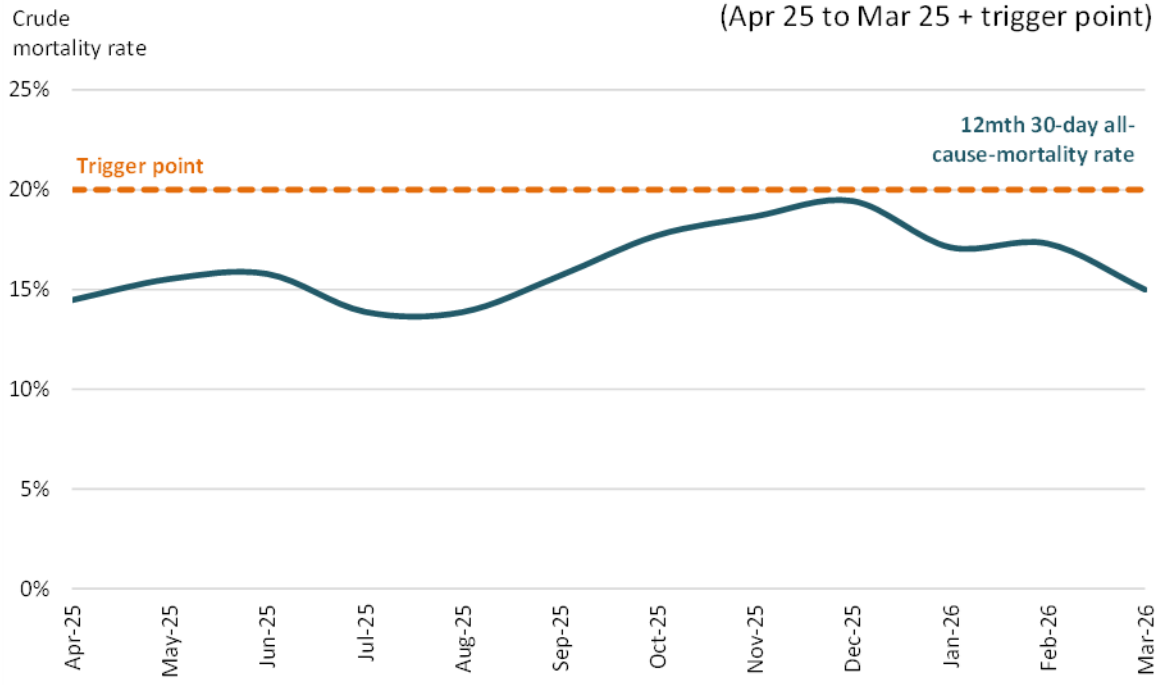
It is recommended in national guidance that 30-day all-cause mortality be monitored in CDI patients. The following graphs therefore show this: the number of patients who have died of any cause in the 30-days after having a positive test for CDI. This data includes patients from all settings.

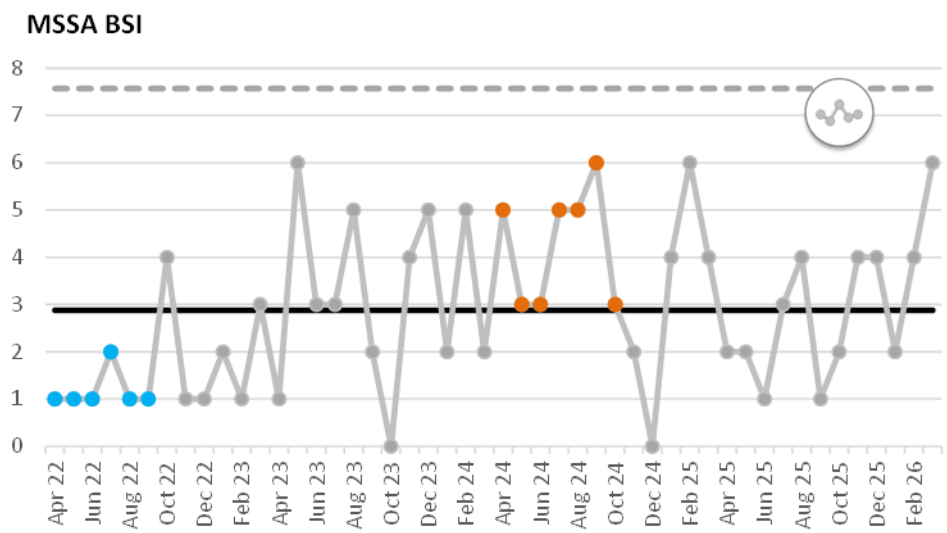
The mortality rate based on rolling 12-month totals showed a generally upward trend until December 2025 while remaining below the 20% trigger point, and at the start of 2026 has shown a welcome reduction and at year end has reduced to 15% where it was at the start of the year.

C. diff infections and 30-day all-cause-mortalities (Apr 25 to Mar 26)



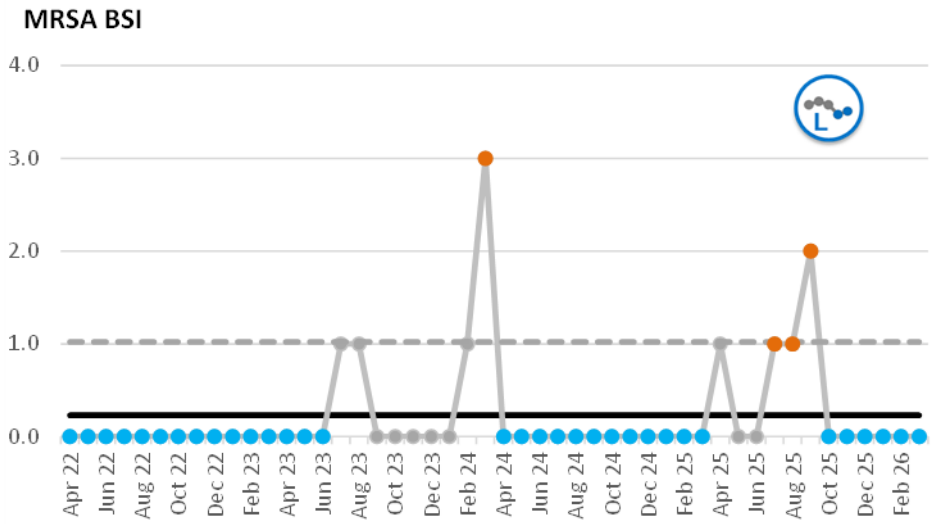
30-day all-cause-mortality rate using rolling 12-month totals
(Apr 25 to Mar 25 + trigger point)



Meticillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia	How Are We Doing?
	Though no national target was set in 2025-26, we continued our focus on reducing MSSA bacteraemia and continued using the internal reduction target of no more than 40 cases set last FY. **We did not meet our improvement target this year.** There were 42 year end cases against our local target of 40.

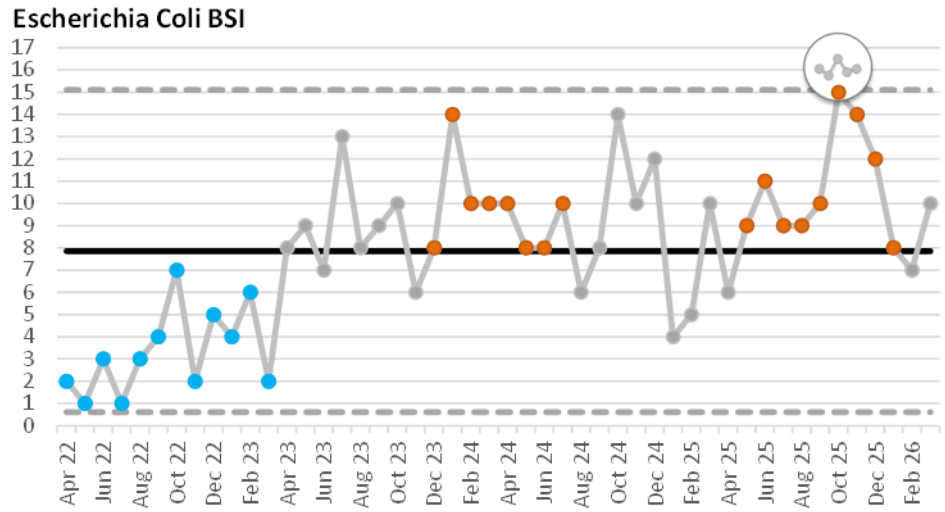
To Reduce These Infections, We Have….

- Initiated the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
- Audit of use of packs by procurement, with link made of use and reduction in BSI risk/non-use and BSI risk.
- Attended Divisional Governance meetings to present/promote PVD projects.
- "Scrub the hub" poster which was rolled out across the Trust.
- In collaboration with the Professional Development Team and BBraun, continued to promote the role of a PVD Champion.
- ANTT training materials on source page: videos and posters
- ANTT training must be completed before staff can complete cannulation training.
- Launched a teaching video on the use of the PVD forms on EPR.
- Promoted the "Gloves Off" campaign focused on staff use of PPE, through spot checks to clinical areas.
- Lessons learned from RSIRG have been conveyed in IPC link worker days.
- Hand hygiene products change over to new supplier.
- RAG cleaning poster promoted.
- Quality improvement project to improve bed cleaning across the trust, updated bedspace check list and produced and launched a bed cleaning video for mandatory training, which is now available on ESR.

MRSA	How Are We Doing?
	Zero Tolerance 4 HOHA and 1 COHA cases reported. The trust reported above threshold infections.

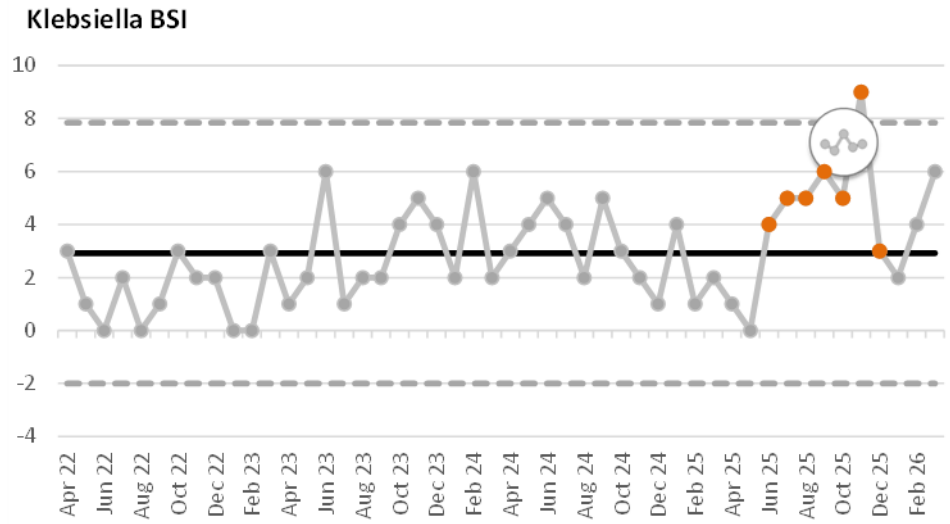
To Reduce These Infections, We Have….

- Link practitioner day -Focus on MRSA
- Updated Policies and A-Z Guidance to make guidance clear in line with national policy and guidance
- Ran the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
- Audit of use of packs by procurement, with link made of use and reduction in BSI risk/non-use and BSI risk.
- Attended Divisional Governance meetings to present/promote PVD projects.
- “Scrub the hub” poster which was rolled out across the Trust.
- In collaboration with the Professional Development Team and BBraun, continued to promote the PVD champion role.
- ANTT training materials on source page: videos and posters
- ANTT training must be completed before staff can complete cannulation training.
- Launched a teaching video on the use of the PVD forms on EPR.
- Promoted the “Gloves Off” campaign focused on staff use of PPE, through spot checks in clinical areas. MRSA updates, lessons learned, PVD, wound management have been included in the link worker days.
- Hand hygiene products change over to new supplier.
- RAG cleaning poster promoted.
- Quality improvement project to improve bed cleaning across the trust, updated bedspace check list and produced and launched a bed cleaning video for mandatory training, which is now available on ESR.

E.coli	How Are We Doing?
	120/108 The trust reported above threshold infections

To Reduce These Infections, We Have….

- Initiated the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
- Audit of use of packs by procurement, with link made of use and reduction in BSI risk/non-use and BSI risk.
- Initiated review of GNBSI using PSIRF model in collaboration with clinical colleagues
- Attended Divisional Governance meetings to present/promote PVD projects.
- "Scrub the hub" poster which was rolled out across the Trust.
- In collaboration with the Professional Development Team and BBraun, continue to promote the role of PVD Champion
- Assessed splash risks in clinical rooms and the use of splash guards, produced communications of risks with estates.
- ANTT training materials on source page: videos and posters
- ANTT training must be completed before staff can complete cannulation training.
- Launched a teaching video on the use of the PVD forms on EPR.
- Promoted the "Gloves Off" campaign focused on staff use of PPE, through spot checks in clinical areas.
- Hand hygiene products change over to new supplier.
- RAG cleaning poster promoted.
- HCAI rates shared with IPC link workers, included urinary catheter care and splash risk in IPC link worker day
- Quality improvement project to improve bed cleaning across the trust, updated bedspace check list and produced and launched a bed cleaning video for mandatory training, which is now available on ESR.

Klebsiella species BSI	**How Are We Doing?**
	We reported 50 vs 35 full year target. We did not meet our improvement target this year.

To Reduce These Infections, We Have….

<u>Focus on water management at link practitioner session.</u>

- Initiated the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
- Audit of use of packs by procurement, with link made of use and reduction in BSI risk/non-use and BSI risk.
- Initiated review of GNBSI using PSIRF model in collaboration with clinical colleagues
- Attended Divisional Governance meetings to present/promote PVD projects.
- "Scrub the hub" poster which was rolled out across the Trust.
- In collaboration with the Professional Development Team and BBraun, continue to promote the role of PVD Champion
- Assessed splash risks in clinical rooms and the use of splash guards, produced communications of risks with estates.
- ANTT training materials on source page: videos and posters
- ANTT training must be completed before staff can complete cannulation training.
- Launched a teaching video on the use of the PVD forms on EPR.
- Promoted the "Gloves Off" campaign focused on staff use of PPE, through spot checks in clinical areas.
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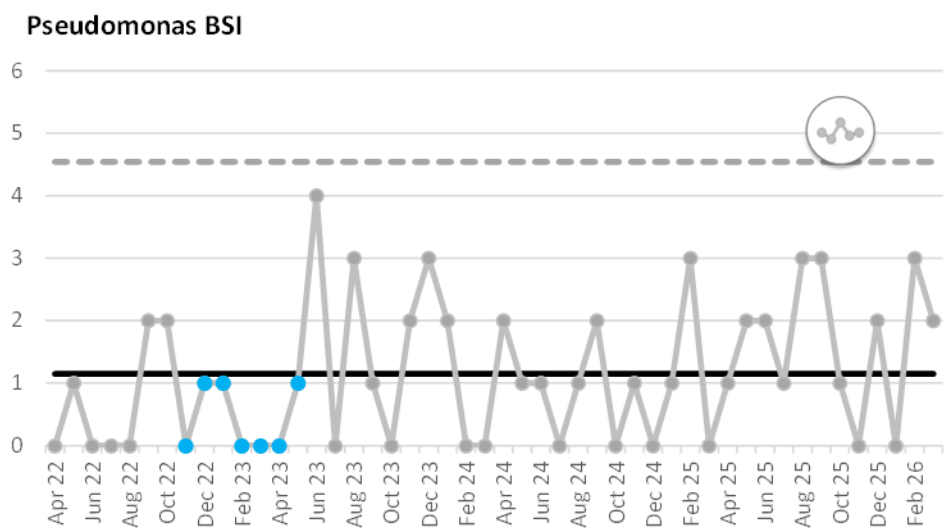
- Quality improvement project to improve bed cleaning across the trust, updated bedspace check list and produced and launched a bed cleaning video for mandatory training, which is now available on ESR.

Pseudomonas aeruginosa BSI	**How Are We Doing?**
	. We reported 20 vs 9 full-year target. **The trust reported above threshold infections.**

To Reduce These Infections, We Have….

- Focus on water management at link practitioner session.
- Initiated the Peripheral Venous Device (PVD) task and finish group.
- Continued the PVD Pack quality improvement project which has involved promotion of the PVD insertion packs across the Trust.
- Audit of use of packs by procurement, with link made of use and reduction in BSI risk/non-use and BSI risk.
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Surgical Site Infection Surveillance Survey

SSIs can range from a relatively a relatively trivial wound discharge with no other complications to a life- threatening condition" National Institute for Health and Clinical excellence (NICE) (2008).

Infections of the surgical site account for approximately 16% of all hospital acquired infections (HCAI), are estimated to double the length of post-operative stay in hospital and significantly increase the cost of care.

In April 2004 surveillance of Surgical Site Infections (SSIs) in Orthopaedic surgery became mandatory in all English NHS Trusts, specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice, as necessary.

At Worcestershire Acute Hospitals NHS Trust during 2025/26, and in line with the national requirement, it was agreed that we would focus on the reporting of data for patients undergoing a knee replacement surgery.

	Jan-Mar 2025 (Q4)	Apr-Jun 2025 (Q1)	Jul-Sept 2025 (Q2)	Oct-Dec 2025 (Q3)	Total
Knee Replacement	**140**	**160**	**156**	**145**	**601**
No. inpatient/readmission	0	0	0	0	0
% Infected	0.0%	0.0%	0.0%	0.0%	0.0%
No. post-discharge confirmed	1	0	0	0	1
% Infected	0.7%	0.0%	0.0%	0.0%	0.2%
No. patient reported	0	0	1	0	1
% Infected	0.0%	0.0%	0.6%	0.0%	0.2%
All SSI	1	0	1	0	2
% Infected	0.7%	0.0%	0.6%	0.0%	0.3%

**Quarter four data is awaiting validation & release from SSISS

During 2025/26, the Trust established a Surgical Site Infection Surveillance Survey (SSISS) Committee, led by the Divisional Director of Nursing for Surgery. This committee is in its infancy at present but aims to focus on identifying opportunities for improvement throughout the surgical pathway to further enhance patient safety and patient experiences. The group seeks to encourage robust engagement from departments involved throughout the surgical pathway, including the Trust Infection Prevention and Control team, Procurement Team, Orthopaedic Surgical and Nursing teams, Theatre colleagues, and the Tissue Viability team.

The SSISS Committee continues to make steady progress against its agreed action plan. A number of actions have been completed, providing strengthened governance arrangements. This includes:

- ✓ Agreement of the scope of the Trust reporting to the national system and agreement of a risk within the Trust's risk register.
- ✓ Reviews of the theatre ventilation which demonstrated compliance with requirements, supported by routine servicing.
- ✓ Infection control audits are established within the theatre environment and continue to be completed in support of patient safety.

The action-focused meeting continues to explore workstreams to ensure:

- Robust internal reporting structures including oversight through the Datix reporting system, linking to the established risk of surgical site infections.
- Clarification of terms of reference to further engage the relevant colleagues.
- Focus on clinical practice and policies – skin preparation policy has been updated following multidisciplinary engagement, and MRSA policy under review within the Trust.
- Review of information provided to our patients pre-operatively and post-operatively about surgical site infections, including signposting.

In addition, we have an established core membership at the Bone and Joint Infection Multi-Disciplinary Team (MDT) meeting, with agreed quorum requirements and formal Terms of Reference.

The Bone and Joint Infection MDT is designed to translate clinical options into clear, evidence-based decisions. It brings together orthopaedic surgeons, infectious disease specialists, microbiologists, radiologists, and Outpatient Parenteral Antimicrobial Therapy (OPAT) nurses to review complex cases, share current research, and ensure a coordinated, multidisciplinary approach to patient care.

The MDT has been co-ordinated by the Surgical Care Practitioner since June 2009, well ahead of many organisations nationally. A strong emphasis is placed on teamwork—this underpins our ethos and the effectiveness of the MDT.

The MDT approach helps build patient confidence in their treatment plans by ensuring consistent, unified communication from the clinical team. This is particularly important where treatment may involve side effects or temporary limitations to independence. Our objectives are to:

- Improve patient safety and reduce delays in treatment planning
- Enhance antimicrobial stewardship
- Strengthen communication across specialties
- Provide a clear and defensible audit trail of clinical decisions
- Support service development (e.g. development of the OPAT service)
- Foster a culture of shared learning and continuous improvement

We maintain close links with the Oxford Bone Infection Unit with representation at the annual conference. We disseminate current best practice locally and have previously aligned our working practices with Oxford protocols, including the OVIVA trial findings. As a result, where clinically appropriate and organism-dependent, we aim to switch patients to oral antibiotics within seven days, reducing the need for PICC or midline insertion, minimising inpatient stay, and avoiding delays associated with OPAT-led IV antibiotic discharge.

We benefit from the expertise of key consultants, including named expertise from Microbiology, Radiology, and Infectious Diseases), who provide essential support to the orthopaedic team.

In addition, we have been running a Revision Arthroplasty MDT since June 2021. Complex cases are often reviewed across both MDTs to ensure optimal surgical planning, appropriate surgeon allocation, and effective antimicrobial management. We also participate in the regional arthroplasty MDT in Coventry, where highly complex or revision cases, including infected cases, can be discussed. All revision knee cases are reported monthly to meet regional requirements. Currently, no dedicated administrative support is provided, and documentation of outcomes is completed by the clinical team.

Continuous improvement:

Key improvements for our MDT process include supporting dedicated administrative function, introducing a formal audit cycle to assess MDT effectiveness, and streamlining referrals by reducing reliance on email chains through a standardised referral template with minimum data requirements (while allowing flexibility for urgent cases). Further priorities are to implement a centralised performance and outcomes dashboard and consider a case submission cut-off (e.g. 48 hours) with appropriate exceptions for emergencies. In turn this would further enable:

- More efficient and focused MDT meetings
- Improved decision-making based on complete clinical information
- Reduced delays caused by missing information or absence of the treating consultant
- Enhanced clinical governance and patient safety

Criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Written by Emma King Interim director for Estates and Facilities

Cleanliness

Our focus on cleanliness has continued throughout 2025-2026 continuing to work in accordance with the National Standards for Healthcare Cleanliness 2025.

The audit scores for each functional area are represented in two ways: a percentage score and a star rating score. The percentage score is for internal verification and scrutiny that a safe standard has been achieved, whereas the star rating score is for external verification of this.

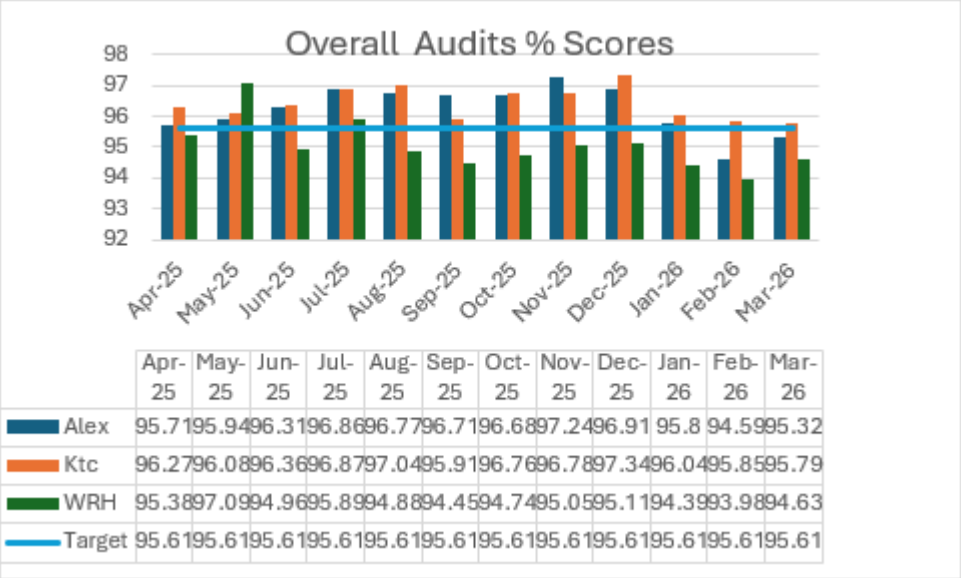
Cleanliness by Site

During March 2026, the star ratings were as follows:

ALEX		KTC		WRH	
Number	% of overall audits	Number	% of overall audits	Number	% of overall audits

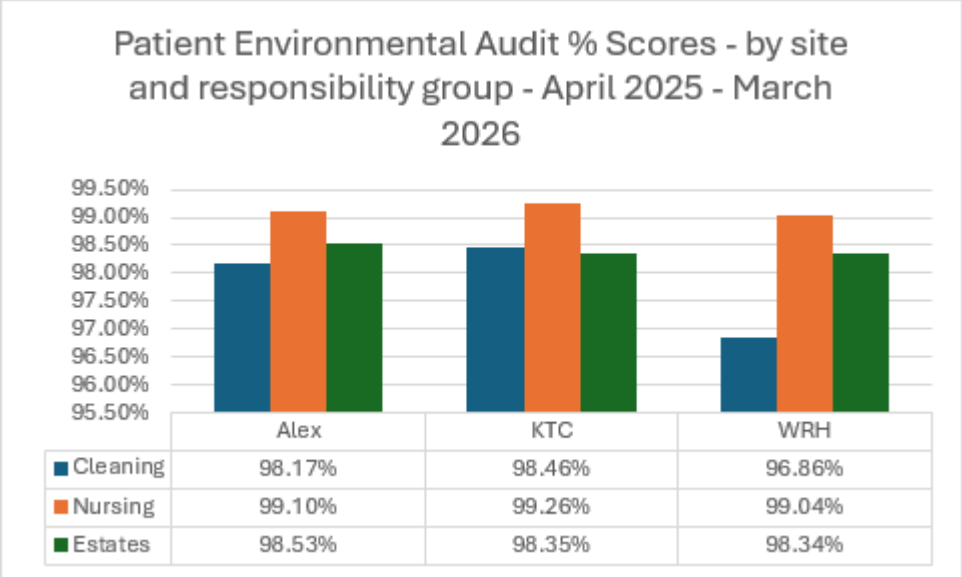
5 Star	45	58%	11	35%	60	39%
4 Star	24	31%	18	58%	63	41%
3 Star	6	8%	2	7%	15	10%
2 Star	2	2%	0	0%	9	7%
1 Star	1	1%	0	0%	5	3%

The trend over the last 12 months has seen cleanliness audit scores overall continuing to be on target or just above target across the organisation We have continued to build on the improved working relationships and collaborative approach between the Estates and Facilities Teams with clinical teams. Regular scrutiny and review sessions are held to maintain focus on the importance of cleanliness to ensure safe environments.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Alex	95.71	95.94	96.31	96.86	96.77	96.71	96.68	97.24	96.91	95.8	94.59	95.32
Ktc	96.27	96.08	96.36	96.87	97.04	95.91	96.76	96.78	97.34	96.04	95.85	95.79
WRH	95.38	97.09	94.96	95.89	94.88	94.45	94.74	95.05	95.11	94.39	93.98	94.63
Target	95.61	95.61	95.61	95.61	95.61	95.61	95.61	95.61	95.61	95.61	95.61	95.61

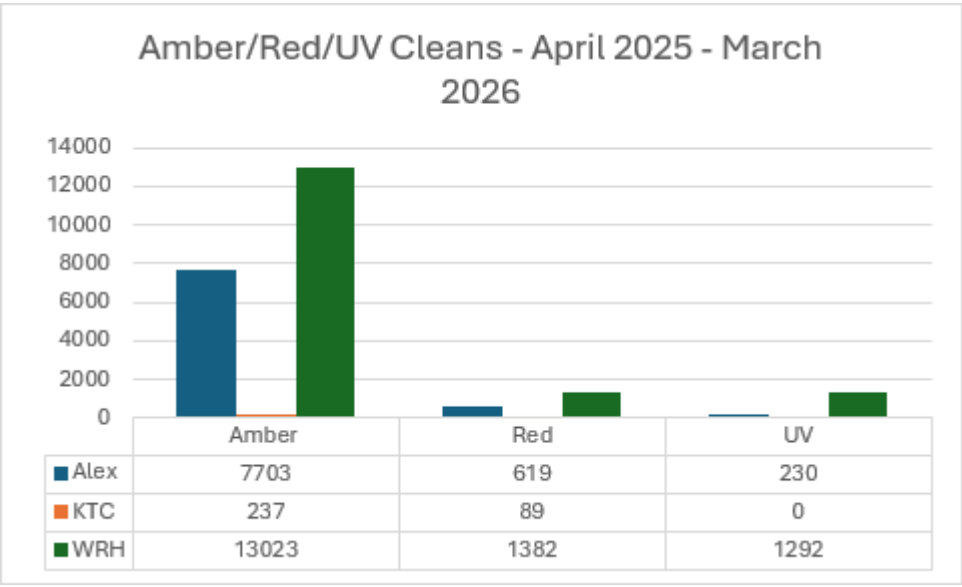
Regular meetings are held with all stakeholder groups to review issues from areas that only attain a 3-star rating. These are led by IPCT, however there have been a number of areas which have had many recurring faults which are now being rectified and hopefully there will be continued improvement on the scoring methodology.



	Alex	KTC	WRH
Cleaning	98.17%	98.46%	96.86%
Nursing	99.10%	99.26%	99.04%
Estates	98.53%	98.35%	98.34%

We have contributed to feedback in relation to the new scoring methodology via various network groups, that potentially the scoring methodology does not provide the necessary accountability for issues raised and is not always reflective of the standards.

Despite capacity levels we have continued with enhanced levels of cleaning including proactive routine Hydrogen Peroxide Vapour (HPV) and Ultraviolet-c (UV-c) decontamination of high-risk areas (at WRH and Alex) This includes dirty utility areas and communal bathrooms. Going forward we will be scrutinising the numbers being requested.



	Amber	Red	UV
Alex	7703	619	230
KTC	237	89	0
WRH	13023	1382	1292

The Trust Monitoring Team continue to report directly into the Quality and Compliance Officer which has enabled the team to remain independent of both cleaning services ensuring monitoring reports are objective and as accurate as possible utilising modern audit software aligned to the National Standards of Cleanliness

Previously we have reported concerns in relation to the performance of our PFI partners, however we have seen a significant sustained improvement, however we will continue to manage closely.

Safe Ventilation Systems

The Ventilation Safety Group meets quarterly and is principally concerned with ensuring that Trust ventilation systems are installed, modified, inspected, tested, maintained, and operated safely across all 3 Trust hospital sites and where Acute Trust staff operates within other Trust areas. The group also has a remit of ensuring that clinical staff are aware of any risks these systems may pose to clinical activity. The terms of reference for this Group are reviewed annually or as mandatory and statutory changes dictate.

In line with national guidance, external Authorising Engineer's (Ventilation) AE(Vent) and Deputies are in place to formally audit the management of the Trust's ventilation systems and recommend the appointment Authorised Persons (APs) to the Trust Designated Person for approval. APs are in place at all WAHT hospitals to manage the ventilation systems. Audits are carried out on an annual basis and covers the template requirements of HTM03 to provide assurance of system compliance and functionality.

All new Critical Ventilation Systems (CVS) are Designed, Installed and Validated to HTM03 requirements with existing CVS being Verified in accordance with HTM03-01 (as far as is reasonably practicable), given their age, our systems verify as being broadly compliant with current HTM's. Where full compliance cannot be assured, additional controls are agreed and put in place which are actively reviewed and managed via Estates Teams, our PFI partners and IPC.

Our specialist units such as Theatres, Endoscopy and Intensive Care Units have additional ventilation requirements in line with published guidance, however, one of our continuing challenges is that much of our hospital estate was built to standards prevalent at the time of construction which do not necessarily comply with current requirements in full (e.g. natural ventilation only rather than mechanical ventilation and Air Change Rates per hour being difficult to increase to provide enhanced flows required by current standards. This means we cannot guarantee that the amount of fresh air entering those areas will fully dilute or remove all airborne viruses which may be present. To mitigate this, the trust has invested in enhanced HEPA air filtration systems which seems to have been relatively successful at containing the proliferation of infections.

All new Capital schemes and major refurbishment work have their designs reviewed by the VSG and AE(Vent)'s to ensure that new systems fully comply with current requirements, where this cannot be achieved for reasons that cannot be designed out, then these are presented as derogations for executive sign-off.

Water Safety

The Trust has two water safety groups, strategic and operational. The membership is multi-disciplinary and has representatives from the Trust, PFI Partners and Authorising Engineers. The Groups continue to monitor water risk assessments especially around Legionella, Pseudomonas, flushing regimens, annual disinfection, Automated Endoscope Reprocessor (AER) and capital developments.

The Water Safety Groups are principally concerned with ensuring that Trust water systems are installed, modified, inspected, tested, maintained, and operated safely across all three Trust hospital sites and where Acute Trust staff operates within other Trust areas. The Water Safety Groups also have a remit of ensuring that clinical staff are aware of any risks these systems may pose to clinical activity. The terms of reference for these groups are reviewed annually or as mandatory and statutory changes dictate.

The groups review and develop the Trusts water safety policy and water safety plan. Our Trust Water Safety Strategic and Operational Groups are chaired by the DIPC. The Strategic Water Safety Group meeting on a quarterly basis with the Operation Water Safety group meeting in the intervening months. Both the strategic and operational groups oversee a system which is provides good assurance on water quality and governance to the Trust.

In line with national guidance, external Authorising Engineer's (Water) AE(Water) and Deputies are in place to formally audit the management of the Trust's water systems and recommend the appointment Authorised Persons (APs) to the Trust Designated Person for approval. APs are in place at all WAHT hospitals to manage the water systems. Audits are carried out on an annual basis and covers the template requirements of HTM04-01 to provide assurance of system compliance and functionality.

The Water Safety Plan (WSP) is currently under review, however our current WSP from our Specialist Water Management is in date and has been implemented which satisfies the latest guidance requirements in addition to HTM 04-01.

Our electronic system for recording water outlet flushing has been in place for over five years and is being replaced with a new system being phased in during 2026. There is a system of escalation to management teams for any areas which do not complete their flushing and reporting.

All new water systems are Designed, Installed and Validated to HTM04-01 requirements with existing systems being Verified in accordance with HTM04-01(as far as is reasonably practicable), given their age, our systems verify as being broadly compliant with current HTM's. Where full compliance cannot be assured, additional controls are agreed and put in place which are actively reviewed and managed via Estates Teams, our PFI partners and IPC.

Our specialist units such as Renal, Endoscopy and Sterile Services Units have additional water requirements in line with published guidance.

All new Capital schemes and major refurbishment work have their designs reviewed by the Water Safety Groups and AE(Water) to ensure that new systems fully comply with current requirements, where this cannot be achieved for reasons that cannot be designed out, then these are presented as derogations for executive sign-off.

A programme of sampling is in place to detect any Legionella and *Pseudomonas aeruginosa* in the water system. Sampling results have been generally good across all sites, however there were several counts of *Pseudomonas aeruginosa* and *Legionella spp*. isolated via 6 monthly routine sampling. The adverse samples were dealt with promptly in accordance with the water safety plan to ensure patient and staff safety. Issue identified was poor condition of

taps including the build-up of lime scale and cleaning deficits. There have been no linked infections to these results.

Sink safety, splash screens and safe water management was a focus for our link practitioner's sessions.

The IPC Nurse manager and DIPC also hold ILM qualifications.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Written by Sadiya Hussain – Clinical Antimicrobial Pharmacist.

The Trust Antimicrobial Stewardship Group have continued to provide leadership and oversight for antimicrobial stewardship (AMS) activities, further building on positive progress made in 2024-25.

Key progress made during 2025-26 includes:

- Increased ward rounds from once weekly to twice weekly across both sites.
- Continued AMS education sessions across both sites.
- AMS Pharmacist actively involved in reviewing PGD's involving antimicrobials and reviewing Clostridioides difficile (C diff) cases.
- Increase in AMS audits taking place across the Trust which can inform on AMS prescribing:

1) Guidance on Antibiotic Course Duration for Community Acquired Pneumonia in Secondary Care
2) Evaluation of antibiotic choice and duration for Urinary Tract Infections in medical wards against Eolas guidelines.
3) AMS audit on oncology ward
4) Antimicrobial stewardship Audit**:** ENT

IVOS (Intravenous to oral switch) antibiotics

For FY 2025/2026, this non-mandatory CQUIN was not continued nationally but was continued as an internal Trust audit for the FY 2025/26. Although this was not incentivised, we were able to perform considerably better than the national criteria.

The aim of this audit was to assess what % of patients are on IV antibiotics who could have been switched to oral treatment. Target is achieving 15% or fewer still receiving IV antibiotics past the point at which they meet switching criteria. Minimum < 25% and maximum 15% (lower % indicates better performance) Inclusion criteria: Adults (>16 years of age) and paediatric (<16 years of age) inpatients with active prescriptions for IV antibiotics at the point of the audit.

Prompt switching of intravenous to oral antibiotic

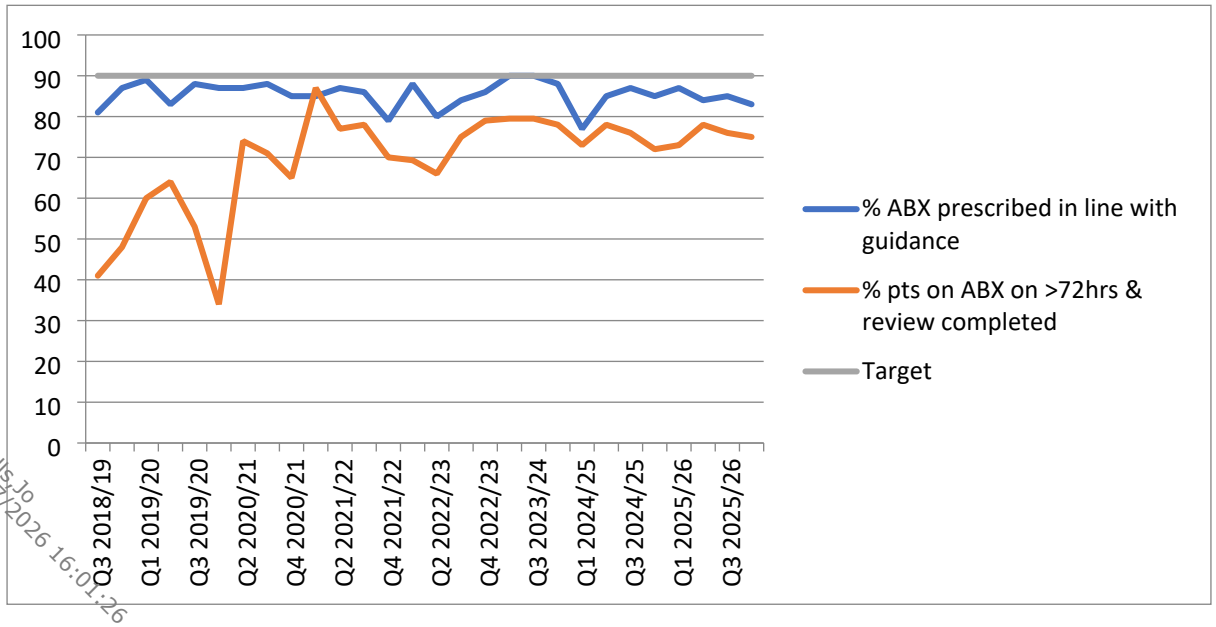
Description	Achieving 15% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	
Numerator	Of the denominator, those who, at the point of audit, have already met the criteria for switching from IV to oral administration of antibiotics according to adult (16+ years of age) or paediatric (under 16 years of age) criteria as appropriate.	
Denominator	Total number of adult and paediatric inpatients with active prescriptions for IV antibiotics at the point of audit (sample size 100 patients per quarter, aim to cover all included wards/specialities).	
Exclusions	Patients in HDU and ICU Patients treated with intravenous antifungals or antivirals	
Data reporting and performance	For local agreement between provider and commissioner – the UKHSA portal will continue to take submissions where providers and commissioners wish to use this route. Details can be found in the AMR Programme FutureNHS Workspace (link below).	
Scope	Acute	Period: All quarters
Suggested thresholds	Minimum: 25% Maximum: 15% **Please note that for this indicator,** **a LOWER % = better performance**	Whole period %
Lead contact	england.amrprescribingworkstream@nhs.net	

The audit undertaken by the pharmacists in all quarters met the target. This audit was registered on the trusts Clinical audit system (CATS)- ID number: 11878.

Audit Results: Antimicrobial Point Prevalence Survey (PPS)

This audit was completed during Q4. Overall, the compliance of antimicrobials in line with guidance has not achieved the target – 83.47%.

The 72-hour reviews have not improved (from 76% to 75%) and have still not achieve the target. At the time of writing this report, this data has not yet been presented to ASG for discussion and development of any actions. The data is now sent to the wards to provide granularity. The PPS audit is completed quarterly. The antimicrobial Pharmacist is working with the EPMA team to get this data on a daily basis as a report that can be reviewed by ward teams.

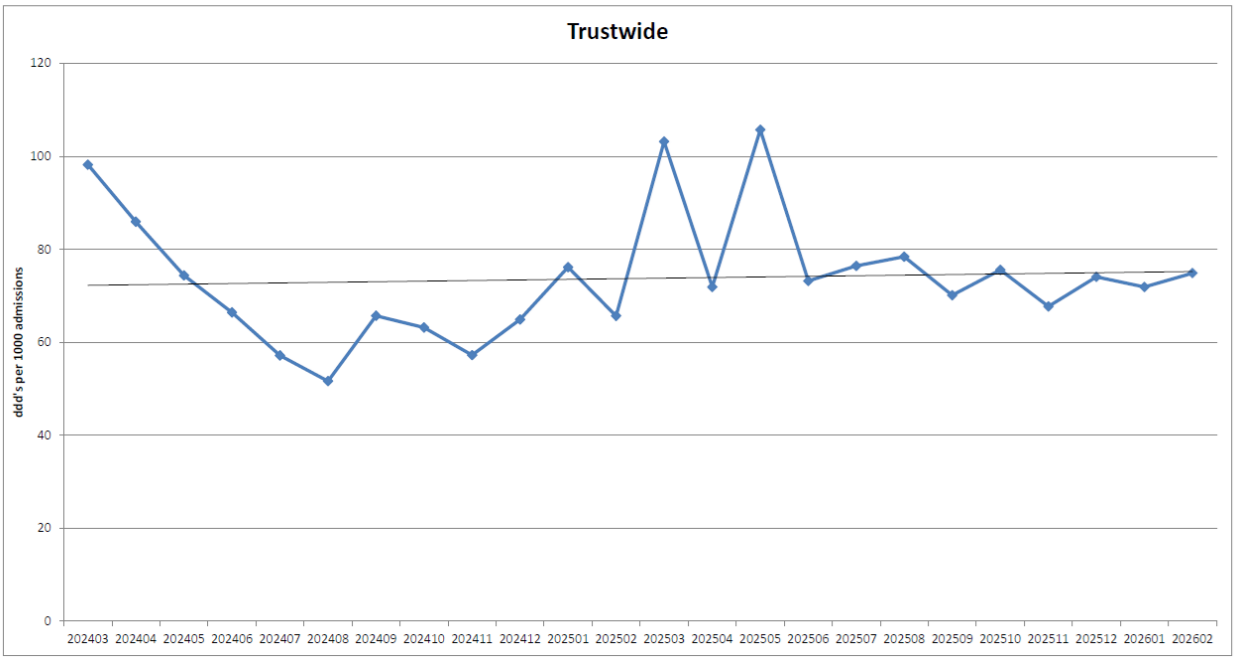


Carbapenem prescribing- Carbapenem usage:

Further to all the work undertaken by our antimicrobial stewardship leads and revision of prescribing policies, the usage of carbapenems has decreased compared to March 2024. There have been fluctauations but this may have been due to new junior doctors commencing and due to high acuity of patients. The ward level data has been and continues to be scrutinised by ASG to identify clinical areas to target. It is noted that the Consultant Microbiologist AMS lead and AMS lead pharmacist have commenced ward rounds specifically looking at Meropenam prescribing. The implementation of EPMA has helped facilitate the ward rounds to review the prescribing of Meropenem.

Trustwide

ddd's per 1000 admissions
Date range in months: 202403 to 202602



NHS Standard Contract – data from FutureNHS relevant for Q2 2025/26:

Current performance against national AMR targets: two key targets have been established:

1. Target 4a: By 2029, total antibiotic use in human populations will be reduced by 5% compared with the 2019 baseline.
2. Target 4b: By 2029, 70% of total antibiotic use across the human healthcare system will be from the Access category (new UK classification).

- Difference in watch and reserve DDDs per 1000 admissions from 2019/2020 baseline: -16%

	Baselines			Rolling 4 quarter performance				
Trust Name	Watch + Reserve DDDs FY 2019/20	Total admissions FY 2019/2	Watch + Reserve DDDs per 1,000 admissions FY 2019/20	Total Watch + Reserve DDDs Q2 2024-25 to Q1 2025-2	Total admissions Q2 2024-25 to Q1 2025-26	Total Watch + Reserve DDDs per 1000 admissions Q2 2024-25 to Q1 2025-26	% difference in Watch + Reserve DDDs per 1000 admissions from 2019/20 baseline	Watch + Reserve Consumption INCREASING or DECREASING from FY 2019/20 baseline
Worcestershire Acute Hospitals NHS Trust	330168	160772	2054	259714	150526	1725	-16.0	DECREASING

- Difference in total DDD's per 1000 admissions from 2019/2020 baseline: +17.4%.

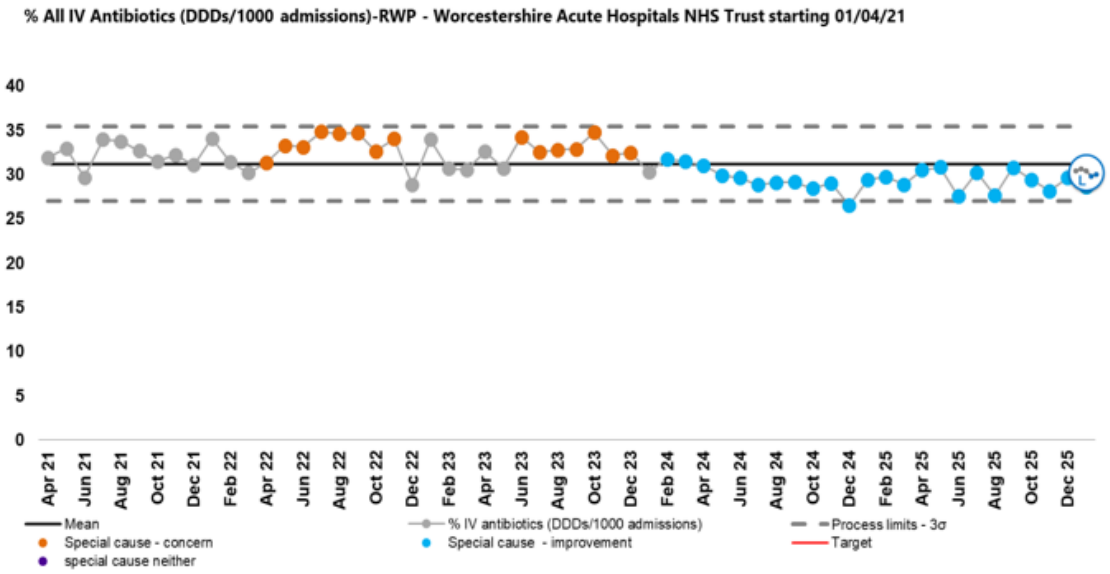
	Baselines			Rolling 4 quarter performance			
Trust Name	Total DDDs FY 2019/2	Total admissions FY 2019/2	Total DDDs per 1,000 admissions FY 2019/2	Total DDDs Q2 2024-25 to Q1 2025-26	Total admissions Q2 2024-25 to Q1 2025-26	Total DDDs per 1000 admissions Q2 2024-25 to Q1 2025-26	% difference in Total DDDs per 1000 admissions from 2019/20 baseline
Worcestershire Acute Hospitals NHS Trust	573525	160772	3567	630494	150526	4189	17.4

It is expected that Q3 results will be available in June 26.

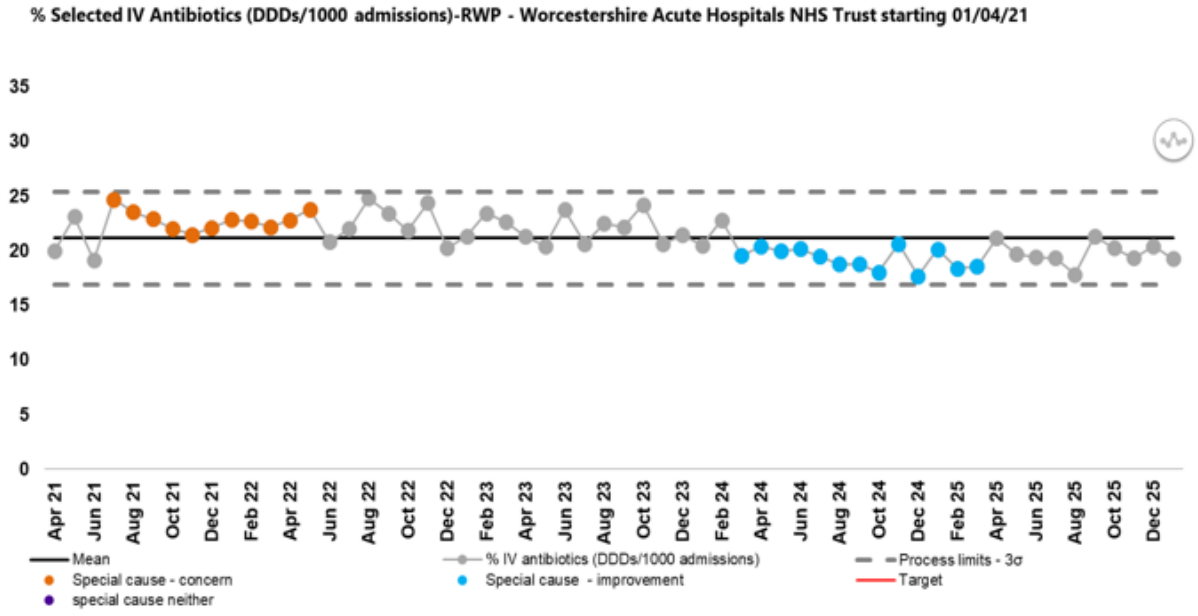
- Benchmarking using the latest English surveillance programme for antimicrobial utilisation and resistance which shows that the Midlands are the highest percentage of Trusts **achieving a reduction in watch and reserve.**

	NHS England Region	No of Trusts	Number of Trusts achieving reduction in Watch + Reserve antibiotic consumption (based on Q3 2024-25 to Q2 2025-26 data)	Number of Trusts not achieving reduction in Watch + Reserve antibiotic consumption (based on Q3 2024-25 to Q2 2025-26 data)	Number of Trusts with antibiotic consumption data missing (based on Q3 2024-25 to Q2 2025-26 data)	Percentage of Trusts achieving reduction in Watch + Reserve antibiotic consumption (based on Q3 2024-25 to Q2 2025-26 data)
2	North West	23	12	11	0	52.2
3	North East and Yorkshire	22	12	10	0	54.5
4	South East	18	12	6	0	66.7
5	London	21	12	9	0	57.1
6	East of England	14	3	11	0	21.4
7	Midlands	23	16	6	1	72.7
8	South West	13	8	5	0	61.5
9	**ALL REGIONS**	**134**	**75**	**58**	**1**	**56.0**

The following graphs show **a sustained decrease in AMS prescribing** of IV antibiotic consumption (total IV and selected IV antibiotics) as a proportion of total antibiotic consumption for the trust: (*Amoxicillin, Co-amoxiclav, Clarithromycin, Clindamycin, Ciprofloxacin, Levofloxacin, Metronidazole, Linezolid):



Selected Antibiotics



Making Data Count (MDC) icon key:

Common cause variation: No significant change	Special cause variation: Concern - measure significantly higher	Special cause variation: Improvement - measure significantly lower

Other ASG activities (some on-going):

- *EOLAS (antimicrobial guide)- adult and paediatric continually being reviewed with additions of new guidelines and drug monographs.*
- *Engaging with the EMPA team to ensure the system can support antimicrobial stewardship and create an AMS dashboard to inform prescribing.*
- *AMS representation at ICS/ICB groups to develop strategic priorities and identify actions. Five key prescribing priorities include: optimise therapy, reduce demand, reduce exposure, shorten courses, and narrow spectrum. Working group formed across the ICB to lead, coordinate, and monitor HW efforts in the prevention, management, and control of C diff. The Group aims to drive continuous improvement, ensure compliance with national guidance and local objectives, reporting group outcomes within their own organisational reporting structures.*
- *Collaborating with Wye Valley regarding guidelines and adding antimicrobials on to the Hereford and Worcestershire formulary- Cefazolin and Pylera (Bismuth subcitrate, metronidazole and tetracycline) added to the formulary. Formulary applications submitted in March 2026 for Dalbavancin and Aztreonam-avibactam.*
- *The ASG terms of reference have been reviewed and meetings have been reduced to quarterly to encourage engagement.*

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

Our continued approach during 2025-26 has been to ensure open and clear communication with our patients, their carers, family and the wider public. Information is available on the internet Trust website and signposts patients/carers to National guidance. The IPC team have produced a patient information leaflet outlining IPC practices and how to stay safe in hospital by carrying out such things as good hand hygiene and wearing the correct PPE as directed by the ward teams.

Social media has been used to promote key messages about preventing infection.. Our public website contains a range of information to help inform the public, including on MRSA, *Clostridioides difficile*, influenza and Norovirus.

Information on specific microorganisms is available on a dedicated section of the intranet which can be accessed by all staff. Key messages are distributed by the communication team using a variety of media that is available across the Trust.

The Team produces a monthly IPC newsletter with topics including cleaning, device care, MRSA, C Auris and winter illnesses. The newsletters are available on The Source.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

We have several assessment tools available to reduce the risk of transmitting infection, and our admission process includes assessment of patients for signs of infection. This has been strengthened further and moved to a Respiratory symptom checker.

Our Infection Prevention Team works closely on a daily basis with wards, our site management teams, and our cleaning teams to ensure patients with infection are rapidly identified, isolated correctly, and additional cleaning is in place as required.

During 2025-26 we identified and effectively dealt with a number of infection outbreaks and incidents relating to a range of infections.

With the introduction of the EPR system there has been a diarrhoea risk assessment tool introduced.

The policy for Outbreaks and Isolation of patients has been updated and an updated RAG poster issued to help decision making re cleans.

Criterion 6: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Strong and visible leadership by all senior clinical leaders continued throughout the year 2025/26, including leadership by the CNO and the DIPC.

Throughout 2025-26 we continued to require all staff to complete the electronic mandatory training rather than face-to-face sessions. We have introduced a face-to-face session for induction for HCAs. This includes donning and doffing, hand hygiene competencies, and clear instruction on where to find policies.

Our compliance target in 2025-26 was 90%. At the end of 2025-2026 the achievement was 86.9% for clinical staff, and 95.4% for non-clinical staff.

Ward-based training and electronic resources have remained in place to support staff during the year.

The IPC team have successfully delivered link practitioner training covering a variety of subjects.

Hand hygiene competencies are delivered at Ward level and there is a requirement for annual update.

Fit Testing
FFP3 mask fit-testing is stipulated by the Health and Safety Executive and any mask that is fit to the face must be fit tested.

This continued over 2025-265 with the withdrawal of government support in April 2023. The provision of the service was supported by NHS Professional staff however, the Trust successfully recruited two permanent staff to oversee fit mask testing. The fusion system was updated to enable direct booking and recording of fit tests.

Fit tests are provided for all Trust staff as well as our PFI partners.

Criterion 7: Provide or secure adequate isolation facilities.

In general, isolation for infection prevention reasons means caring for someone in a single room, preferably with ensuite toilet and washing facilities. Of our bed-base we had 175 single rooms across the Trust, which is 18% of our hospital beds. Of these 134 are ensuite, which is 13% of our beds. These beds are routinely used for isolation. When the number of patients with possible infection rises, patients with the same infection/suspected infection are nursed together in cohorts.

Cohort isolation continued to be used throughout 2025- 26 for influenza, CPE, RSV, COVID-19, and norovirus cases.

The Trust introduced a more standard model of isolation, with patients being isolated in single rooms and bays within the ward most appropriate for their clinical care based upon their reason for admission (our 'presenting condition model'). The national guidelines were adapted to ensure that the Trust was maintaining patient safety. Within the Frailty areas we continue to isolate patients who are classified as COVID and influenza contacts. This is supported by a risk assessment agreed at TIPCC.

We have infection assessment tools for patients on admission. If someone develops common symptoms of infection such as diarrhoea or respiratory symptoms during admission, these tools are used by staff to identify the need for isolation.

ED at Worcester has access to single cubicles, however, there remains significant attendees in the department that add to the overcrowding there. Increased cleaning has been implemented in both EDs, but this remains a challenging environment.

Due to the pressures on side rooms and often the demand outweighing the supply, IPC works with capacity and site to review side room provision and the 'live' side room" tool developed with Informatics' helps to support the clinical decision-making process. The Trust has developed an A to Z guideline of infection, a Winter Respiratory Virus Plan to aid staff in placing the patient in the correct area. The Trust has outbreak management policies and specific organism policies available on the Trust Source page.

Criterion 8: Secure adequate access to laboratory support.

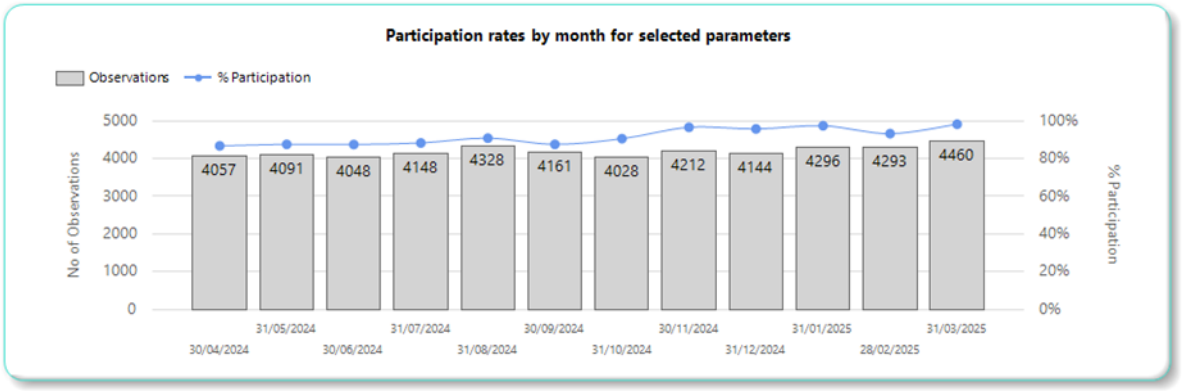
We have our own trust-wide on-site microbiology laboratory, based at Worcestershire Royal Hospital. This provides a full range of microbiology services, linking with the national reference laboratory network for specialised testing which cannot be performed locally. The laboratory is UKAS accredited, confirming it operates an effective and quality-controlled system.

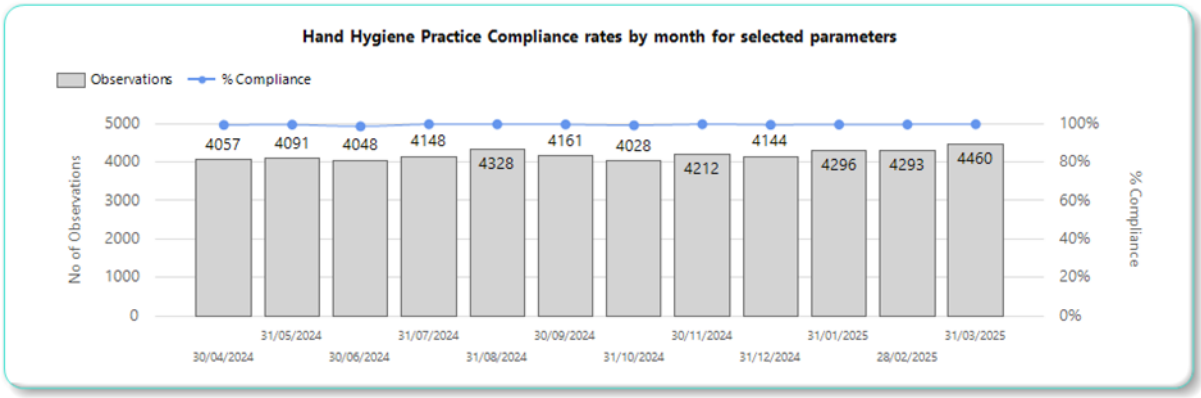
Throughout 2025-26 the laboratory has maintained sufficient increased capacity to provide all the required testing for COVID-19 for the health system across Worcestershire, via a range of rapid and standard tests. In 2026-27 the laboratory will continue with work to further extend the range and number of rapid testing platforms available for other infections. This includes molecular based testing for enteric pathogens including a wider range of viruses to assist in the control of infection.

The department has been challenged at times due to the lack of staff but there have been no incidents reported relating to performance due to staffing levels.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

We monitor adherence to a number of our *Fundamentals of Infection Prevention and Control* with a programme of monthly auditing via our electronic system with reporting in real-time. The national High Impact Intervention audit tools issued by NHS Improvement have been used as the basis for the monitoring tools. The compliance information is included routinely within divisional reports to TIPCC, supporting detailed review of good practice.





During the past year, the audit program and response to alert organisms have shifted and a cleanliness and standard infection control interventions are measured. Work is in progress to

move the IPC audits to GAP to ensure that all clinical areas can audit at any time and contribute to the ward accreditation process.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
Written by Julie Noble, Head of Health & Safety and Fire Safety

The Health and Safety Team are responsible for ensuring there are systems and processes in place to enable legal compliance against secondary legislation, which if complied with effectively, protects staff from exposure to infectious diseases. An example is compliance against The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. To comply with this regulation the Trust has an Inoculation Policy and a Safer sharps group (that includes Occupational Health leads) that meets bi-monthly to analysis inoculation injuries with the aim to identify areas of concern/improvement and implement corrective and preventative measures.

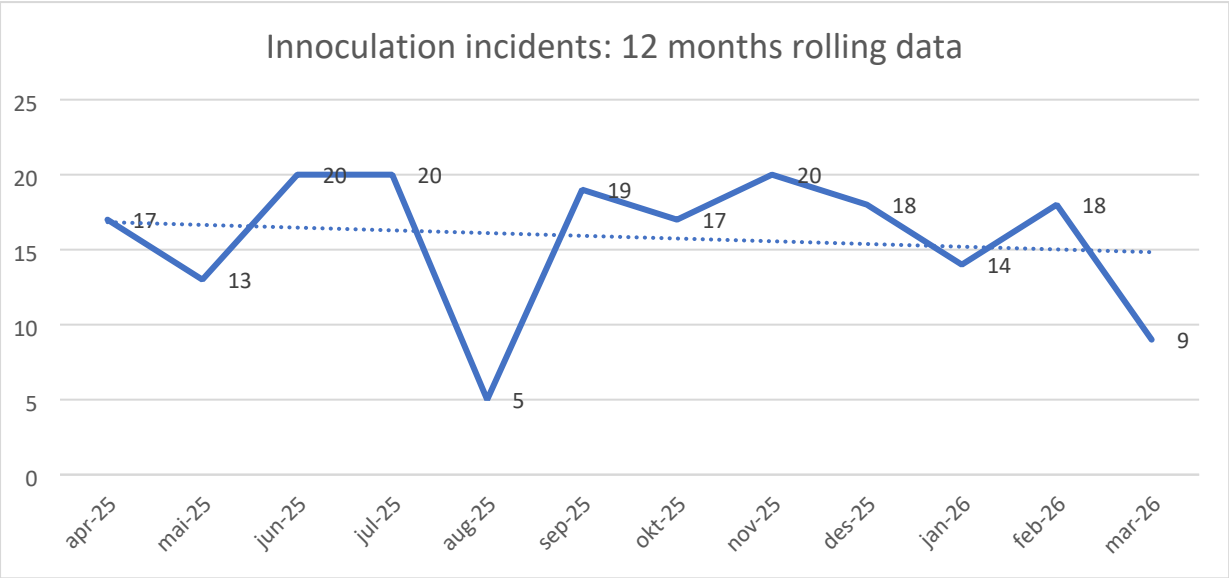
Inoculation injuries were the highest cause of injuries reported under the H&S category during 25/26 via Datix with the number of inoculation incidents significantly increased since last year (190) compared (144 last year). Part of the increase in number is due to continuing promotion / improvement work to enable the Trust to be legally compliant and to reduce the number / severity of injuries by:

The Trust Safety Sharps Group analyses inoculation incidents to identify causes, notable affected groups or working locations, training needs, device improvements etc all to enable the identification of preventative measures.

Trust Inoculation Scrutiny and learning group; this has membership from across the divisions where key incidents are presented and discussed. This is a positive and nurturing group committed to learning from / preventing incidents.

- Trust “Inoculation News” – this is a newsletter produced by the H&S team dedicated to highlighting to all issues, preventatives measures and learnings from inoculation incidents per quarter.
- Continual introduce of safer sharps devices, with training for users.
- The requirement for all staff to complete Sharps awareness training.

Reviewing the number reported per month; despite the overall number increasing, month the trend is declining. This is particularly due to August (5) (where it is believed there was significant under reporting during the holiday season) and similar to March 2026. This will be monitored during 26/27 for other emerging patterns.



Reviewing all 25/26 inoculations incidents it's noted that in the main:

- Most injuries were preventable and caused by inattentiveness (this being that if conducted in a non-live clinical setting clear focus on the task would be consistently applied and the likelihood of an injury would be low). It is believed that in the clinical setting, work demands, and patient interactions contribute to these injuries occurring.
- The type of device used, resulting in the most injuries was when using a hollow-bore needle.
- Most incidents affected nursing staff.
- The top three causes of incidents occurred during a surgical intervention, or due to poor disposal processes or when taking bloods.
- Locations reporting 3 or more inoculation incidents were:

Site	Location (exact)	Number	Changes compared to 24/25
Worcestershire Royal Hospital	Theatres (all)	16	Increase from 12
Worcestershire Royal Hospital	Hospital Sterilisation & Disinfecting Unit	11	Increase from 3
Worcestershire Royal Hospital	Accident & Emergency	10	Decrease from 12
Worcestershire Royal Hospital	Obstetric Theatre	8	Increase from 7
Alexandra Hospital - Redditch	Theatres (all)	7	Increase from 5
Worcestershire Royal Hospital	Avon 2 - General Medicine	6	Increase was below 3
Alexandra Hospital – Redditch	Accident & Emergency	6	Increase from 5
Alexandra Hospital – Redditch	Acute Medical Unit (AMU) ALX	6	Increase was below 3
Kidderminster Treatment Centre	Theatres (all)	6	Increase from 4
Worcestershire Royal Hospital	Intensive Therapy Unit/CCU	5	Increase from 3
Worcestershire Royal Hospital	Trauma and orthopaedic unit SIDE B	5	Increase from 3
Worcestershire Royal Hospital	Beech B	4	Increase was below 3
Worcestershire Royal Hospital	Delivery Suite	4	Increase was below 3
Alexandra Hospital - Redditch	Ward 18	4	Increase was below 3
Worcestershire Royal Hospital	Aconbury 3 - Renal	3	Increase was below 3
Worcestershire Royal Hospital	Hazel Trauma	3	Decrease from 5
Worcestershire Royal Hospital	Neonatal Unit	3	Increase was below 3

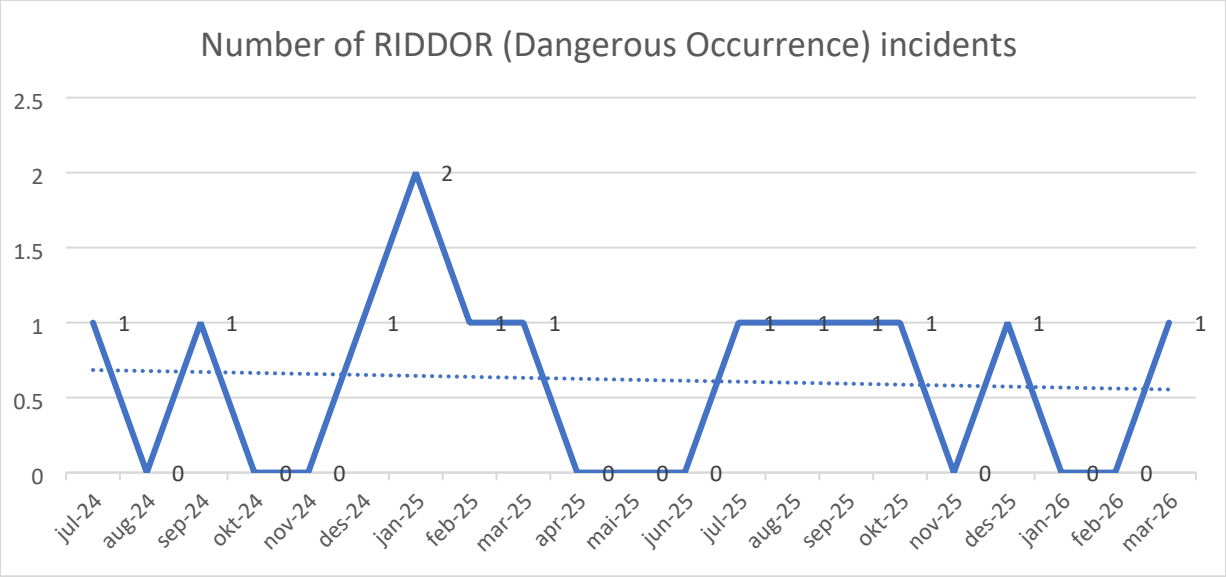
Worcestershire Royal Hospital	Ophthalmology Department	3	Increase was below 3
Worcestershire Royal Hospital	Riverbank Children's Unit	3	Increase was below 3

- WRH Theatres is the highest reporting area; with the number increasing compared to last year. The theatre team need to review their practices to prevent / reduce incidents of harm. Most incidents occurred during the surgical progress; this is preventable with focus and good surgical techniques.

- WRH HSSU is the second highest reporting area – but the increased number compared to last year is a concern. The team need to reflect on the underlying causes and address. Most occurred when handling/cleaning sharp instrumentation.

- WRH ED was a concern last year; it still is as it reported the third highest number of incidents however it's noted that the number reported is less than last year despite their on-going clinical demands.

- During the year 7 inoculation incidents were RIDDOR reportable as the injury led to the staff member being exposed to e.g. Hepatitis C or HIV. These are significant health concerns for the staff resulting in the need for urgent screening or treatment and/or counselling via Occupational Health, however the graph below shows a slight decreasing trend.



- Action: All staff must report inoculation incidents as this enables identification of preventative measures for the safety of all; staff must robustly follow needle stick action protocols. Staff must be particularly focused when caring for patients with known Hepatitis C or HIV to prevent exposure and possible health impacts.

Occupational Health Services

The Occupational Health (OHS) helps to monitor, prevent, and manage infectious risks amongst healthcare workers (HCW's) within the Trust. Our key services include:

New Employee Health Assessment

The main purpose of the new employee health assessment is to ensure that HCW's are fit to perform the duties of the post for which they are to be employed without risk to their own or others health and safety. The type of assessment will depend on the hazards of the workplace, occupation, medical history of the employee and the requirements of health and safety legislation. Screening of all potential new HCW's by confidential health questionnaires is undertaken in the first instance. New HCW's should not commence work until cleared by the OHS.

TB Screening

New HCW's who will be working with patients or clinical specimens should not start work until they have completed a TB screen or health check as part of the pre-employment process.

All new entrant HCW's from countries of high incidence of TB and who have not been previously screened on entry to the UK or by a previous employer in the UK within the previous 12-months will require IGRA testing. A positive IGRA result will require a chest x-ray and onward referral to the respiratory team for further clinical assessment. A positive IGRA test does not prevent HCW's from starting work providing they are symptom free.

Exposure Prone (EPP) Workers

If HCW's are to work in areas where they will be undertaking Exposure Prone Procedures (such as maternity, theatres, A&E) then validated EPP bloods are taken (prior to medical clearance being given) for Hepatitis B Surface Antigen, Hepatitis C Antibody and HIV Antibody/Antigen.

Immunisation Programmes

The OHS has a programme of staff health assessment to ensure HCW's are both protected from infectious disease by vaccination and are screened as required on employment to ensure they do not pose an infection risk to patients. All HCW's are health screened on employment, vaccination status is checked at this stage and any outstanding vaccinations are offered on commencement of employment. All HCW's are *offered* BBV testing at preplacement. Decisions on offering immunisation is made in line with OH Policy, local risk assessment and guidance from the UKHSA Green Book to all employees who have patient or specimen contact.

Vaccines are free of charge to all HCW's. Vaccination clinics are held at Worcester, Kidderminster, and Redditch Hospitals for accessibility.

Vaccinations include:

Hepatitis B

Measles and Rubella (MMR)

Varicella (Chickenpox)

Additional Vaccinations that will be offered to specific staff groups:

Diphtheria (lab workers)

Hepatitis A (lab workers and sewage workers)

Meningococcal Meningitis (lab workers)

Pertussis (whooping cough) (healthcare workers in midwifery/obstetrics/maternity settings, neonatal and paediatric intensive care, general paediatric wards/areas)

Polio (lab workers)

Tetanus (lab workers and gardeners following a recognised exposure)

Tuberculosis (BCG) (any healthcare worker or laboratory worker, who has either direct contact with TB patients or with potentially infectious clinical materials or derived isolates)

Typhoid (lab workers)

Influenza:

Our staff winter flu vaccination programme was promoted for 25/26 and the OHS held over 25 flu clinics with a combination of drop in and booked appointments. The campaign was also supported by peer vaccinators across the Trust.

Improving uptake continues to be a challenge but WAHT achieved its 5% improvement ambition as reported by The Midlands Vaccination Commissioning Team report for NHS England.

Vaccine	**Population**	**Doses**	**Percentage**
Flu	**7242**	**3120**	**43.1%**
Employee Staff Group		Uptake	
Nursing and Midwifery		42%	
Additional Clinical Services		36%	
Medical and Dental		45%	
Allied Health Professionals		44%	
Estates and Ancillary		40%	
Admin and Clerical		49%	
Healthcare Scientists		52%	
Add Prof Scientific and Technical		52%	
Students		13%	

1. **Inoculation Injuries**

The OHS provides timely risk assessments and appropriate advice after accidental occupational exposure to blood and body fluids. Information provided on Datix is cross checked daily against information held by the OHS to ensure that incidents are not missed.

2025-26	Number of injuries reported to OH	Number of injuries reported on Datix

April	20	19
May	15	12
June	24	17
July	20	21
August	12	10
September	28	23
October	21	21
November	24	22
December	16	16
January	18	15
February	19	18
March	17	11

The OHS also have a direct line for reporting of incidents during the Departments working hours, Monday to Friday 8.30-16.30, outside of these hours staff report incidents via ED.

2. Contact Tracing

The OHS work closely with the IPC team to provide advice and support in the event of infectious disease outbreaks and once notified of staff contacts will check the HCW vaccination status and follow up as required.

Over the last 12 months, the OHS have supported/managed contract tracing episodes for outbreaks of Diphtheria, Measles, iGAS, TB, Meningitis, Mumps, Varicella, Shingles, and Norovirus.

The IPC team also assisted with peer influenza vaccination of Trust staff.

SECTION FIVE - Our Plan for 2026-27

In the coming year we will continue to strive for clean safe care for our patients. We will continue to focus on protecting patients and staff from all infections, reacting and risk assessing the Trusts requirements against the national guidance to ensure we follow recommended good practice.

Our overall aim remains to achieve excellent infection prevention standards and very low rates of infection. Although we have not met all of the Trajectories and thresholds, we have worked to increase the engagement with teams and increase their understanding of IPC and improve our standards.

We will continue our focus on hand hygiene, cleanliness, antimicrobial prescribing, and the care of invasive devices.

With the introduction of Patient Safety Incident Response Framework (PSIRF) the IPC team have worked with the clinical and governance teams to align the reviews to the new way of working. There is a strong focus on actions and learning from infection incidents. There is work underway to have the DATIX form as the assessment tool for the incident to enable an

auditable process and to track completion of actions. There will be shared learning disseminated across the Trust.

Top three priorities will be:

1. Optimisation of C.diff management and blood stream infection reduction. – focus on AMS, cleaning, and patient assessment.
2. Promotion of the fundamentals of infection prevention and control, to include cleaning both environmentally and equipment. This will cover all responsible groups.
3. Education and training to ensure that we have a skilled workforce that have good knowledge of IPC to deliver safe clean care. In line with the Infection Prevention and control education framework.

To deliver these improvements and continue responding to the Quality Priorities we are implementing a comprehensive annual infection prevention improvement plan for 2026/27. This continues our focus on our '*Fundamentals of Infection Prevention and Control'* along with the other core actions we must take to achieve our aim.

References

1. The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). (Updated 2022) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

2. Start Smart Then Focus: antimicrobial stewardship toolkit for English hospitals (2015). https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus

3. Infection prevention and control education framework 2023. https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

4. UK 5-year action plan for antimicrobial resistance 2024 to 2029 https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029

Appendix 1: Outbreaks and Incidents

During 2025-26 we identified the following infection outbreaks and incidents which were not related to COVID-19:

Organism	Summary-ward outbreaks	Learning and Key Actions
CDiff	**2 X outbreaks** **WAH Beech B – 2 cases** **ALEX Ward 2 – 5 cases**	Robust cleaning is in place as per policy. Improvement required in D&V risk assessment and stool chart completion.
CPE	**1 x outbreak** **WAH ITU**	Estates works, Rolling HPV clean and surveillance screening implemented in both areas, drain treatment and screening remains in place
Influenza	**5 ward outbreaks**	Ward closure and cleaning in larger outbreaks and rolling HPV completed.
Norovirus	**4 ward outbreaks**	Ward closure, isolation of patients and deep cleans completed.
MRSA	**2 outbreaks** **NNU x 4 cases** **Aconbury 3** **3 cases**	Robust cleaning is in place as per policy. Increased MRSA screening undertaken. MRSA screening introduced to Transitional care
Citrobacter	**NNU** **2 cases**	Robust cleaning is in place as per policy. Increased screening undertaken. Deep cleans completed

Appendix 2: WAHT Infection Prevention and Control Improvement Plan 2026-27

WAHT Statement of Intent

The Trust is committed to achieving excellent infection prevention practices, and we aim to be one of the best organizations in the UK for our rates of infection.

The prevention of infection remains as a key priority for Worcestershire Acute Hospitals NHS Trust in 2025-26. This will be achieved through continuing and determined focus on improving clinical practices, antimicrobial stewardship, and the environment of care, and by continually improving the knowledge of our staff so that they can achieve excellent standards of infection prevention practice.

This improvement plan supports delivery of the WAHT Quality Improvement Strategy.. It sets out the objectives and actions that will be taken across WAHT to achieve our ambition to be one of the best organizations in the UK for our rates of infection, and to ensure compliance with Care Quality Commission Standards and 'the Hygiene Code' (2022), and our Infection Prevention & Control Board Assurance Framework.

Key Issues and Elements for Focus

Focus: Infections

- *Clostridioides difficile* infection
- *Staphylococcus aureus* bacteraemia, including MRSA.
- E coli and other gram-negative bacteraemia
- Respiratory Viruses
- Multi-Drug-Resistant Organisms, including Vancomycin Resistant Enterococci and *Carbapenemase Producing Enterobacteriaceae*
- Urinary Tract infections, including th related to urinary catheters.
- *Pseudomonas aeruginosa* in augmented care
- Preparedness for Ebola, MERS, Plague and other novel or emerging infections
- Norovirus

Priority Elements of Improvement Programme

- *Fundamentals of IPC – embed standards.*
- Hand hygiene and bare below the elbows
- Environmental Cleanliness
- Management of the environment to minimise aerosol and droplet transmission, including improvements in ventilation
- Prescribing of antimicrobial agents and proton pump inhibitors
- Decontamination of medical devices
- Aseptic non-touch technique (ANTT)
- Policy development, staff training and competence to support implementation.
- Audit and monitoring of policies, facilities, and key practices
- Sharps safety & waste management
- MRSA, CPE and other MDRO screening and MRSA decolonisation, respiratory swabbing
- Update and Implementation of care bundles; specific focus on invasive devices, wounds
- Isolation facilities, including negative pressure facilities and practices.
- Refurbishment of facilities; fabric of the estate
- Emergency preparedness for annual threats, and novel/emerging infections (HCID)
- Public involvement and information provision for patients, visitors, and the public
- Collaborative working across secondary, primary and community care.
- Research & development opportunities to improve local practices and knowledge.

Drivers: Guidance, Standards, Reports

- Priorities and Operational Planning Guidance (NHSE)
- National Infection Prevention & Control Manual
- Patient feedback
- Learning from incidents and outbreaks
- CQC Standards, and the Hygiene Code (2022)
    - National infection Prevention and Control Board Assurance Framework
- National guidance including on MRSA & CPE prevention, TB, Influenza
- National guidance on infection prevention practices: epic3
- NICE Quality Standard 113 (2016), Quality Standard 49 (2013) and Quality Standard 61 (2014)
- UK Five-Year Antimicrobial Resistance Action Plan
- National Standards for Cleaning (2025)
- Safer Sharps legislation, H&SaW Act
- Care Excellence Awards

	Objective	Reporting
1.	***Clostridioides difficile* infection** • The number of new cases of Trust-attributable *Clostridioides difficile* infection will meet the national target of no more than the contractual set trajectories.	Via TIPCC and monthly performance reporting
2.	***Staphylococcus aureus* bacteraemia** • There will be no Trust-attributable cases of MRSA bacteraemia. (zero tolerance) • The number of new cases of Trust-attributable MSSA bacteraemia will meet the national target once this is announced: locally agreed target no more than cases per annum	Via TIPCC and monthly performance reporting
3.	**E coli bacteraemia** • The number of E coli bacteraemia will reduce to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
4.	**Klebsiella species bacteraemia** • The number of *Klebsiella spp* bacteraemia will reduce to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
5.	***Pseudomonas aeruginosa* bacteraemia** • The number of *Pseudomonas aeruginosa* bacteraemia will reduce to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
6.	**Respiratory Viruses** • Patients, staff, and visitors will be protected from nosocomial respiratory infection. • The number of HCAI infections will be minimised, aiming to benchmark at or better than the Midlands rate.	Via TIPCC
7.	**Carbapenemase-Producing *Enterobacteriaceae* (CPE) and other multi-drug-resistant organisms.** • There will be no detected Trust transmission of CPE or other MDRO during the year. • Screening programmes will be in place in key departments with at least 95% compliance with the screening programme	Via TIPCC
8.	**Antimicrobial prescribing** • More than 90% of antibiotic prescriptions are in line with prescribing guidance or specialist advice. • More than 90% of antibiotic prescriptions are reviewed within 72 hours of initiation. • Reduce consumption of 'Watch' and 'Reserve' category antibiotics by 4.5% compared to 2018 baseline. • Minimum 90% participation and 90% compliance *with Start Smart Then Focus* monthly audits	Via ASG and Medicines Safety Committee; also reporting to TIPCC. Report to ICB AMS group
9.	**Norovirus & Influenza Preparedness** • The Trust will be appropriately prepared for infection emergencies, including large outbreaks in hospitals, and new or emerging infections with significant public health implications. • Preparedness for high-consequence infections will be reviewed.	Via TIPCC, with link into Emergency Planning & Resilience Response Meeting
10.	**Fundamentals of IPC** • Fundamentals to be promoted and embed. • Scrub the Hub • This includes hand hygiene performed consistently by staff in accordance with the World Health Organisation '5 moments for hand hygiene' at least 98% of the time	Via TIPCC and Divisional governance meetings
11.	**Cleanliness & Care Environments**	Via TIPCC, cleanliness and Scrutiny Meetings PEOG and

	Objective	Reporting
	• All areas across WAHT will consistently meet or be above the national minimum standards for cleanliness, as set out in the *Fundamentals of IPC.* • Environments will support effective infection prevention, by complying and being maintained in compliance with relevant Health Building Notes, and Health Technical Memoranda. • Water safety and the safety of critical ventilation systems will be maintained. • Improvements will be made in ventilation in clinical areas to reduce risk of spread of airborne infections.	Divisional governance meetings
12.	**Decontamination of Medical Devices** • Medical devices will not pose a risk of infection to patients; they will be single-use or decontaminated effectively in compliance with HTM 01-01 and 01-06. • Scrub the hub	Via TIPCC and Divisional governance meetings
13.	**Staff Training and Competence** • All staff will possess the knowledge, skills and competence needed to practice safely and minimize risk of infection, and this will be reflected in key standards audits; in particular, all relevant staff will be trained and competent in ANTT, and statutory and mandatory training: 95% minimum. • All staff will complete donning/doffing training, and relevant staff will be FFP3 mask fit tested.	Via TIPCC and Divisional Governance Groups
14.	**Patient & Public Involvement** • Patients, visitors, and the public will be informed about and involved in infection prevention. Information on the internet will be developed and improved. • Involvement in the development of information • Engagement with cleanliness reviews	Annual review by TIPCC
15.	**Research & Development** • New and novel programmes of work will be identified and progressed in support of the ambition of the Trust, to achieve very low rates of infection, and excellent standards of infection prevention practice.	Annual review by TIPCC

Governance & Management

This corporate plan underpins, integrates, and influences improvement plans in the Divisions and the corporate Infection Prevention Team. Lead responsibility and accountability for local plans rests with Divisional Management Teams. A detailed delivery plan has been developed to achieve the aims and objectives set out in this summary plan.

Progress with this programme will be monitored via the Trust Infection Prevention and Control Committee (TIPCC), chaired by the Chief Nursing Officer/DIPC, and supported by the DIPC. Updates will be provided to the Trust Management Executive Meeting, the Quality Governance Committee, and to the Board as part of regular reporting in place.

Progress with local plans and escalated issues will be monitored and managed via Divisional Governance Meetings, and updates will also be provided to the Infection Prevention and Control HCAI Scrutiny meeting.

Approval: TIPCC **Date: 05.05.2026**

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

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

Brief Description of Report Purpose

Purpose: To provide TIPCC with an update on Trust compliance with the National IPC Board Assurance Framework.

Background: The National Infection Prevention and Control board assurance framework (BAF) is issued by NHS England for use by NHS organisations. It is a self-assessment tool which it advises can be used to provide assurance to Boards on IPC standards and compliance with the requirements set out in the National Infection Prevention and Control Manual (NIPCM), and the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2022). A detailed self-assessment was previously performed in January 2026.

This BAF has been completed on the new NHSE V5.2 format.

BAF Update April 2026:

The standards within the BAF have been reviewed, and currently available evidence considered in relation to Trust compliance with the requirements it contains.

Section 1 – there are two areas of partial compliance

Section 2 – there are four areas of partial compliance

Section 3 – there are two areas of partial compliance

Section 4 – there is one area of partial compliance

Section 5 – fully assured

Section 6 – there are three areas of partial compliance

Section 7 – there is one area of partial compliance

Section 8 – fully assured

Section 9 – fully assured

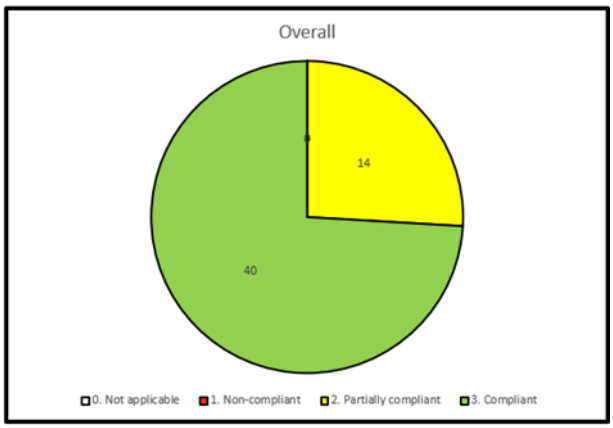
Section 10 – there are two areas of partial compliance.

There are no areas on non-compliance and three sections of full compliance as shown in the graphs and tables below.

The IPC BAF has been updated to reflect our current position with our measles outbreak and the work that is taking place with our Occupational Health department to understand our staff vaccination position, this also includes our PFI partners including ISS and Equans.

The Trust is also undertaking a piece of work to strengthen our HR recruitment processes with Occupational Health and line managers prior to individuals commencing employment, focusing on the Trust response to non-engagement with Occupational Health and vaccination status.

February 2026



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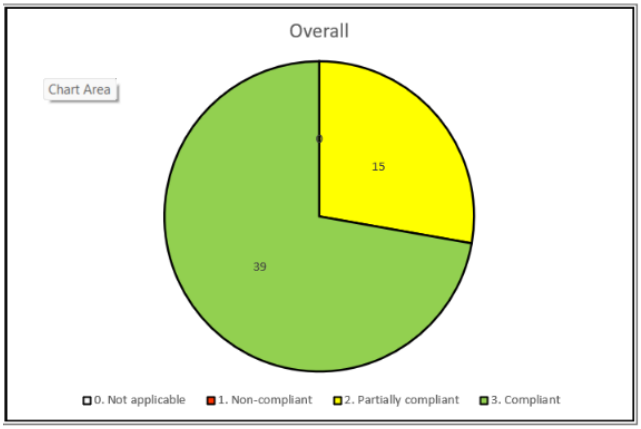

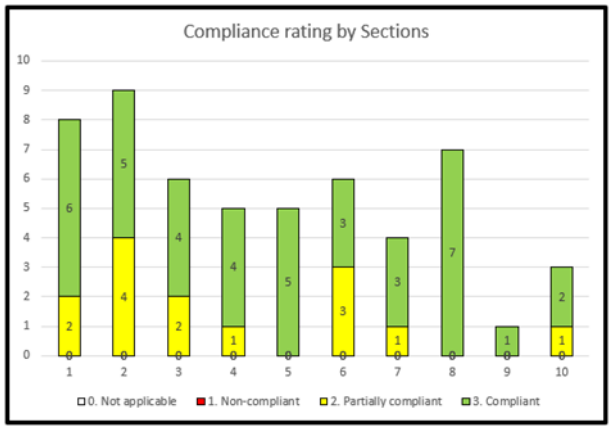

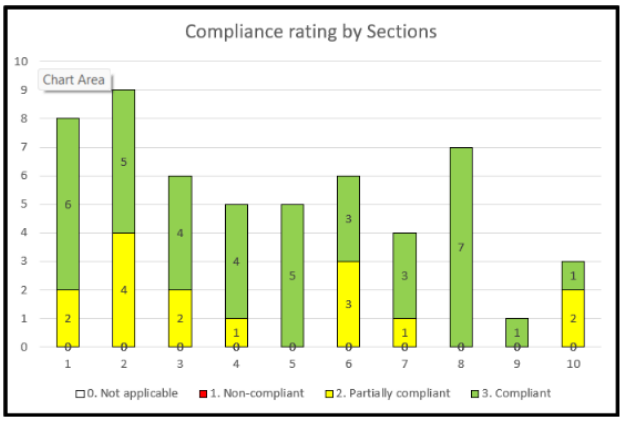

Recommended Actions required by Board or Committee

1. Review the summary assessment reported above.

2. Endorse the level of assessment for criteria

3. Note that further work is required to complete the detailed evidence mapping to underpin the assessment.

Executive Director Opinion[1]
This report provides moderate to high assurance that the Trust has a comprehensive and maturing Infection Prevention and Control (IPC) governance framework aligned to national standards, with no areas of non-compliance identified across the Board Assurance Framework (BAF) **The IPC BAF has been updated to reflect our current position with our measles outbreak and the work that is taking place with our Occupational Health department to understand our staff vaccination position, this also includes our PFI partners including ISS and Equans.** **There is** • **Robust governance structures from ward to Board, including TIPCC oversight and executive accountability** • **Effective surveillance, reporting, and system-wide partnership working with NHSE, UKHSA and the ICB** **However, 15 areas of partial compliance remain, indicating that while systems are in place, delivery is not yet consistently embedded across all services.**

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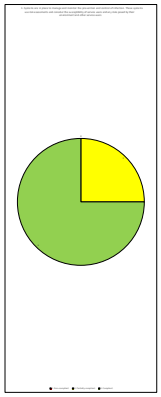
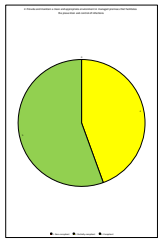
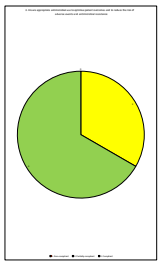
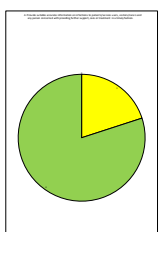
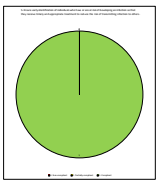
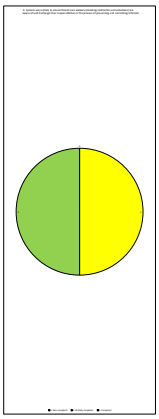


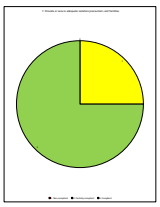


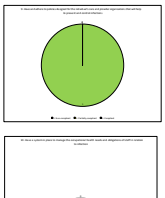


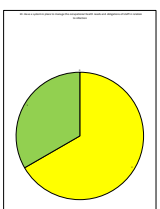












Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Public Trust Board
Date of Meeting:	14 July 2026
Title of Report:	Integrated Safeguarding Annual Report 2025/2026
Lead Executive Director:	Hayley Flavell, Chief Nursing Officer
Author:	Deborah Narburgh, Head of Safeguarding
Reporting Route:	Integrated Safeguarding Committee QGC
Enclosures included with this report:	Integrated Safeguarding Annual Report 2025/2026
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Integrated Safeguarding Annual report 2025/2026 details the work undertaken over the last year in relation to Safeguarding and Prevent activity for adults, children and young people in order for Worcestershire Acute Hospitals NHS Trust to fulfil its legal and statutory safeguarding duties.

Recommended Actions required by Board or Committee

The Board is asked to receive for assurance, the Integrated Safeguarding Annual Report 2025/2026.

Executive Director Opinion[1]

The Trust continues to deliver a robust and effective safeguarding service with strong governance and partnership working. However, increasing demand, workforce pressures, and training compliance gaps require focused action to sustain performance and ensure continued assurance of patient safety.

Wells Jo 09/07/2026 16:01:26

[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.

1.0 Introduction/Background

The Annual Report for 2025/26 reflects the continued rise in safeguarding activity and complexity of cases being seen across the Trust. This mirrors the national picture.
This poses an ongoing challenge for us as an NHS provider of healthcare services, and our system partners to ensure we maintain continued heightened vigilance in relation to safeguarding, to protect those most at risk of harm.

2.0 Issues and options

2.1 Leadership Arrangements

The Chief Nursing Officer (CNO) is the Executive Lead for safeguarding adults, children, young people and PREVENT. The Deputy Chief Nurse leads the safeguarding portfolio on behalf of the CNO.

2.2 Assurance

The Trust Integrated Safeguarding Committee is chaired by the CNO and meets bimonthly. The Integrated Safeguarding Committee reports to the Quality Governance Committee (QGC) gaining assurance on behalf of the Trust Board that its legal and statutory duties in respect of safeguarding adults, children & young people are met.
The Integrated Safeguarding Committee work in accordance with an agreed work plan. Attendance at the Committee by a representative of Herefordshire & Worcestershire Integrated Care Board (ICB) provides a level of oversight and scrutiny as part of the safeguarding assurance process.
Terms of reference are updated annually.

2 Integrated Safeguarding Committee Meetings were stood down during 2025/26 due to Critical Incident and Resident Doctor strikes.

2.3 Safeguarding Risk Register

The Integrated Safeguarding Committee review all risks on a bi-monthly basis and mitigation is in place.
Safeguarding is currently linked to the following open risks:

2.3.1 Current high risks:

ID4119 Policy Revision
ID3430 Safeguarding Alerts – transfer of narrative from Oasis to Patient First System
ID5857 - Training compliance matrix for Safeguarding Adults Level 3 is not as per the Intercollegiate Document published 2024.

Current high risks (12- 14) are:

ID2873 – Safeguarding training compliance
ID5952 – Use of Safety hand mittens
ID5987 – CP-IS checks

2.3.2 Moderate risks:

ID5856 - Safeguarding alerts do not transfer to stand alone systems
ID4621 Adoption records –also monitored via Data Quality /Health Records Group
ID4622 – clinical applications and feeding of alerts

2.3.3 Low risks

ID5361 – Integrated Safeguarding Team capacity
ID5668 – EPR and partner access to Trust systems in order to undertake safeguarding activity where the H&H&WHCT represent 'health' e.g. Paediatric Liaison
ID6059 – FGM commissioning pathway

2.4 Information Governance Incidents

IG Breach – WEB262741

There has been 1 case during 2025/26 where a clinical member of staff sent PID via a non-secure e mail. Immediate action taken at time of breach. Assessed as Low risk.

3.0 Care Quality Commission (CQC) Regulatory Activity - Mandatory Training

Strategic priority: patients, excellence

What needs to happen: CQC 'Must / Should do': Mandatory training compliance of 90% across all levels of safeguarding training, MCA & DoLS

Care Quality Commission inspections have repeatedly cited mandatory training compliance as an area of ongoing concern. Despite the training compliance position, the regulator has acknowledged within inspection reports that staff are able to recognise and protect patients from abuse, working well with other agencies to do so.

3.1 Outturn Position as at 31st March 2026:

3.1.1 Safeguarding Adults

	Q4 2024/25	Q4 2025/26	Compliance required 90%
SGA L1	95%	95%	Compliant
SGA L2	92%	93%	Compliant
SGA L3	77% (152/198 completed)	64% (149/234 completed)	Partial compliance

As at year end, Safeguarding Adult training Trustwide L1 & L2 is fully compliant with the 90% requirement. Work has been completed to bring the Trust in line with the revised Intercollegiate Document for Adult Safeguarding (2nd Ed). Initial data for the coming quarters will see a drop in SGA L3 compliance due to the increase in the numbers and groups of staff now required to complete this level of training.

Associated Risk:

Adult Safeguarding: Roles and Competencies for Health Care Staff (2nd Ed) –Published July 2024

Risk register ID5857. This work has now been completed and staff groups aligned in ESR to the revised levels of training. Risk closed.

3.1.2 Safeguarding Children

	Q4 2024/25	Q4 2025/26	Compliance required 90%
SGC L1	95%	95%	Compliant
SGC L2	93%	93%	Compliant
SGC L3	83%	82% (1127/1368 completed)	Partial compliance

As at year end, Safeguarding Children training Trustwide L1 & L2 is fully compliant with the 90% requirement. L3 compliance has dropped slightly over the last year.

3.1.3 MCA & DoLS

	Q4 2024/25	Q4 2025/26	Compliance required 90%
MCA & DoLS L1	93%	94%	Compliant
MCA & DoLS L2/3	82%	80.5%	Partial compliance

Trust compliance with MCA & DoLS higher level remains below the 90% Trustwide requirement.
A range of training opportunities for staff to access is on offer, including bespoke sessions.

3.1.4 Medical & Dental Staff Training Compliance:
Safeguarding Adults and Children:

Staff Group	Competency	Sum of % completed 31st Mar 2024	Sum of % completed 31st Mar 2025	Sum of % completed 31st Mar 2026	Trend	Compliance required 90%
Medical & Dental	SGA L2	76%	82%	85%	↑	Partial compliance
	SGC L2	74%	77%	84%	↑	Partial compliance
	SGC L3	79%	80%	76%	↓	Partial compliance
	MCA & DoLS L2	50% (234/467 completed)	48% (238/495 completed)	44% (235/529 completed)	↓	Partial compliance
	MCA & DoLS L3	86% (313/363 completed)	79% (312/394 completed)	77% (337/436 completed)	↓	Partial compliance
	Combined L2/3 – Higher level	66%	64%	61%	↓	Partial compliance

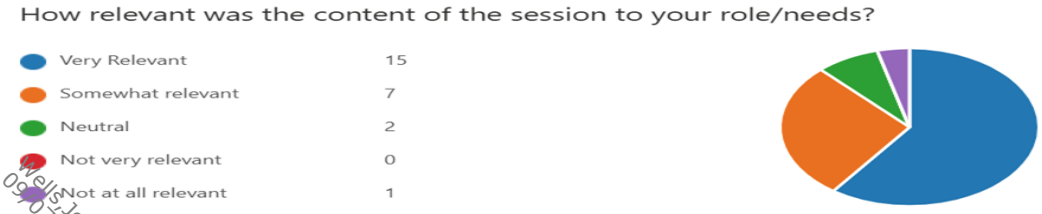
2025/26 has seen continued improvement in medical and dental L2 training compliance for adults and children. L3 children has declined when compared to the previous year outturn. An additional 6 bespoke SGC L3 sessions were delivered to medical & dental staff during July and August 2025. 25 staff attended.

MCA & DoLS compliance has also declined, however, the numbers required to complete has increased when compared to previous years.

3.1.5 Level 4 NHS impact
The Trust and system partners have continued to experience extreme operational pressures during 2025/26. A trustwide critical incident response was declared on 6th January 2026.

3.1.6 Industrial Action – Resident Doctors
Junior and resident doctors have undertaken multiple strikes during 2025 and 2026 over pay, working conditions, and training concerns. This has a direct impact on medical staffing and the need to deliver key services in order to keep patients safe.

3.1.7 Safeguarding Training Feedback
As of December 2025, the team now have a mechanism for training feedback. Overall, staff report a high level of satisfaction in terms of content, clarity & quality:



How would you rate the overall quality of the training on a scale of 1-5 where 1= POOR and 5= EXCELLENT

1	1
2	1
3	1
4	8
5	12

3.2 Care Quality Commission(CQC) Inspection outcomes – Safeguarding

There have been no core service inspections undertaken by the regulator during 2025/26.

4.0 PREVENT/WRAP

The Trust is fully compliant with its statutory obligations and training compliance for PREVENT in accordance with the PREVENT Duty requirements.

4.1 Training compliance

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty. NHS Trusts are a health specified authority within the Act. NHS England has incorporated *Prevent* into its safeguarding arrangements, so that *Prevent* awareness and other relevant training is delivered to all staff who provide services to NHS patients. This is supported by a Prevent Training and Competencies Framework (NHSE October 2017). Trusts were required to achieve an 85% compliance rate for PREVENT basic awareness and WRAP as of March 2018.

Basic Prevent Awareness Training (BPAT)	Compliance 85%
Q4 2025/26	
95% (1885/1983 staff completed)	Compliant

Prevent L3 and above	Compliance 85%
Q4 2025/26	
94% (5841/6235 staff completed)	Compliant

The Trust has consistently sustained the national requirement of 85% for PREVENT training across all levels in accordance with the PREVENT Duty.

4.2 PREVENT referrals

The Chief Nurse is the Executive lead for PREVENT. The Operational Lead is the Head of Safeguarding. Compliance with the PREVENT duty is reported quarterly to NHS digital, and the PREVENT Lead for the Integrated Care Board. The Trust has made 2 referrals to PREVENT during 2025/26. Cases referred have included:

- Concerns re Nazism
- Hating the British, idolisation of Adolph Hitler and Osama Bin Laden

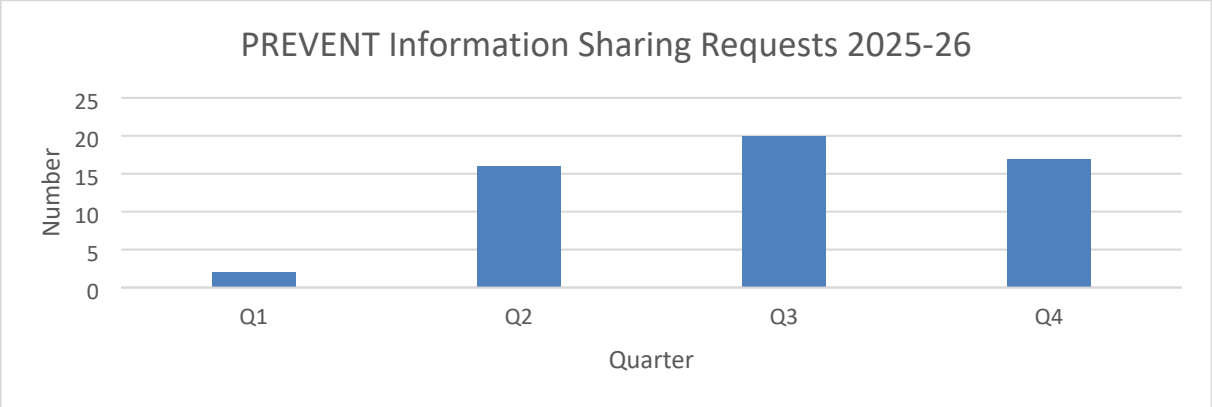
A further case was escalated to a partner agency in respect of far-right extremism.

4.2.1 Counter Terrorism Information Sharing Requests

This information is requested under the terms of s38 of the Counter-Terrorism and Security Act 2015. Consent for this Prevent Information sharing request is not sought from the subject as it is not required due to exemptions under Section 115 Crime and Disorder Act 1998, Common Law, and the Data Protection Act. During 2025/26 the Trust has shared information in respect of 55 cases.

Themes:

- Fascination with slitting people's throats with a machete
- Online radicalisation
- White supremacy views
- INCEL related beliefs
- Nazism
- Anti-islam rhetoric and activity
- Fascination with weaponry and military



4.2.2 PREVENT data upload to NHSE PSCAT

The Trust has met all statutory reporting deadlines for PREVENT during 2025/26.

4.3 PREVENT Partnership working

4.3.1 Current National Threat Level - Joint Terrorism Analysis Centre (JTAC)

The current threat level is SEVERE – this means an attack is highly likely. The threat level was increased on 30th April due to the Golders Green stabbing and rise in Islamist and Extreme Right Wing Terrorist threats across the UK.

4.3.2 Counter Terrorism Local Profile (CTLP)

The Head of Safeguarding represents the PREVENT Executive Lead on behalf of the Trust. Actions coming from the Counter Terrorism Local Profile (CTLP) inform the Worcestershire Strategic PREVENT Strategy and associated work streams. Outcomes are shared via the Integrated Safeguarding Committee. The Trust received the full CTLP briefing in February 2026.

Action taken:

The CTLP Partner Briefing package was circulated during March 2026. Information in relation to:

- Signs & symbols
- Minecraft parental guide
- Roblox parental guide
- Prevent National Referral Form
- 2026 CT Briefing (partners)

4.3.3 Protection of Premises Bill (Martyn's Law) – Protect & Prepare Duty

The Terrorism (Protection of Premises) Act 2025, also known as Martyn's Law, received Royal Assent on 3rd April 2025. This Act delivers the Government's manifesto commitment to strengthen the security of public premises and events following the Manchester Arena attack.

The Government intends for there to be an implementation period of at least 24 months before the Act comes into force, thereby allowing the Security Industry Authority's (SIA) new function to become established, whilst ensuring those responsible for premises etc have sufficient time to understand their new obligations.

Agencies are asked to focus on the following:

- Understand the threat
- Reasonable worst-case scenario e.g. vehicle, fire, marauding attacker, IED, cyber, CBR attack
- Vulnerability review – risk assessment
- Training – ACT E learning
- Communications campaigns
- Test /exercise plans – rehearse
- Think about our outside spaces
- Do we have a thriving security culture
- Are our command structures robust in the event of a crisis
- Have we got good, detailed plans
- Are we prepared for high threat / no notice attack

Action taken:

The first meeting was held in June with the EPRR team to review Martyn's Law and its implications for the Trust. Statutory guidance is expected during Spring 2026. The EPRR Lead is the recommended 'Designated Senior Individual' for this piece of legislation.

4.4 Prevent Audit

In order for the Trust to provide assurance that staff are working in accordance with the Prevention of Extremism and Radicalisation (Prevent) Policy and the wider Prevent agenda an audit was undertaken throughout the month of September 2025. 51 face-to-face interviews were conducted, involving staff from a wide number of disciplines.

Findings:

Prevent compliant Mandatory Training	94%
Aware of location of Prevent Policy	96%
Had seen the Prevent Annual Newsletter	20%
Know the Trust Prevent Lead	24%
Gave an appropriate response when asked who they would contact if they had a prevent concern about a colleague or patient	100%
Gave an appropriate response when asked who they would report to if they saw someone acting suspiciously	100%

The audit provided a high level of assurance that staff were up to date with training, aware of the Trust Policy & procedure and knew how to report prevent related concerns.

The Integrated Safeguarding Team are considering how they can reach a wider audience /use a number of other mediums to promote the annual newsletter and prevent lead information (historically included in the annual newsletter).

4.5 PREVENT Strategy Group

4.5.1 Prevent Assurance and contribution to the Worcestershire Strategic Action Plan

During May, the Trust submitted its Prevent Assurance Statement in relation to the key priorities and its contribution to the wider Worcestershire Strategic action plan. The Trust was able to offer a high level of assurance to the partnership in this regard.

4.6 Supplementary activity

Newsletters, briefings and podcasts continue to be circulated to professionals to keep them appraised of PREVENT activity including:

- Key principles of Prevent FAQ
- NHS Estates Technical Bulletin – Terrorism Protection of Premises Act – application to healthcare buildings
- Early threat identification notice for safeguarding professionals
- Run, Hide, Tell: Firearms and weapons attack
- Incels & Misogyny
- Reporting of community tensions
- Com networks briefings
- Stickers & graffiti
- Use of gaming cultures

4.7 Prevent Policy Update

During 2025/26, the Prevent Policy has been fully revised to include updated CONTEST statutory guidance, Prevent Duty guidance and Martyn's Law. Republished September 2025.

5.0 Female Genital Mutilation (FGM)

Strategic priority: patients, excellence, collaboration, effectiveness

The Trust has robust systems and processes in place to recognise and report cases of FGM in accordance with the FGM Mandatory Reporting Duty (2015).

The Named Midwife and Named Doctor are leads for FGM within the Trust providing oversight and statutory reporting of identified cases of FGM. The Named Midwife has responsibility for upload of the FGM indicator to the NHS Spine to alert staff that there is a family history of FGM.

5.1 FGM National Dataset reporting

There have been 6 reported cases of FGM during 2025/26. All referrals received by the Named Midwife were via BadgerNet.

5.2 FGM Pathway Commissioning of Specialist Services for under 18's – Risk ID6059

Following a case where it was identified that the pathway for children identified no commissioned service was in place for specialist FGM assessment, the ICB led a piece of work to develop a pathway. This work is now complete.

5.3 FGM Awareness Day 6th Feb 2026

Trustwide communications circulated to raise staff awareness of FGM. Although FGM is predominantly identified in obstetric services, other areas need to remain alert e.g. surgery, urology.

6.0 Homelessness 'Duty to Refer' - Homelessness Reduction Act 2017

Strategic priority: patients, excellence, collaboration, effectiveness

The Trust has in place systems and processes to meet the requirements of the Homelessness Reduction Act 2017.

Information taken from the homelessness liaison pathway quarterly reports: referrals to the homelessness liaison service for a homeless approach:

- Apr – Jun 2025 - Total number = 37 referrals, of these: Worcester Royal Hospital=30 referrals, Alexandra Hospital = 7 referrals
- Jul – Sept 2025- Total number = 61 referrals, of these: Worcester Royal Hospital=48 referrals, Alexandra Hospital = 13 referrals
- Sept – Dec 2025 – no data available.

Cessation of Funding

As of January 2026, the ICB have confirmed the homelessness liaison post is no longer funded.
Internally, this will now be overseen by the Integrated Discharge Team who also attend the housing meeting to discuss any concerns.

7.0 Modern Slavery / Human Trafficking

Strategic priority: patients, excellence, collaboration, effectiveness

The Trust has in place systems and processes to meet the requirements of the Modern Slavery Act 2017 working with our partners to protect those at risk.

The Integrated Safeguarding Team continue to provide advice and support to staff when concerns are identified on a case-by-case basis.

7.1 Home Office – Modern Slavery Statement

The Trust annual Modern Slavery statement was uploaded to the Home Office during June 2025.

7.2 Slavery & Trafficking Survivor Care Standards – Human Trafficking Foundation

The Slavery and Trafficking Survivor Care Standards aim to improve service provision by ensuring that adult survivors of human trafficking and modern slavery consistently receive high quality care wherever they are in the UK. Their ultimate goal is to promote an integrated, holistic and empowering approach that places the real needs of survivors at the centre of the process of sustained recovery.
Action taken: the updated standards were circulated via the Integrated Safeguarding Committee during November.

7.3 Support for On Call Teams

Further to some recent cases out of hours, the Head of Safeguarding provided some training for the on call teams in respect of the processes to be followed when modern slavery or human trafficking concerns arise. This included information on the National Referral Mechanism (NRM) process and who can refer.

8.0 Suicide Prevention

Strategic priority: people, patients, excellence, collaboration, effectiveness

The Trust is actively working with partner agencies in relation to suicide prevention and the support and signposting agenda.

8.1 Worcestershire Suicide Audit Group

Commenced during 2022/23 the group was set up to look at a real time surveillance system (RTSS). The aim of the RTSS is to seek to reduce deaths by suicide in Worcestershire. The process will help to provide bereavement support to residents of Worcestershire affected by suspected suicides in a timely fashion. Data and information gathered during this process is used to identify patterns and trends so that suicide prevention strategies can be adopted and inform public health interventions and strategies. The Head of Safeguarding represents the Trust on this group. Priorities for focus within Worcestershire for 2025 included raising awareness, providing resources and fostering open conversations about mental health. Work /communications undertaken during 2025/26 includes:

- Promotion of the Herefordshire & Worcestershire Pocket Guide for Mental Health
- Promotion of the self-help for good mental health page (Local Authority)
- Promotion of bereaved by suicide resources for adults and children – MIND
- After a suicide attempt – a guide for families and friends – circulated to raise awareness
- Prevention of Suicide Alert – the Peaceful Pill Handbook
- Miles Cross – sentenced for offences for encouraging or assisting suicide of another

8.1.1 Upload to the RTSS - commenced Q3

The Trust has uploaded information for 17 cases to the real time surveillance system during 2025/26 (Q3 n8, Q4 n9).

8.1.2 RTSS Case xx Internal Review

A 47yr old female had 4 hospital attendances during a very short space of time prior to her death. Suspected death by suicide (ligature). The Trust undertook a deep dive with Mental Health to ascertain if there were any missed opportunities to signpost / intervene prior to death.

Findings: The pathways for a patient presenting with suicidal ideation were followed and the necessary Mental Health Assessments completed. This included signposting to support services.

8.2 Domestic Homicides and Suspected Victim Suicides 2020-2024 Report

The fourth annual report from the national Domestic Homicide Project which works across England and Wales was published in March 2025. The report examined all deaths identified by police as domestic abuse related, with the aim of improving the understanding of risk indicators, victim, and perpetrator demographics. The unique dataset collects detailed information on these deaths not available from any other source to help police and partners improve their response to domestic abuse, domestic homicide and victim suicide following domestic abuse.

Key findings:

98 deaths were recorded between 1 April 2023 and 31 March 2024. *For the second year in a row, suspected suicides following domestic abuse have overtaken the number of homicides involving current or previous partners.* Over four years (1 April 2020 – 31 March 2024), the number of people killed by their current or previous partner consistently represents around a third of domestic abuse-related deaths each year.

Action taken: The links between domestic abuse and suicide risk has been incorporated into mandatory training packages. This link has also been reflected within the Domestic Abuse Policy. The Trust continues to work as a partner agency in the Domestic Homicide review and suicide prevention agenda with the aim of reducing the number of deaths by suicide.

8.3 Suicide Prevention Training

Fully funded suicide prevention training promoted Trustwide.

9.0 Mental Health Act

Strategic priority: people, patients, excellence, collaboration, effectiveness

Medical staff need to ensure s5(2) paperwork is completed in accordance with requirements of the MHA to ensure the detention is lawful.

The Mental Health Act 1983 (amended in 2007) is the law which sets out when a person can be admitted, detained and treated in hospital for a mental disorder. The Act is supported by a 2015 Code of Practice. All applications for admission are made out to the 'Hospital Managers', meaning the organisation in charge of the hospital. In practice, most decisions are delegated to clinicians. Providers require specific registration with the Care Quality Commission to deliver care.

9.1 Mental Health Act Amendment – December 2025

The Mental Health Act 2025 received Royal Assent on 18 December 2025, introducing significant amendments to the Mental Health Act 1983. There is a proposed implementation schedule of up to 10 years.

The updated MHA Code of Practice is intended to be out for consultation by the end of 2026.
Two areas of the Act have been updated so far, these will not impact on Acute Trust providers.
There have been no case law decisions relevant to Acute Trust providers to date.

9.2 Types of Detention

Section 2	detention in hospital for up to 28 days for assessment and/or treatment
Section 3	renewable treatment section which lasts for up to 6 months initially. Once renewed twice, the section duration becomes one year
Section 4	Admission for assessment in cases of emergency where only one doctor is available; lasts up to 72 hours. Can be converted to a section 2
Section 5(2)	Doctors' holding power, allows detention for up to 72 hours for the purposes of assessment. Patients must already have been admitted to hospital

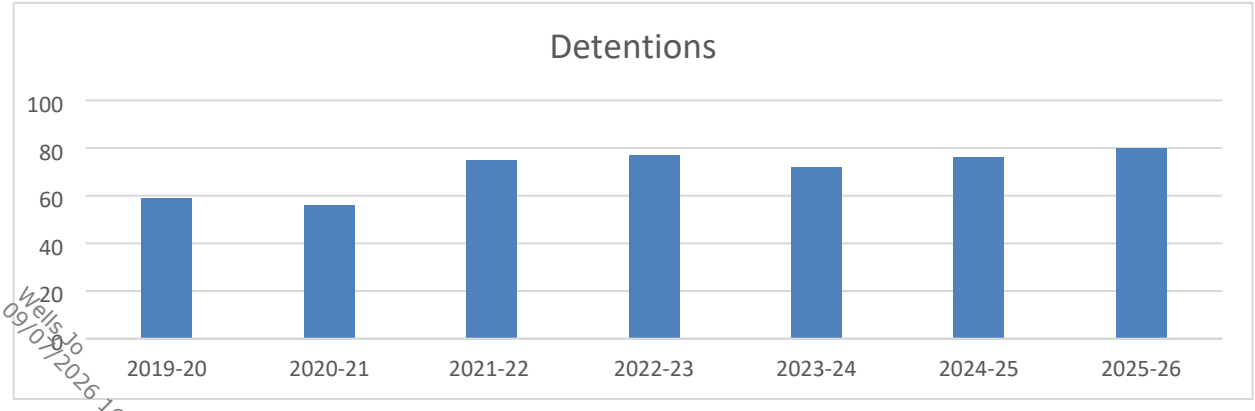
9.2.1 Uses of Section

The Trust were Hospital Managers to 81 detentions within 2025/26, affecting 61 individuals. Detentions per annum since the start of the contract average over 70, but since the year of the pandemic, this has increased to 76.

There was 1 detention open as at year end.

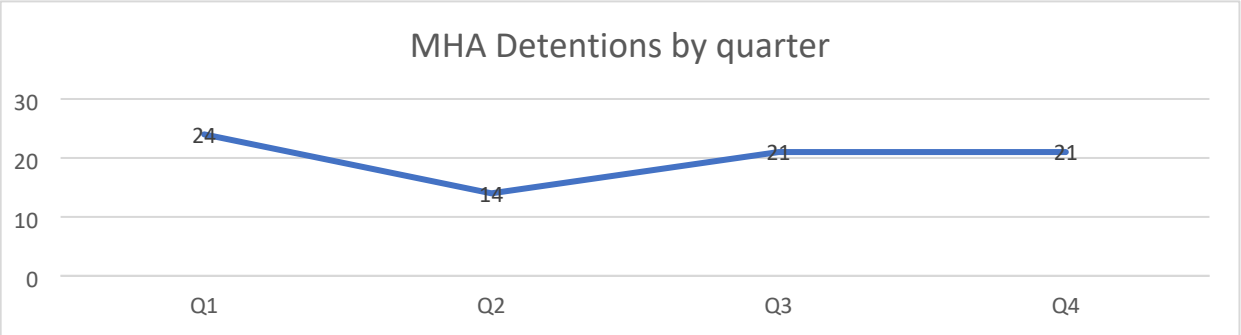
9.3 Detention activity

The contract allows for 20 detentions per annum; this number has been exceeded each year since the contract commenced:



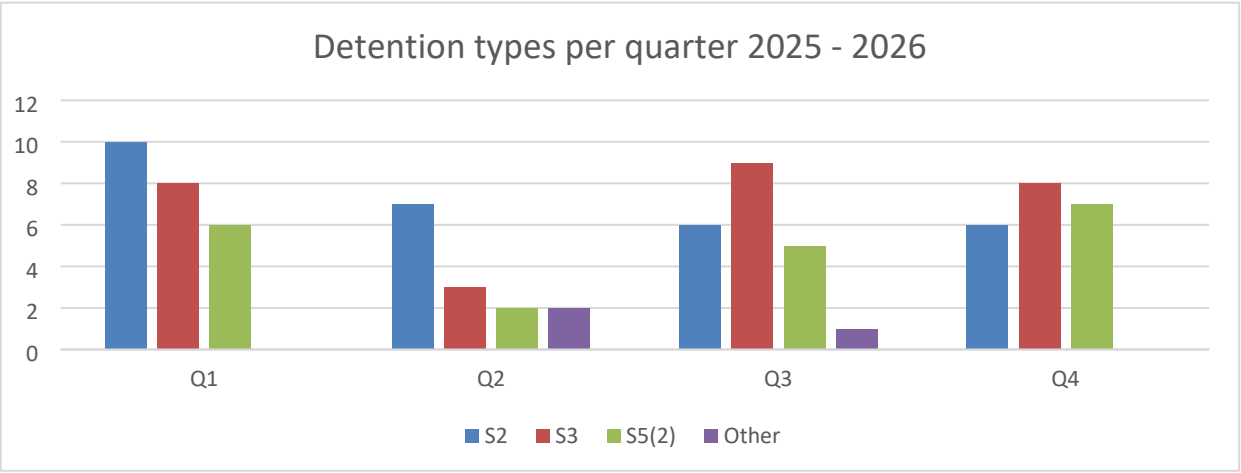
2025/26 has seen the highest number of detentions since the contract commenced in 2019/20.

9.3.1 Detentions by Quarter 2025/26



Fluctuation is normal and there are no patterns or trends which are particularly evident.

9.3.2 Types of Section used by Quarter



Across the year, the numbers of s2(n29) and s3(n28) use remain comparable.

9.3.3 Section Activity by Hospital

MHA Admin capture data using the hospital sites as well as the ward names. This was to more accurately capture where the detentions were taking place.

In the last year, the 80 detentions were split as follows:

- Alexandra 41
- WRH 39

Detention activity in the past year has been evenly split across the hospital sites. Over previous years the activity has predominantly taken place at the Alexandra Hospital, which is located nearer to New Haven, an older adult mental health unit based in Bromsgrove.

9.3.4 Section Activity by Ward

The wards with most detention activity are as follows:

Alex

- AMU - 27

WRH

- AMU - 11

These 2 wards accounted for 47% of total activity.
The most common way for sections to start in WAHT within this year was a regrade from informal (40).

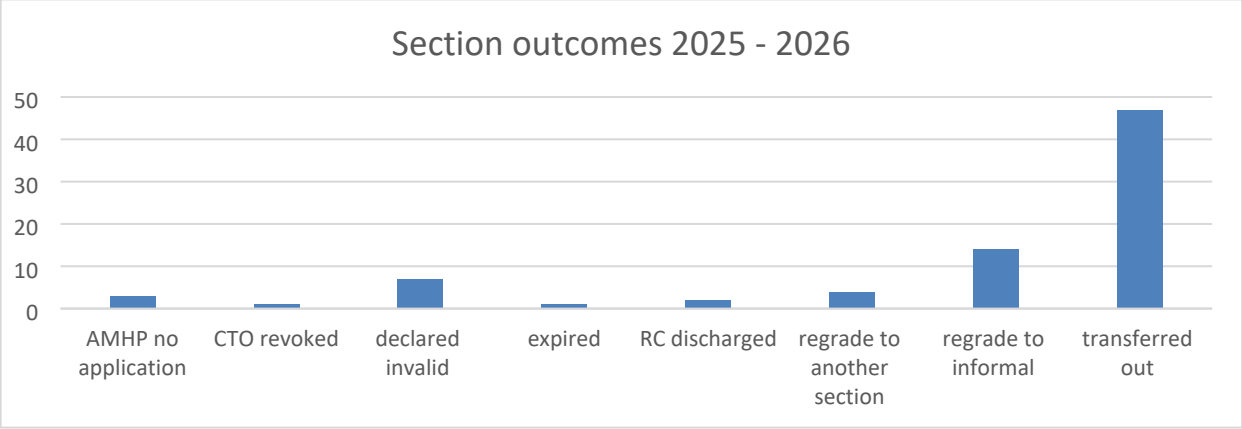
- 34 sections were transferred into the care of WAHT. All but 3 of these transferred into WAHT from HWHCT.
- 4 sections were regraded while the patient was receiving care at WAHT; and
- 2 patients were admitted directly to the care of WAHT on section

9.3.5 Time Spent on Section

In total, patients spent 595 days on section within the year, an average of 8 days each. Of those, 3 individuals accounted for 182 days (31% of the total).

9.3.6 Section Outcomes 2025/26

As would be anticipated, most patients who were sectioned were transferred out to mental health care providers once their physical health was stabilised. The majority (39) continued to be detained locally, but 8 were transferred out of the area.



9.4 Breakdown of Sections

There are a variety of ways in which sections can start:

Direct Admission (where the admission under section takes place directly to the Hospital Managers of the Trust)
Regrade (where a section changes type whilst under the care of the Hospital Managers of the Trust)
Regrade from Informal (this is where a section is started after a person has been admitted voluntarily. Usually – but not always – a holding power)
Transfer (where the section was started whilst the patient was under the care of another provider and subsequently moved to WAHT)

The most common way for sections to start in WAHT within this year was a regrade from informal (40).

- 34 sections were transferred into the care of WAHT. All but 3 of these transferred into WAHT from HWHCT.
- 4 sections were regraded while the patient was receiving care at WAHT; and
- 2 patients were admitted directly to the care of WAHT on section

9.5 Gender and Ethnic Breakdown of Detained Patients

Of the 61 individuals detained:

Gender

- 35 were female
- 25 were male
- 1 was transgender

Age

- 16 were over 65yrs
- 41 were between 18 and 65yrs
- 4 were under 18yrs

Ethnicity

- White British 51
- Any other European Background 2
- Any other White Background 4
- Black British 1
- Pakistani 1
- Chinese 1
- Not known 1

9.6 Rights & Hearings

Patients who are detained under the Act are encouraged to appeal to the First Tier Tribunal and to the Hospital Managers. Patients are entitled to legal aid for the former, but not the latter. The Associate Hospital Managers (AHMs) are delegated the right of discharge by the Hospital Managers. In addition to appeals, the AHMs hold a review when a patient's section is renewed or when a Nearest Relative is barred from exercising their power of discharge.

Whenever a patient is detained within WAHT, they will receive information relating to the section and their rights of appeal in accordance with the MHA 1983 and the Code of Practice 2015.

9.6.1 First Tier Tribunal (Mental Health) (FTT)

Patients have the ability to apply to the FTT once in every period of detention and are legally aided to obtain representation in doing so. At certain junctures, the Hospital Managers are obliged to make an application to the FTT if the patient themselves has not done so. Although FTT hearings have been arranged for patients detained within the Trust, none took place within the year.

9.6.2 Associate Hospital Managers (AHM)

The AHMs are specially trained lay people who sit on hearings panels and work to ensure that patients have hearings on appeal and at the renewal of a section. There were no AHM hearings within WAHT within 2025/26.

9.7 Sections Declared Invalid

7 sections were declared invalid within the year; all were documentation errors within the statutory forms used for Doctors' holding powers. In each case, MHA Liaison were advised and via them, the wards. The person and their Nearest Relative will have been notified in writing that an error had occurred. This was a reduction on the previous year (n10).

Action taken:

A Trustwide practitioner guide was re-circulated giving *step by step instructions* for medical and nursing staff to ensure the legal documentation for s5(2) detentions are met.

9.8 Care Quality Commission Notifications
There were no notifications to the CQC required within the year. One notification of death submission was required to be made jointly between WAHT and HWHCT.

9.9 Training
Training takes place in a variety of different ways. This can be both ad hoc and formal. An update session was provided for the Trust Board in April 2026, as well as a bespoke session for the paediatric ward staff.
Reports are regularly shared between HWHCT and WAHT which allow for triangulation of data. Specific issues are either raised within regular meetings between the Trusts, or at the wider inter-agency monitoring group operating in Worcestershire.

9.10 Changes to Statutory Advocacy Service Provider – Feb 2026
A change to statutory advocacy service provider was implemented as of February 2026. Onside Advocacy was replaced by Southwest Advocacy Network (SWAN).
Action taken: Trustwide briefings were circulated to alert staff to the new provider.

10.0 Deprivation of Liberty Safeguards (DoLS)

The Trust has a system and process in place to monitor DoLS applications to the Local Authority and the necessary CQC notifications are completed.

During 2025/26 the Trust received 923 DoLS notifications from the Local Authority.
Of these, 870 were deemed 'low' priority.
16 Standard Authorisations were granted and the relevant CQC notifications completed.
6 applications were for out of area cases.

10.1 Supreme Court Ruling June 2026 – Change to the Definition of a Deprivation of Liberty.
On 2nd June 2026, the Supreme Court published a judgment changing the definition of deprivation of liberty. These changes apply with **immediate effect**. The ruling concluded that:

- the Cheshire West 2014 judgment was incorrect
- instead of relying on the single 'acid test', an assessment of whether someone is deprived of their liberty must now consider multiple factors
- the Cheshire West 2014 judgment wrongly assumed that if someone lacks legal capacity under the MCA 2005, they cannot give valid consent to the arrangements. The 2026 judgment clarifies that a person's expression of their wishes and feelings carries significant weight. A person can give valid consent if they are conscious of their environment, have a basic level of understanding and are capable of expressing a view that they accept and/or are happy with the situation. However, if there is serious doubt, no conclusion of valid consent can be drawn.

The implications are being worked through and Trustwide communications circulated as new information emerges. Further guidance and Code of Practice updates are awaited.

10.2 Liberty Protection Safeguards(LPS)

Consultation on LPS was due to begin this year. Further information is awaited following the impact of the Supreme Court ruling.

10.3 NHSE Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability

This guidance supports all providers of acute care to enable front line staff to fulfil their legal requirements around the Mental Capacity Act (MCA) 2005; specifically, when supporting people with a learning disability.

Action taken:

The guidance has been shared widely with professionals, incorporated into training delivery and presented to the LD Liaison / Steering Group to raise staff awareness.

11.0 Safeguarding Supervision

The Trust has systems & processes in place to deliver safeguarding supervision in relation to Midwifery & Maternity, Children & Adults and requirements of the combined regional assurance tool.

Safeguarding supervision continues to be delivered across the Trust via several mediums.

During 2025/26:

- 126 supervision sessions were undertaken by Specialist Midwives as either 1:1 or group sessions
- 69 staff have received safeguarding children supervision
- Locality specialist midwives are safeguarding case load holders, as per the Trust safeguarding supervision policy they are required to attend supervision every six weeks. Named Midwife Safeguarding delivers supervision to this group via twice monthly virtual meetings and 6 weekly 1:1 sessions.
- Named Professionals receive their individual supervision by individual supervision, group supervision or local, regional or national forums
- Safeguarding newsletters are used to circulate key messages Trustwide
- Specialist teams receive regular supervision from the Named Professionals due to the complexities of their caseloads
- Trust volunteers were provided with information in respect of suspected domestic abuse should they be approached by a member of the public (ask for Ani /Angela). Guidance issued will be included in the Volunteer welcome handbook. This information was also shared in the volunteer 'hot off the press' volunteer weekly e mail

12.0 Safeguarding Alerts

Action required: The Trust has several standalone systems that do not speak to PAS. This can create risk if staff do not check PAS alongside the stand alone system. Risk ID5856

12.1 Strategy Meetings – sharing health information: forthcoming OPD attendance

The Trust is notified by H&WHCT of any child for whom a strategy discussion has taken place. The Integrated Safeguarding team then check whether the child has any forthcoming outpatient appointments with the Trust and ensure the respective clinician is made aware. An alert is added to clinical systems to appraise practitioners that concerns have been raised that have met the threshold for a strategy discussion. Prior to this, practitioners would not have been aware that concerns around the child had met the threshold for a strategy discussion as some parents/carers do not disclose such information in order to avoid detection. A significant number of these cases result in child protection enquiries (s47) being undertaken.

- Strategy notifications 2025/26 received – 1254 ↑
- Children discussed – 2025/26 n2472
- 142 of these children had forthcoming OPD with the Trust

12.1.1 Outcomes:

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
S47	448	441	506	573 ↑
S17	97	57	63	76
NFA	39	12	28	49
EH	0	4	10	2
Continue with Plan	44	28	31	29
No outcome	5	3	4	14

12.1.2 Categories: Top 3 –red, amber, green

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Sexual Harm	147	115	136	150
Physical Harm	123	109	132	149
Emotional Harm	65	51	65	80
DA	106	103	123	166
Neglect	126	85	93	91
CE	46	49	48	69
Other	20	33	45	38

12.2 Paediatrician Attendance - Out of Hours Strategy Discussions

During June 2024, the Designated Doctor for H&W ICB confirmed that there was no commitment for health representation at strategy discussions out of hours. The only scenario where representation for an OOH strategy meeting would be for a patient admitted to the ward for health reasons. Otherwise, the expectation is that the strategy meeting would be called in-hours on the following morning where the IST from the Health and Care trust would represent 'health' and share information.

The Trust has received 10 out of hours requests during 2025/26.

12.3 Child Protection Information Sharing System (CP-IS) – Flagging of Unborns subject to CPP

During 2024/25 further to lateral safeguarding checks, it became apparent that not all unborns subject to a CPP were being flagged by the Local Authority in CP-IS. This was escalated locally and Nationally and remedial action taken. The Named Midwife continues to monitor this and exception report into the Integrated Safeguarding Committee /escalate on a case-by-case basis.

During 2025/26, 13 unborns were identified who did not have an alert on CP-IS:

Q1 (n10)

Q2 (n0)

Q3 (n3)

Q4 (n0)

Action taken:

This issue has been re-escalated to the Manager of initial contact and referral at Worcester Children's Services. Following delivery, the Safeguarding team receive a weekly report of children who have started on a CPP (this includes newborns). Checks are completed via CP-IS to ensure the alert has been transferred from mother to baby. Where no alert is present on the baby, this is then escalated to the named Social Worker.

12.4 CP-IS roll out Phase 2 - NHS England

NHSE Safeguarding requirement:

Existing CQC regulated NHS Foundation Trusts, Acute Trusts and Community or Mental Health Trusts must have a plan by 30/03/2026 and launch CPIS and RA access code before September 2026 to ensure all services which have contact with children can view CPIS, even via NCRS.

Action taken: Plan submitted to the ICB in accordance with agreed timeframes. Work is now underway with the Care Groups to meet the required deadline.

12.5 Worcestershire Special Allocation Scheme (SAS) -updated guidance December 2025

The Special Allocation Scheme (SAS) is for violent and/or aggressive patients who cannot be seen in routine Primary Care. The scheme is mandated nationally but delivered locally. For a patient to be placed on the scheme, there must be an incident within General Practice for which the police have been contacted and an incident number provided. All patients on the scheme are reviewed on a regular basis. The ICB liaises with other organisations when patients are placed/removed from the scheme.

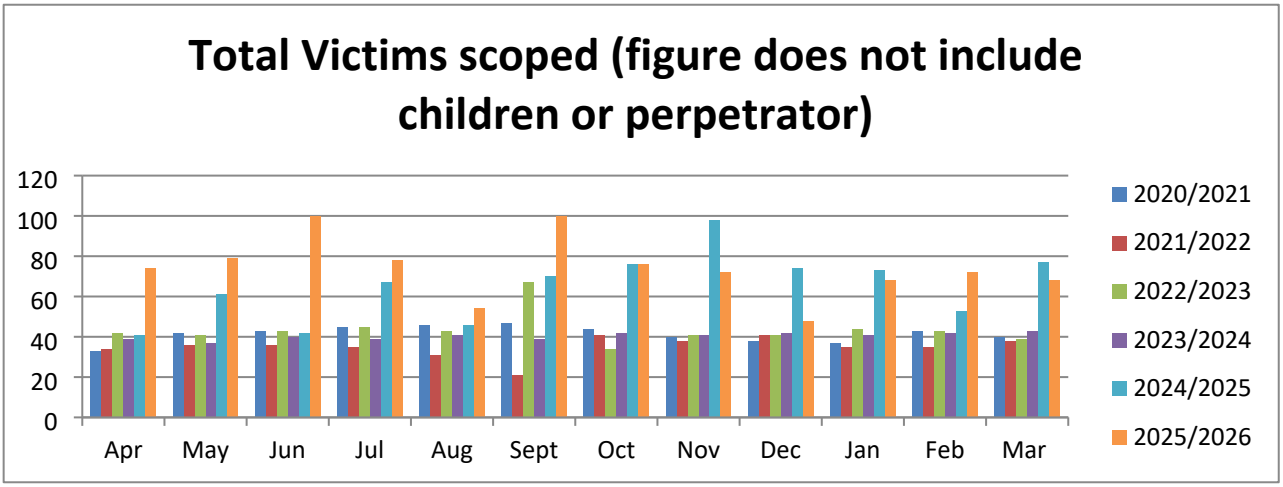
Action taken: the Trust flags any patient subject to the SAS scheme.

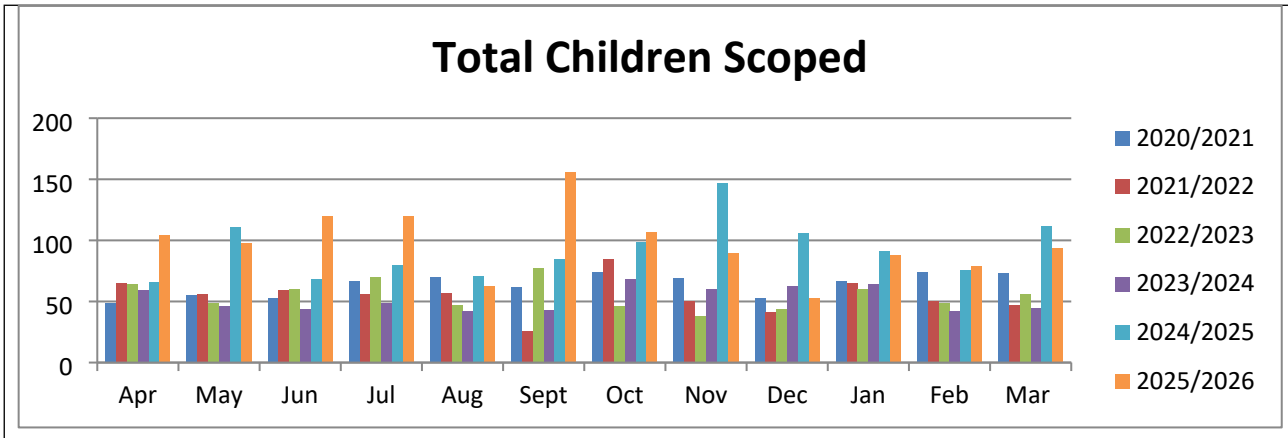
13.0 Domestic Abuse /Domestic Violence

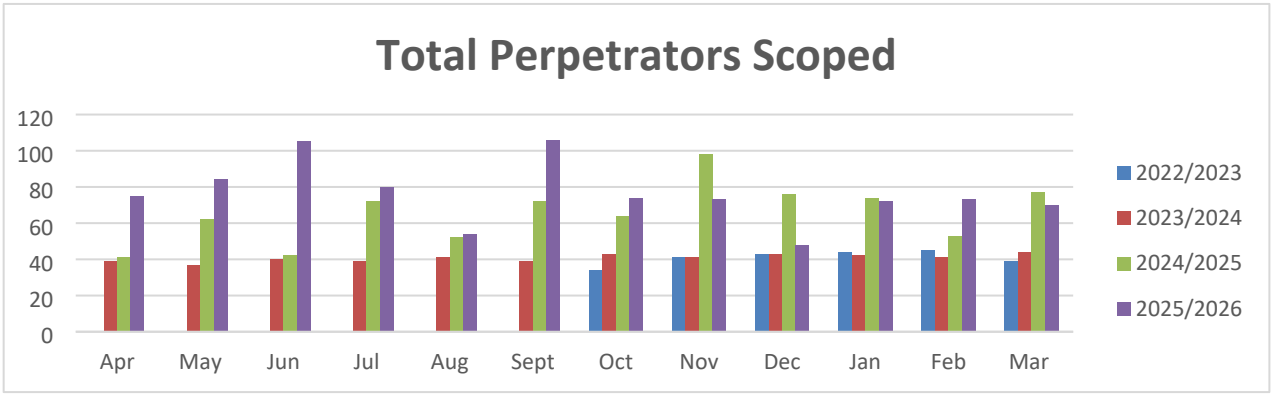
The Trust has established systems and processes in place for the identification and reporting of domestic abuse, including support services for onward advice & support (this service covers both staff and patients).

13.1 Multi-Agency Risk Assessment Conference (MARAC)

The Trust has undertaken 2975 (2024/25 n2673) individual scoping's for *high-risk* domestic abuse during 2025/26. The trend over the last year has continued to see an increase in MARAC associated workload. This intense scoping practice /adding of alerts to clinical systems, ensures that staff are alerted to high-risk victims and children of domestic abuse should they fail to attend departments or appointments.







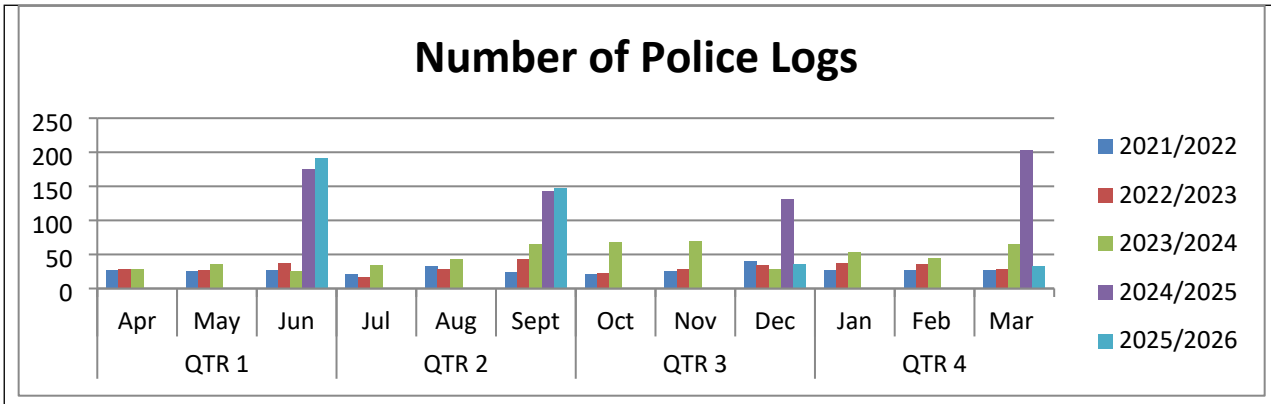
13.1.1 MARAC repeat cases –changes effective as of 07.05.2025

Due to the high number of cases MARAC have been receiving, they are trialling a new process in Worcestershire (which is currently already in place in Herefordshire MARAC).

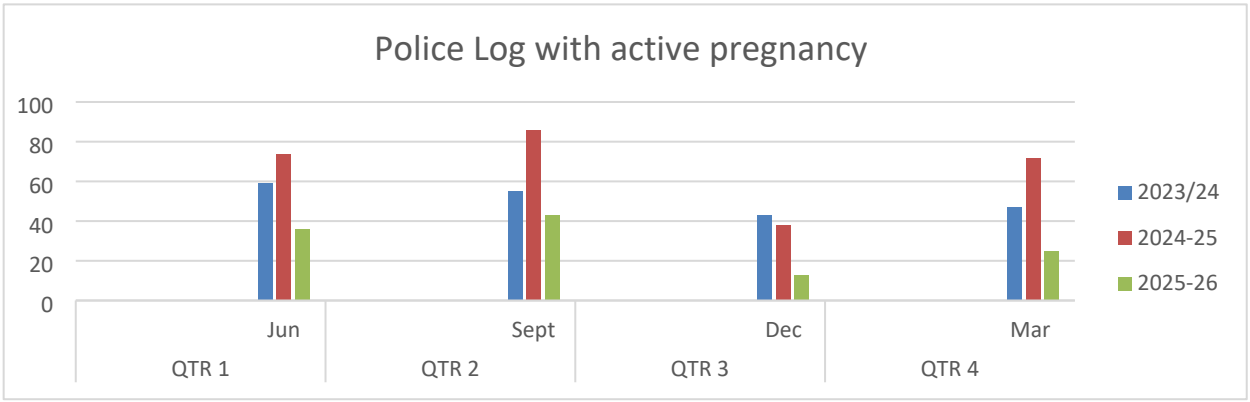
If information is received regarding a new offence linked to parties that have recently been discussed at MARAC and the new incident is not rated as high risk then an email will be sent out where agencies will be asked to check whether they have any information, not known to police, which might indicate that the incident was a high risk. If that is the case, then the agency will be asked to submit a referral to MARAC and the case will be listed in the usual way. If no agency indicates that they believe the case to be high risk then the case will not be listed as a repeat case.

13.2 Police Logs flagged:

Police Logs are received by WAHT Integrated Safeguarding Team. All victims and their children are "flagged" on Trust Information Systems. Police Logs are received when the victim or perpetrator is pregnant or have recently delivered. 408 Police Logs have been reviewed and flags added to clinical systems during 2025/26.



Of the 408 logs received,117 (29%) had an active pregnancy. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth.



13.3 Move from Harm Assessment Unit to Vulnerability Hub Model

There has been a significant decrease to the number of Police Logs received during 2025/26. It is suspected that this is as a direct result of the new Vulnerability Hub model implemented by West Mercia Police. This noticeable drop in activity has been escalated back via the MASH Managers meeting.

13.4 Hospital Independent Domestic Violence Advisor (HIDVA) – change to provider - AXIS

Preparation took place during March 2026 for the transfer of commissioning from West Mercia Women's Aid to Axis support services.

13.4.1 Referral data:

Referral to HIDVA by area: only available until Q3 due to change in service provider.

	Q1	Q2	Q3	Q4	Total
Worcestershire North	10	18	11		**39**
Worcestershire South	10	30	18		**58**
TOTAL	**20**	**48**	**29**		**97**

Appropriate referrals:

	Q1	Q2	Q3	Q4	Total

Redditch Alexandra Hospital	3	4	6		**13**
Worcester Royal Hospital	6	15	16		**37**

The above data continues to demonstrate referral to the HIDVA service with numbers of appropriate referrals rising steadily over 2025/2026. Referrals remain highest on the Worcester site.

13.4.2 Maternity referrals to HIDVA
During 2025/26 there have been 18 maternity referrals to the HIDVA service. The Named Midwife receives these referrals and attends monthly meetings with the HIDVA's to discuss the referrals. This process ensures victims are engaging with the HIDVA service and Specialist Midwives are aware of the outcomes.

13.5 Domestic Abuse & Alerts on Newborn's: Wren report
During September 2024, JTAI announced its most recent theme for inspection, namely multi agency response to children who are victims of domestic abuse. The scope for children includes unborns. Children named within MARAC referral's and police logs are flagged appropriately to inform staff that there are concerns of domestic abuse. Expectant mothers are also flagged in the same way.
When an expectant mother has a DA alert on her record, it was agreed that the alert should be transferred to the baby upon delivery to inform staff that there is a *risk of pre-natal domestic abuse.* This would then serve to alert practitioners in the event the child should attend.
Action taken:
This report became live 01.06.2025. The report identifies all women with Domestic Abuse, Police Log or MARAC-related safeguarding warnings whose newborn children do not have the same warnings recorded. The data includes births from April 2025 onward and is intended to help ensure appropriate safeguarding information is consistently applied across both mother and child records. The report is reviewed and the necessary alerts are added daily. During 2025/26, 132 alerts were transferred to newborns ensuring appropriate safeguarding information is consistently applied across both mother and child records

13.6 U18 years and non-fatal strangulation
Strangulation can be defined as obstruction or compression of blood vessels and/or airways by external pressure to the neck impeding normal breathing or circulation of the blood (Crown Prosecution Service, 2022). Non-fatal strangulation (NFS) is where such strangulation has not caused death or not directly caused the death of the victim.
There is increasing awareness around the dangers and prevalence of strangulation in interpersonal violence. Whilst anecdotally, paediatricians acknowledge that strangulation may occur during child abuse, there is little reported in the literature regarding its prevalence.
Action taken:
Representatives of the Integrated Safeguarding Committee were alerted to the increased prevalence of NFS being seen in children and young people presenting to services e.g. sexual assault referral services.

13.7 Domestic Abuse Policy
Fully revised and updated. Published February 2026.

13.8 SafeLives Strategy 2025-2028
SafeLives have published their strategy for 2025 to 2028 to continue to prevent, respond and ultimately end domestic abuse. Worcestershire Local Authority have recently undergone a review by SafeLives into domestic abuse. The findings of this and any partner implications will be shared in due course.

13.9 White Ribbon Campaign – 25th November 2025

Trustwide communications and resources circulated. HIDVA and her manager attended WRH and interacted with staff members and members of the public. They reported a positive reaction from both staff and members of the public.

13.10 Domestic Violence Disclosure Scheme - Clare's Law – Supervision Newsletter October 2025
Circulated Trustwide to remind staff of Clare's Law, and how to apply for a disclosure. The scheme allows an individual to:

- "Right to ask": request information from the police about a partner's history of domestic abuse
- "Right to know": Police can proactively disclose information if they believe that someone is at risk
- Not just the victim/survivor – anyone can apply for the information
- Police will give the disclosure to the victim/survivor

13.11 Changes to the Harm Assessment Unit (HAU) as of September 2025
Due to relocation of Policing resources, the HAU will become known as the 'Vulnerability Hub' and has been centralised to Bridgnorth.

14.0 Safeguarding Children – Exploitation

The Trust works with partner agencies in respect of the exploitation of children and young people

14.1 GetSafe – Child Exploitation
GetSafe is Worcestershire's multi-agency response to the protection of children at risk of exploitation and works in a focused and co-ordinated way to protect those most at risk.
During 2025/26, Trust staff submitted 39 GetSafe referrals (previous year n12).

14.1.2 GetSafe Portal and Weekly Triage Meetings
The Trust has provided information for 1256 children/young people during 2025/26. Of these:

- 449 new referrals
- 807 reviews

14.2 Multi-Agency Child Exploitation (MACE)
The Trust 'flags' on clinical systems any child for whom it receives a MACE report. This ensures practitioners are kept informed of the risks surrounding the child in the event they should attend any of our services. During 2025/26, 300 MACE scoping / flagging have been undertaken. This is a slight reduction on the previous years' activity (n328).

14.3 WREN Report ED Attendances
In order to identify children/young people attending the Trust who may be at risk of exploitation a WREN report is run daily based upon key words from the attendance: gun, gang, knife etc. The report is reviewed daily by the Integrated Safeguarding Team to ensure all appropriate actions have been taken in order to protect and safeguard the individual or others:

- During 2025/26, 3656 children/young people attendances were reviewed via this process (previous year n3193)
- Of the 665 referrals recorded into the Family Front Door, 481 were made by Trust staff or the Integrated Safeguarding Team (72%).
- Conversion rates continue to be monitored by the QAPP sub-group of the WSCP

14.4 GetSafe Operational Group Audit Activity
A deep dive was undertaken during July and December. Concerns in relation to missing episodes, drug use. Overall rating: GOOD

15.0 Statutory Partnership Working – Children

The Trust is meeting its statutory requirements as a partnership agency and contributing to the work of the Worcestershire Safeguarding Children Partnership and its associated sub groups

15.1 Working Together to Safeguard Children 2026

The statutory guidance was further updated in March 2026.
Action taken: several webinars have been promoted to appraise staff of the changes to the statutory guidance. These changes will be woven into workstreams and Policy.

15.2 Case Escalations

The Trust has made 16 escalations for complex cases during 2025/26. Themes:

- Mental health
- Complex discharge planning
- ? Non accidental injury
- High risk young person discharge from secure unit out of area to children's home – frequent self-harm
- Vietnamese child - sexual abuse /exploitation
- Fabricated illness
- Child abandoned in the Emergency Dept

15.3 WSCP Newsletters

Circulated Trustwide to keep staff appraised of learning and work of the Worcestershire Safeguarding Children Partnership.

15.4 Audit activity - Quality of referrals to Family Front Door

57 Trust referrals were reviewed during 2025/26. Of these:

- 12 rated as outstanding
- 29 rated as good
- 16 rated as requires improvement – feedback given to respective practitioners

15.5 Multi-Agency Safeguarding Hub (MASH)

The Trust has shared information for 30 MASH requests for children during 2025/26.
Themes:

- FII
- Mental health
- Domestic Abuse
- Restricted eating as a form of self-harm
- Ineffective parenting
- Dogs
- Physical abuse
- Substance misuse

15.6 Worcestershire Safeguarding Children Partnership

15.6.1 Child Death Overview Panel (CDOP)

The Named Doctor attends CDOP on behalf of the Trust.
Action taken:

- The Trust continues to support the Sudden Unexplained Death in Childhood (SUDIC) and CDOP process via information sharing and attendance at respective meetings.
- National Guidance is currently being rewritten – draft expected late autumn.

15.6.2 Sudden Unexplained Death in Childhood (SUDIC)
The Named Professionals have scoped and submitted reports/attended on behalf of the Trust for 6 SUDIC cases during 2025/26.
Themes:

- Death by hanging
- Genetic disorder – found unresponsive
- Road traffic collision – child known to GetSafe
- Crush injury by a digger
- Unresponsive – severe peanut allergy, asthma
- Baby – found unresponsive

15.6.3 Rapid Review / Child Safeguarding Practice Review (CSPR)
The Trust has undertaken scoping for 4 rapid review during 2025/26: Themes:

- Non accidental injury – injuries attributed to another sibling
- Child exploitation
- Physical, sexual & emotional abuse

15.6.4 Child Safeguarding Practice Review (CSPR) status:
Child 1 – CSPR commenced. Child alive. Blame for injuries put on older sibling.
Child 2 - In April 2025, parent B (adoptive father) shared video footage from a baby monitor showing repeated child abuse (physical, emotional and sexual) by Child's adoptive mother. Child alive.
Following the emergence of further information, the three lead agencies (ICB, Children's Social Care, and the Police) reconvened and collectively agreed to progress to a full authored Child Safeguarding Practice Review.
Action taken: an internal safeguarding review of attendances was undertaken to inform the full CSPR. This CSPR remains in progress.
Child 3 – CSPR in progress. Road traffic accident. Child deceased. Child known to GetSafe.

15.7 Supplementary activity:
15.7.1 Joint Targeted Area Inspection (JTAI) - New Theme - child sexual abuse in the family environment
The new theme was published on 10th September. Work is in progress across the partnership to raise staff awareness of a JTAI and what they may need to consider to support an inspection on this theme.
Action taken: initial communications have been sent to key staff appraising them of the new theme.

15.7.2 Joint Targeted Area Inspection (JTAI) - New Theme - child sexual abuse in the family environment – Practitioner Briefing November 2025.
The new theme was published on 10th September. Work is in progress across the partnership to raise staff awareness of a JTAI and what they may need to consider in supporting an inspection on this theme.
Action taken: A practitioner briefing was circulated Trustwide during November.

15.7.3 Alfie Steele (CSPR) – 7 minute briefing
Alfie Steele was a nine-year old boy from Droitwich, Worcestershire. He suffered extreme abuse at the hands of his mother, Carla Scott and her partner Dirk Howell, culminating in his death February 2021. 18 February 2021: Alfie was found unresponsive in a cold bath, his body temperature was just 23 °C, and he had more than 50 injuries. The couple delayed calling 999. Over 60 contacts were made to police and social services (36 to the council, 28 to the police) from 2018 to 2021 reporting abuse signs—often ignored or dismissed. In June 2023, Dirk Howell was convicted of murder and received a life sentence with at least 32 years to serve. Carla Scott was found guilty of manslaughter (cleared of murder), sentenced to 27 years (minimum 17 years served).
Action taken: the briefing was circulated to share the key learning points from the CSPR.

15.7.4 WSCP - Managing risk for children having contact with Registered Sex Offenders –Learning from CSPR
An independently led multi-agency audit reviewed five cases where children or young people are having close and regular contact with family members who are registered sex offenders. Each agency reviewed their own involvement within each of the five cases using the audit tool provided. Agencies were asked to consider from their own perspective how effectively the relevant risk assessment tools and pathways had been applied in each case, and how any identified risks had been responded to, how the child's and carer's views had been sought, and evidence of any conflict and/or challenge between agencies and if so whether the escalation process had been used to resolve those.
Action taken: the key findings and learning have been shared via the Integrated Safeguarding Committee. Good practice noted in respect of:

- In addition to those agencies who were involved in the direct management of the offender, Health agencies had safeguarding alerts on the child's record so information would be shared should the child come to their notice.
- There was clear evidence of multi-agency planning through pre-birth assessments, child protection plans and regular core group meetings.

15.7.5 Togetherness NHS Briefing
Togetherness is the new face of inourplace, the NHS emotional health digital learning hub funded to provide families with free access to expert learning about childhood development, wellbeing, brain changes, and much more to enable parents to connect with their children and make sure they thrive. The briefing was circulated to appraise staff of its availability.

15.7.6 WSCP - Child Sexual Abuse (CSA) Training, Webinars & Survey
Circulated Trustwide during November, to raise staff awareness of child sexual abuse and the West Midlands CSA pathway. This also included a partnership practitioner survey to help increase understanding of how child sexual abuse within the family environment is identified and responded to across our local safeguarding partnership and contributing to future improvements in multi-agency working and support for children.

15.7.7 Signs of Safety (SOS) Training
Signs of Safety is a relationship and strength-based approach to working with children, young people and their families. Training availability promoted to support practitioners attending where SOS scoring is used.

15.7.8 Use of Language matters
The concept of the 'toxic trio' of parental domestic abuse, substance misuse and mental illness meaning a child will experience abuse is not robustly evidenced by research.
It is negative, stigmatising and fails to account for full range of adversities and barriers families can face. The factors within the 'trio' cover a broad spectrum of concerns that can affect families in different ways. Practitioners should be supported to evaluate the bigger picture and respond to the specific *individual needs of families and children.*
The term has been replaced by the term 'trio of harm'.

15.7.9 "It's Silent": Race, racism and safeguarding children - March 2025
Race, racism, and racial bias have had increased prominence in rapid reviews and local child safeguarding practice reviews (LCSPRs). These social determinants of children's lives have been explicitly referenced or considered as factors influencing how professionals identify, acknowledge and intervene in the lives of Black, Asian and Mixed Heritage children and families when harm is present.
Action taken: The Trust has contributed to the work of the safeguarding system following the publication of this report in ensuring these factors are considered as a golden thread.

15.7.10 Home Office Tackling Child Sexual Abuse – Progress update 2025 (published April 2025)
Despite children making up only 20% of the population, they are the victims in 40% of all sexual offences. 7.5% of all adults in England and Wales are estimated to have been sexually abused before the age of 16yrs, according to the Office for National Statistics' Crime Survey for England and Wales. That equates to 3.1 million adult victims and survivors of child sexual abuse.
The National Crime Agency's National Strategic Assessment of the Child Sexual Abuse Threat in 2025 makes clear that the risk to children from sexual abuse continues to increase, aggravated by evolving online environments and technology adoption. It estimates there are up to 840,000 offenders who pose some degree of sexual risk to children, and there are 400,000 searches for online child sexual abuse material every month in the UK alone.
The Centre for Expertise on Child Sexual Abuse estimates that 500,000 children are sexually abused every year – in the family home, in institutions, within communities and online. IICSA, focused on how institutions have failed to protect children from sexual abuse, but our response must go further, addressing all of the spaces in which child sexual abuse is perpetrated.
Action taken:
The Trust works with partner agencies to recognise report and support victims of Child Sexual abuse. This includes our commitment to the Get Safe multi-agency approach within Worcestershire.
This is achieved through mandatory training and awareness raising to staff delivering our services.

15.7.11 Use of weight loss injections in children
Given the epidemic of obesity and associated rise in type 2 diabetes in young people, concerns are emerging in relation to the potential for overuse and abuse of such medications by young people.
Action taken:
The Named Doctor shared the concerns in order for clinicians to be alert to the risk.

15.7.12 Worcestershire Safeguarding Children Partnership Annual Report 2024/25
Circulated to share the work of the partnership in safeguarding children and young people:
Independent Scrutineer:
A critical challenge remains: ensuring that professionals across the partnership are supported to 'think the unthinkable'. This is vital in light of the national review of intra-familial child sexual abuse, which highlighted the importance of overcoming barriers to professional curiosity, and the imperative for practitioners to be vigilant, questioning, and open to the possibility of child sexual abuse occurring in families. Nurturing this approach demands ongoing reflection, robust supervision, and a culture of shared learning so safeguarding practice is never limited by assumptions, but remains proactive, curious, and prepared to address even the most concealed forms of harm. In adopting the lessons from the national review, the Partnership strengthens its determination to protect children not only from risks in plain sight, but also from those obscured by complexity. It should never be down to children to carry the burden of disclosure in order for abuse to be recognised or acted upon. We must listen to the messages that children and young people are giving us through changes in behaviour, school attendance, mood, relationships, physical signs, act on these insights, and remain alert to changing needs and risks.

15.7.13 Joint Herefordshire and Worcestershire Multi Agency Levels of Need: Guidance to help support children, young people and families in Herefordshire and Worcestershire - Updated September 2025.
The updated guidance was circulated Trustwide and added to the Safeguarding Hub page.

15.7.14 Get Safe Child Exploitation Risk Assessment – updated
Resources and links updated.

15.7.15 Families First Partnership (FFP)
The FFP Programme is a national programme set up in the Department for Education (DfE) and supported by the Department of Health and Social Care and the Home Office. Through the programme, the government is working in partnership with local areas (local authorities, police, health, education, childcare settings and other relevant agencies) to improve their local services and systems that help and protect children and families. The reforms

include the introduction of Family Help, strengthening multi-agency child protection, and improving engagement with family networks.
The reforms are part of broader Children's Social Care (CSC) reform. In November 2024, DfE published 'Keeping Children Safe, Helping Families Thrive'. It set out how government will break down barriers to opportunity and deliver reforms that support all children to succeed, regardless of their background. A key enabler of CSC reform is the Children's Wellbeing and Schools Bill, which includes measures on multi-agency child protection teams and family group decision making. Alongside this, DfE is investing £44 million of new funding in 2025-26 to support children in kinship and foster care - the largest ever, national investment in kinship care.
Action taken: A FFP Health engagement group has been set up to progress the work required. The Trust has representation on this group. Initial focus has been on the Multi-Agency Child Protection Team (MACPT) and how this should look for Worcestershire, with a focus on case-based work with individual children and families, managing specific child protection cases rather than broader service-level strategy. MACPTs will not replace MASH, but will be the next level of support for children already within the child protection pathway. A project /delivery plan with associated workstreams is in place.

15.8 Advice & Support Logs – Children & Young People
The Integrated Safeguarding Team responded to 381 contacts for advice and support for children & young people during 2025/26.
Themes:

- Young person that attended our ED under influence drugs & alcohol - out of area
- ? non accidental injury
- Advice around a mother who had attended ED after taking an overdose whilst 15-month-old was in her care.
- Inquiry from WCS – received a 111 referral – child fell from a height of around 1 metre. Check to see if he was taken to A&E. Were there any safeguarding concerns.
- Advice around parental conflict – previous Domestic Abuse – parents fighting over custody of children
- Advice about 12 yr old that was abandoned in ED ALX
- Advice around DA – non molestation orders etc

16.0 Midwifery & Maternity

The Trust provides a robust service in relation to the safeguarding of vulnerable women and children overseen by a Named Midwife

16.1 Multi Agency Safeguarding Hub (MASH)
The Trust has shared information /attended MASH for 36 unborns during 2025/26. As of Q1 2025/26, Locality Specialist Midwives have been attending their locality Unborn MASH meetings to share Health information.

16.2 Specialist Midwifery Referrals:

Locality	Q1 2025-2026	Q2 2025-2026	Q3 2025-2026	Q4 2025-2026	Annual totals
Abbey -Evesham & Pershore	48	51	49	43	191
Abbey -Redditch	89	69	106	97	361
Severn valley	123	113	160	113	509
Cathedral	218	223	192	148	781
Avoncroft	95	124	116	124	459
Total	**573**	**580**	**623**	**525**	**2301**

16.3 Reason for referral:
*** Individual referral may have multiple safeguarding issues as listed below ***

'Top 3' highlighted:

	Q1 2025-2026	Q2 2025-2026	Q3 2025-2026	Q4 2025-2026	Annual total
Domestic Abuse -previous	118	96	107	112	433
Domestic Abuse – Current	48	44	36	25	153
CSC -current	34	42	46	35	157
CSC previous	159	132	171	142	604
Mental health	199	210	235	168	812
Learning disability	2	3	9	12	26
Exploitation	0	0	0	0	0
FGM	0	2	1	1	4
Substance misuse	115	152	117	123	507
Other	116	164	136	150	566
TOTAL	**791**	**843**	**858**	**768**	**3262**

16.4 Unborn Strategy Discussions
The Trust has contributed to 134 unborn strategy discussions during 2025/26, and all were attended either by the Named Midwife or Specialist Midwife.

16.5 Teenage Link Midwifery Service
The 4 Teenage Link Midwives are based within the Community Midwifery Teams. They offer an enhanced package of care to this vulnerable group of young parents to be. During 2025/26 there were 187 teenage bookings.

16.6 Urine Toxicology Screening

2025 - 2026	Q1	Q2	Q3	Q4	Totals
Total nos of tests	131	113	131	151	526
Positive result	27	39	52	29	147
Negative result	104	74	79	122	379

During 2025/26, 28% of UTS tests provided a positive result for illicit substances in pregnancy. Early identification enables support to be offered to reduce the risks to both mother and baby.

16.7 British Pregnancy Advisory Service
British Pregnancy Advisory service (BPAS) notify the Integrated Safeguarding Team of women who have sought consultation or have had a consultation but not attended for further follow up. This is to ensure the woman is not concealing the pregnancy and has accessed antenatal care. They also advise of women who have decided to continue with the pregnancy but safeguarding concerns have been identified. 10 notifications were received during 2025/26. Lateral checks are then completed and if in receipt of antenatal care, the locality specialist midwife is notified.

16.8 West Midlands Ambulance Service – High Risk Cases Alerts
As of October 2024, improvements to communication and alerting WMAS to high risk safeguarding maternity cases was implemented. This process is supported by an agreed standard operating procedure.
During 2025/26 34 alerts have been shared for high-risk maternity cases.

16.9 NICU/TCU WREN report
The Named Midwife for Safeguarding receives a daily report highlighting babies within the units who have safeguarding alerts held within Trust information systems.

Action taken:
The Named Midwife reviews safeguarding documentation within Badger Net and discusses with NICU/TCU staff, offering support and guidance to the staff who need to attend safeguarding meetings. 63 babies have been identified from this report during 2025/26.

16.10 Mother to Baby Reports – WREN
Unborn's who are subject to Child Protection Plan's or Child In Need plans are flagged on WAHT information Systems and maternity Badger Net on mother's records. At the time of delivery, it is the responsibility of the delivering midwife to register baby on WAHT information systems and add the safeguarding alert. This report is received daily and a datix incident submitted when an alert has been missed. The Named Midwife is notified of any babies who have not had the alert added. She will contact the delivering Midwife and offer supervision and guidance on adding alerts to Allscripts PAS.
During 2025/26, 30 alerts were not added at the point of delivery /registration.
Action taken:

- Named Midwife has met with Matron and a robust plan has been initiated.
- Significant decrease for missed mother to baby alerts in Q4 (n1) following Effective Handover communication and sharing of the SOP.

16.11 Court Reports
Following the court granting an Interim Care Order and baby being placed in Foster Care, a review court hearing will be scheduled "Not before 12 days and not later than 18 days after the ICO was issued".
A "Court Directive" is issued by the judge requesting a court statement be submitted for the review hearing. The directive will outline what must be included within the statement i.e. summary of contacts, chronology, summary of child and professional opinion.
Locality Specialist Midwives will complete the statement and send to the Named Midwife for quality assurance prior to being submitted.
During 2025/26, a total of 48 court statements were submitted within the timeframes stipulated on the Court Directive. Of these 48 statements:

- 19 were following ICO being granted, these ICO's were granted within 10 days post-delivery prior to mum and baby being discharged.
- 29 statements were requested following safeguarding incidents outside of the 10-day post-delivery when mum and baby had been discharged home.

16.12 Advice & Support Logs
During 2025/26, the Named Midwife and Integrated Safeguarding Team has provided advice and support in relation to 269 contacts for unborn's and babies under 1year.

16.13 Managing babies or pre-mobile infants with suspected birth marks, including Congenital dermal melanocytosis (also known as Mongolian blue spots or Lumbosacral dermal melanocytosis), and birth trauma
The aim of this guidance is for professionals to understand the importance of bruising in babies and pre-mobile infants as a potential indicator of physical abuse; and clarify the arrangements between health and social care colleagues in relation to the recording and investigation of bruising in babies or pre-mobile infants.
Action taken: developed with system partners and published.

16.14 Protecting all vulnerable babies better - Child Safeguarding Practice Review Panel – Baby Marten – National Review February 2026
This national review was prompted by the tragic death of baby Victoria Marten in 2023. While the circumstances of her short life were unique, the professional challenges encountered in the years, months and weeks leading up to her birth are not. These challenges, persistent parental non-engagement, concealed pregnancy, frequent moves

and complex risks such as domestic abuse and serious offending, are reflected in rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) received by the Panel from local safeguarding partners every year.
The review also highlighted a critical lesson: keeping children safe by removing them with just cause from their parents only serves to protect those children. It does not address the root of the problem, and it does not prevent the same set of circumstances from happening again. Indeed, it may increase the risk of harm for the next child, not yet born, not yet even conceived.
Action Taken: The Named Midwife and the safeguarding system is reviewing their systems and processes based upon the recommendations within the report.

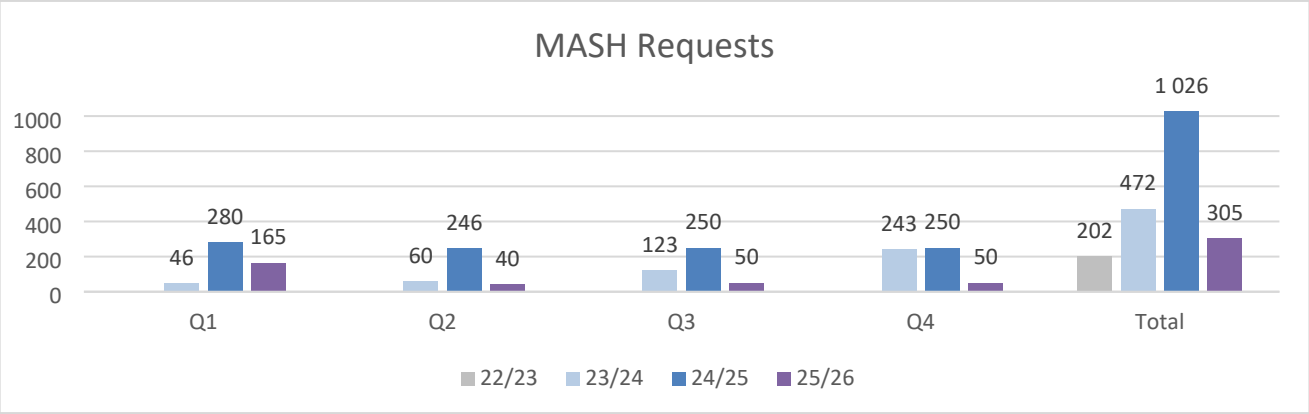
17.0 Safeguarding Adults

The WSAB objectives are incorporated into all safeguarding work streams in order to provide assurance to the Board that WAHT is fulfilling its statutory requirement as a partner agency. WAHT either attend, or are represented on all of the WSAB associated sub groups contributing to the work of the Board. WSAB newsletters are circulated to promote the work of the Safeguarding Adult Board amongst staff groups

17.1 Multi-Agency Safeguarding Hub (MASH)

During 2025/26, the Trust responded to 305 MASH requests. Themes in relation to:

- Self-neglect
- Domestic abuse
- Physical abuse
- Financial abuse

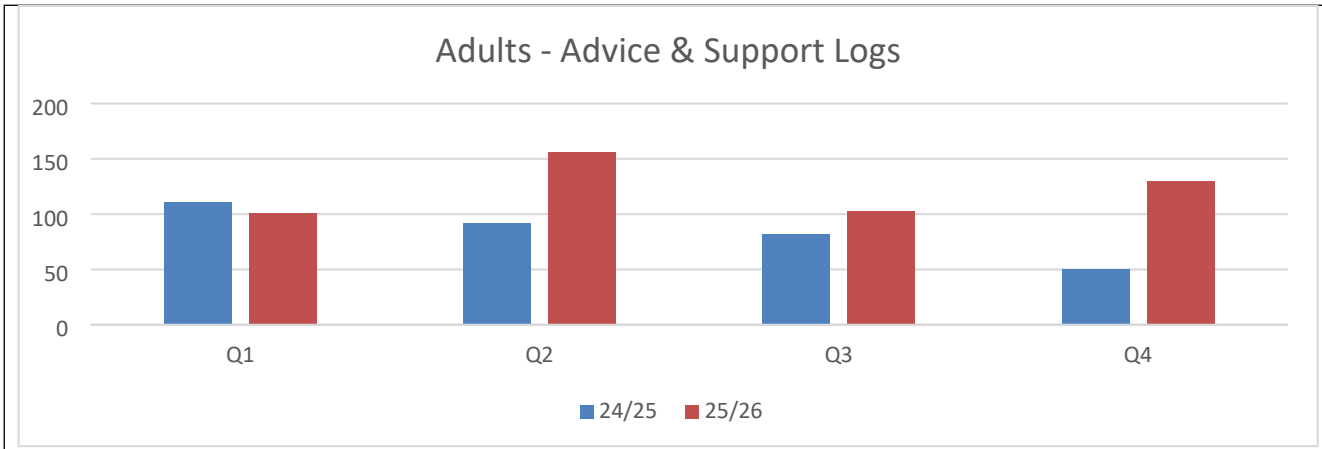


The Local Authority had IT issues in adding new cases on the MASH Portal during June 2025, therefore numbers over the last year are lower than previous (2024/25 n1026).

17.2 Advice and support logs - Adults

The Integrated Safeguarding team have provided advice & support for 490 cases involving adults during 2025/26 (previous year n371). Cases have increased in complexity.
Themes:

- Mental Capacity complex cases
- Legal queries
- Complex family dynamics and care provision



17.3 Cases progressing to S42 Enquiry

6 cases have progressed to S42 enquiry during 2025/26.

Themes in relation to:

- Care provision
- Medication
- Discharge
- Medical complaint and CQC enquiry (QL6525), WEB251437

17.4 Safeguarding Early Response & Triage Team (SERTT)

35 cases have been scoped to inform the triage process prior to a full s42 enquiry during 2025/26. Themes in relation to:

- Discharge planning
- Tissue Viability
- Nursing home concerns
- Care provision in the community
- Self-neglect

17.5 Worcestershire Safeguarding Adult Board (WSAB)

17.5.1 Rapid Review (RR) and Safeguarding Adult Reviews(SAR)

There has continued to be a significant amount of work in relation to the rapid review and safeguarding adult review process during 2025/26. The reviews are in various stages of completion.

The Trust contributes to this work as a partner agency of the Worcestershire Safeguarding Adults Board and associated subgroups.

17.5.2 SAR Triage

The Trust continues to scope several cases to inform the SAR triage process with the aim being to streamline the process and help inform whether the criteria for a full SAR scoping is met.

17.5.3 Combined SAR & Domestic Homicide Review (DHR)

The Trust has contributed to 2 joint SAR and DHR during 2025/26:

- DHR51 & SAR97
- DHR46

17.5.4 SAR Learning

Learning from SAR and rapid review is a standing agenda item on the Integrated Safeguarding Committee agenda. All published SAR are shared to keep staff appraised of the learning from SAR to improve practice. Published SAR report learning shared during 2025/26 has included:

- Robert – learning in respect of self-neglect, professional curiosity, alcohol dependency, physical & mental health, barriers to support
- Vera – learning in respect of coercive control, continuing healthcare, hospital discharge arrangements (out of area discharges)

There were no single agency actions for WAHT for either review.

17.5.5 Multi Agency Action Plans /Assurance

Multi-agency Assurance – Performance & Quality Assurance Subgroup – 'James'

The Trust was able to provide a high level of assurance to the WSAB in respect of the following recommendations:

Recommendation 2 (a): WSAB should seek assurance from relevant agencies that the progress of transitions processes ensures all relevant history is transferred and that re-referral forms for transfer to adult services include space for relevant history.

Recommendation 2 (b): WSAB should seek an update on transition work in health services, ensuring that parents are prepared and that gaps are minimised.

Recommendation 2(c): WSAB should ensure that the recent toolkit published on the ICB website is widely known about: What is transition?

17.5.6 Annual Learning Audit Assurance – LDP&C

During January, the Trust submitted our annual learning audit to the LDP&C sub-group of the Board in respect of:

- Self-Neglect Policy
- CARM
- MCA
- WSAB website
- Adult Exploitation.

17.5.7 Mental Capacity Act 2005 Competency Framework -updated

During March 2026, the WSAB published the updated MCA competency framework.

Action proposed: this will be fully reviewed in due course to ensure all staff are aligned.

17.5.8 Prevention of Future Deaths (POFD) Report

Cases continue to be reviewed by the partnership to inform learning and areas that may require further consideration /assurance.

17.5.9 Local Authority CQC Inspection – report published 15th May 2026

During 2025/26, Worcestershire Local Authority underwent their CQC inspection. In relation to safeguarding and partnership arrangements the score was 3 (good).

The local authority worked with the Worcestershire Safeguarding Adults Board (SAB) and local partners to deliver a coordinated approach to safeguarding adults in the area, with good representation from partners and appropriate senior leaders attending the main board and executive group. There was a well-developed multi-agency safeguarding partnership. Roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place so that concerns were raised quickly and investigated without delay.

17.5.10 WSAB Newsletters

The newsletters continue to be shared across the organisation to keep staff appraised of the work of the Board in safeguarding adults.

Learning Briefs have also been shared in relation to:

- Culturally appropriate person-centred care (case 66)

17.6 Domestic Homicide Reviews

2025/26 has continued to see a significant amount of work undertaken by the Trust in relation to DHR:

- DHR12 – Dudley –in progress – limited involvement
- DHR34 –joint DHR & CSPR – in progress
- DHR37 – in progress. Final version of report awaiting sign off.
- DHR38 – criteria met for DHR. On hold.
- DHR39 - criteria met for DHR. Report in progress.
- DHR40 – criteria met for DHR. Report in progress.
- DHR41 – criteria met for DHR. Report in progress.
- DHR42 – scoping submitted. Currently under review by Home Office.
- DHR43 - criteria met for DHR. Scoping commenced.
- DHR44 – criteria met for DHR. Author awaited.
- DHR45 - criteria met for DHR. Author awaited.
- DHR46 – criteria met for DHR. Criteria met for SAR.
- DHR47 – criteria met for DHR.
- DHR48 – criteria not met for DHR at this stage
- DHR49 – criteria met for DHR
- DHR50 – scoping submitted
- DHR Shropshire – scoping submitted.

17.7 Complex Adult Risk Management (CARM) Framework

The CARM framework was introduced by WSAB in May 2022. Funding for the CARM Project Lead ceased as of March 2026. The Named Nurse Adults has contributed to 19 CARM meetings during 2025/26:

Q1 – n8
Q2 – n3
Q3 – n6
Q4 - n2

17.8 WSAB Self-Neglect Guidance -updated September 2025

During September, WSAB updated and re-promoted the self-neglect guidance.
The new guidance was promoted Trustwide, shared with allied health professional colleagues and uploaded to the Safeguarding Hub on the Trust intranet as a resource for staff.

17.9 WSAB Annual Learning event -'seeing me' - multi-agency working with people who neglect their own needs – November 2025

Promoted Trustwide building on the partnership work in relation to neglect.

17.10 Safeguarding Adults week 17th November 2025

Several resources were shared Trustwide with a focus upon self-neglect and CARM.

17.11 WSAB Recognition Awards 18th November – Emergency Care & Mental Health Liaison

The Trust was recognised at the annual recognition awards for the following 2 categories:

- Safeguarding Champions – Emergency Care
- Safeguarding is Everyone's business – Mental Health Liaison team

17.12 Prisoners being bailed to Acute Hospitals

Information has been shared with practitioners following cases where patients have been bailed to the Acute Hospital. Staff alerted to the risks of patients breaching bail as a result of actions we take during their admission and the need to consider whether a change to bail conditions is required e.g. discharge destination.

17.13 LeDER Annual Report 2025

The Integrated Safeguarding Team continue to contribute to the work of the Trust LD Steering Group with the aim of improving outcomes for those with a learning disability. Work in relation to LD is taken via the Quality Governance Committee.

17.14 Safeguarding Adults Protocol – pressure ulcers and raising a safeguarding concern –updated June 2025
Pressure ulcers may occur because of neglect. Neglect may involve the deliberate withholding or unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support.
Action taken: the updated guidance has been widely circulated to inform clinical practice.

17.15 Safeguarding Adults National Network (SANN) Professional Curiosity Practitioner briefing
Developing and maintaining a sense of professional curiosity is vital if practitioners are to work together to keep children and adults at risk of harm safe. A lack of professional curiosity is identified regularly in adult and child safeguarding learning reviews.
Action taken: the briefing has been circulated to enhance the work already undertaken in respect of professional curiosity /respectful uncertainty.

18.0 National Campaigns

The Trust promotes National Campaigns to raise staff awareness of safeguarding matters

Campaign materials in relation to the following have been promoted during 2025/26:

- Female Genital Mutilation - 6th Feb 2026
- Stop Loan Sharks week – 19-25th May 2025
- Suicide Prevention: focus Mental Health - September 2025
- Safeguarding Adults week –17th November 2025
- White Ribbon Campaign – 25th November 2025
- Illegal Money Lending Newsletter – May 2025

19.0 Further Audit / Quality Assurance

Action required: audit schedule completion in accordance with Audit Schedule

The audit plan is monitored as a standing agenda item by the Integrated Safeguarding Committee**.** All statutory safeguarding returns have been submitted within agreed timeframes.

19.1 360 Assurance (Final Report June 2025)
An assurance exercise was undertaken by 360 Assurance in respect of safeguarding. The overall objective of the review was to provide an independent assurance opinion on the systems and processes that support the safeguarding arrangements in the Trust.
The audit process tested:

- Governance
- Policies
- Training
- Partnership working

Overall rating: Significant Assurance.
Further assurance: Training to be at 90% Trustwide requirement.

19.2 WSAB Performance & Quality Assurance MCA and Advocacy Audit findings
During August, the Trust provided assurance to the WSAB in respect of the audit findings and what we have in place as an organisation.

19.3 Safeguarding Regional Assurance Framework (Adults & Children)

Trust responses were submitted during Q2 in accordance with the deadline of 26.09.2025. A quality assurance exercise is yet to be completed by the Safeguarding Adults Board.

19.4 NHSE Provider Assurance Tool
All submitted in accordance with agreed timeframes. The Trust is now able to declare compliance with A2.1 standard in relation to a training strategy underpinned by the Intercollegiate Document and National Guidance further to the alignment work completed this year.

19.5 WSCP – Quality Assurance Practice & Procedures subgroup audit activity
The following audit activity has been undertaken during 2025/26:

- Q1 Quality of Core Groups + practitioner audit
- Q2 Elective Home Education
- Alfie Steele CSPR – Males in the Home
- Children on CP Plans -Physical Abuse
- Under 2 Audit – Health cases that went straight to legal planning
- Q4 Child Protection Plans with focus on CSA within the home

Findings have been shared via briefings across the partnership to inform practice improvement.

20.0 Managing Allegations

The Trust has an agreed Policy and Procedure in place for the management of allegations and safer recruitment practices.

The Trust has in place an agreed Policy and Procedure to manage allegations made in regards to people in a position of trust.

20.1 Increased number of Position of Trust referrals
The workload in relation to the Management of Allegations remains significant. The Chief Nursing Officer as Executive Lead retains oversight of the cases and actions being taken.

20.2 Case Profile
Themes during 2025/26 have been in relation to:

- Agency workers (Registered Nurses) and assault of vulnerable patients
- Substance misuse – alcohol, illicit substances
- Domestic Abuse
- Alleged assault of a patient under DoLS by a HCA
- Counter Fraud concerns
- Failure to disclose concerns subject to Police and/or Children's Social Care involvement – transferrable risk to job role

20.3 Chaperone Policy – Adults
Fully reviewed in light of the NHS England Improving Chaperoning Practice in the NHS: key principles and guidance (updated December 2025).

20.4 Volunteer Action Plan – Saville & Lampard – DBS Checks & attendance at Trust Induction – Annual Assurance
Safeguarding Audit ID 10352 (July 2019) demonstrated a poor level of compliance in relation to information held on the Trust Volunteer database relating to DBS checks and attendance at Trust Induction. An action plan was

created and progress to provide assurance has been communicated through the Integrated Safeguarding Committee.
Annual assurance update was provided to the Integrated Safeguarding Committee on the 27th May 2025.
Assurance has been sustained. This is monitored via a dedicated volunteer app.

20.5 Local Authority Designated Officer (LADO) Managing Allegation Training
Training availability promoted internally.

20.6 360 Assurance
360 Assurance is an NHS hosted service (hosted by Leicestershire Partnership Trust) delivering internal audit, assurance, counter fraud and consultancy work to a large number of organisations, predominantly within the NHS. The Integrated Safeguarding Team underwent a 360 assurance exercise with a focus on managing allegations. Significant level of assurance found.

20.7 New Photo ID Verification Requirement for Temporary Sunrise EPR Accounts
Further to a managing allegation case whereby an agency worker assumed the identity of another worker, added security has been implemented for access to Sunrise EPR account access.

20.8 French Surgeon Joel Le Scouarnec – could this happen here?
In May 2025, Surgeon Joel Le Scouarnec was convicted of raping and sexually assaulting 299 victims, mostly children (patients) in a number of hospitals in western France, over a 25-year period from 1989 to 2014. Most of his victims were under the age of 15, with the youngest child aged just one year old.
He had received a suspended sentence in 2005 for downloading child abuse images but was allowed to continue his surgical practice. He was arrested in 2017 and sentenced in 2020 to 15 years' imprisonment for the rape and sexual assault of four children. The investigation into that case uncovered his journals, in which he had recorded his abuse of hundreds of patients. They were used to track down victims, some of whom learned for the first time that they had been raped or assaulted while under anaesthesia or sedation, and to bring further charges concerning 299 victims against him, in what was the largest child sexual abuse case in France.
Action taken:
The Surgical Division were asked to review the case and findings and ask themselves, 'could this happen here?' and reported:
In theatres, I have no concerns – sedated or anaesthetised patients would, at a minimum, have an anaesthetist and ODP present at all times in addition to members of surgical teams.

20.9 Independent Inquiry into the issues raised by the David Fuller case - Phase 2 Report
David Fuller was a 67-year-old male who killed 2 women in separate attacks in 1987. He was subsequently convicted in 2021 of abusing more than 100 corpses of women and children in two Kent mortuaries between 2007 and 2020 whilst working as a hospital electrician. The initial report identified that there had been "little regard" given to who was accessing the mortuary, with Fuller visiting 444 times in a year - something that had gone "unnoticed and unchecked".
In November 2023, the Inquiry completed Phase 1 of their work, in which they considered how David Fuller was able to offend undetected for so long in the mortuaries in hospitals in Tunbridge Wells. 17 recommendations were made to Maidstone and Tunbridge Wells NHS Trust (some of which also applied to Kent County Council and East Sussex County Council) to prevent anything similar happening there again.

Phase 2 focused on the arrangements in place to protect the security and dignity of deceased people in other NHS trusts. Phase 2 of the report also gave specific responsibilities to the Executive Lead for Safeguarding in respect of care of the deceased: Recommendations 19 & 20:

19: NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.

20: The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.

Action taken: SCSD are leading on the practical aspects associated with care of the deceased and consideration of the Phase 2 report. The Integrated Safeguarding team have updated all of the relevant Safeguarding Policies and Procedures and training packages to reflect the findings of the Fuller Inquiry.
A Safeguarding Newsletter was published Feb 2026 to raise staff awareness of the case and considerations for practice.

20.10 DBS Outreach Service Workshops
Promoted internally.

21.0 Policy Development

Action required: All policies reviewed in accordance with Policy revision schedule

A Policy review schedule is monitored via the Integrated Safeguarding Committee. Risk Register ID4119. Work undertaken over 2025/26 includes:

- Application of Mittens as a Physical Restraint for Patients requiring Naso-gastric Feeding – published April 2025
- Domestic Abuse – published February 2026
- Missing inpatient guideline – published June 2025.
- Safeguarding Adults: Prevention of Extremism & Radicalisation (Prevent) Policy – published September 2025
- Safeguarding Adults: Trust Policy for Safeguarding Adults -published April 2025
- Safeguarding Children Pathway: Supervision Policy -published April 2025
- Safeguarding Adults: Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005 -published September 2025
- Chaperone Policy – published March 2026
- Managing Babies with Suspected Birth Marks and Birth Trauma

22.0 Priorities / Forward Plan 2026/27

- Regulatory - Safeguarding mandatory training compliance -90% Trust requirement –all levels adults & children
- Contribute to the work /priorities of the Worcestershire Safeguarding Adults Board (WSAB), Worcestershire Safeguarding Children Partnership (WSCP) and associated subgroups
- Embed the CARM exit plan into work streams
- Martyn's Law – contribute to the work required to achieve compliance
- Policy review and update in accordance with review schedule
- Deliver audit schedule in accordance with audit programme
- Continue to look for opportunities to improve safeguarding systems & processes to ensure they are robust –internal & external
- Multi-agency partnership working
- Embed system changes as a result of revised guidance / legislation
- Continue to provide a robust safeguarding service in light of National reform to NHSE and ICB
- Address changes to legislation e.g. DoLS, MHA
- Deliver CP-IS Phase 2 roll out by Sept 2026

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Public Trust Board
Date of Meeting:	14th July 2026
Title of Report:	Safer Staffing report - Nursing
Lead Executive Director:	Chief Nursing Officer
Author:	Sue Smith, Deputy Chief Nursing Officer
Reporting Route:	NWAG
Enclosures included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during May 2026 with numerical data also presented for May 2026.

Recommended Actions required by Board or Committee

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

Executive Director Opinion[1]

Staffing on Neonatal and all Adult in patient areas have been maintained at safe levels throughout May 2026. In paediatrics whilst BAPM level was not achieved on 100% of shifts, professional judgement indicates that areas and staffing were safe. The % of shifts achieving BAPMS was 95.16%, with 3 shifts showing as short by 0.3 members of staff.

There were 124 red flags raised, all were deemed insignificant and minor harms relating to the reporting of 'stay in the bay' rather than patient harm.

Due to the continued capacity and flow pressures in April 2026 additional capacity has continued to be utilised, with PDU remaining open alongside the PDSA processes in AMA and ASA. Overall costs of additional capacity and PDSAs (not including additional staff in cross county A&E's) is £250k in month, a slight reduction from £255K in March 26. To note: there is a proposal to close PDU during the month of June 2026 thereby reducing these costs.

Nursing and Midwifery have achieved a further reduction of agency (as a % of total spend) to 1.91% in Month 1. The Price Cap Compliance (PCC) work has ensured compliance has stayed at 99%.

To note: An independent review is underway of the Safer Nursing Care Tool (SNCT) methodology and application by the NHSE CNO safer staffing faculty lead through May, June and July 2026 with a document submission having been completed.

[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.

Nursing Staffing Levels
June 2026 (May 2026 data)

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

1. Introduction

(including relevant updates)

1.1 This briefing provides the QGC with an overview of the Nursing and Midwifery workforce for May 2026 data and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016. It provides assurance that arrangements are in place to safely staff our services with the right number of Nurses and Midwives, with the right skills, at the right time.

2. Key highlights

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

Nursing (Registered)

Key Performance Indicator	Target	May-26	Apr-26	Additional notes
Vacancy rate RN		5.02%	4.26%	Following an initial rise in month 1 following addition of new business cases. In month 2 a further 23 WTE funded RN were added to the overall funded establishment for Registered nursing . – we are currently' quartile 2 (MHS) (good) for Registered Nurses.
Annual turnover RN	11.5%	5.43%	5.45%	Retention of registered nurses is stable and below both trust target (11%) and model health system (7.7%) and last year's position within the Trust was 7.9%
Sickness rate	4%	6.14%	5.60%	Active sickness management in place as per policy and staff well-being is supported
Vacancy rate HCSW		12.77%	10.49%	Vacancy position increased despite positive recruitment pipeline due to Month 1 increase in ADI. In month 2 a further 43 HCA were added to the ADI compared to April We are currently in Quartile 2 on MHS (good) for HCA's
Annual turnover HCSW	11.5%	12.65%	12.63%	Unregistered nursing turnover remains relatively static. New induction / onboarding process in place. Model health system benchmark is 16% and last year's position within the Trust was 13.32%
Sickness rate HCSW	4%	6.72%	6.52%	Active sickness management in place as per policy and staff well-being is supported

3. Expectation 1: Right Staff

3.1 Evidence Based Workforce Planning

3.1.1 Safer Nursing Care Tool (SNCT)

- The last SNCT data collection period took place over September 2025 and October 2025, utilizing the following Safer Nursing Care Tools: Adult Inpatient Wards in Acute Hospitals, Adult Acute Assessment Units and Children's and Young People's Inpatient Wards. The Spring / Summer study is currently underway and running from May 18th to June 16th inclusive across all inpatient adults' wards and assessment units.
- Following completion of the study, data will be run and meetings will be held with divisions. Paper to be submitted to hoard in October 2026.
- Independent review taking place of the SNCT methodology and application by the NHSE CNO safer staffing faculty lead with desktop review scheduled for the end of June 2026 and onsite visit in August 2026 - required papers and evidence have now been submitted by Nursing workforce to NHSE in preparation for this review.

3.1.2 Bi-Annual Establishment Reviews 2026

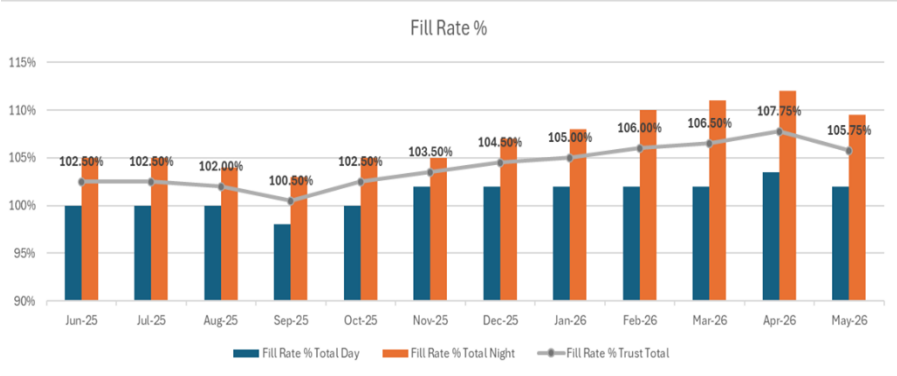
- The first bi-annual review for this year commenced on 18th May 2026 using the relevant SNCT
- The second review will be undertaken in November 2026 using the relevant SNCT
- Any change in ward template or specialty will trigger a SNCT review of establishment
- Preparation for a pediatric study is also underway. Allocate has been revising the pediatric tool, with finalization anticipated in May 2026. As part of this process, we have engaged with Allocate to obtain updates and, because of our continued interest, our Trust has been selected as the first to implement the software and will serve as the pilot site for this trial.

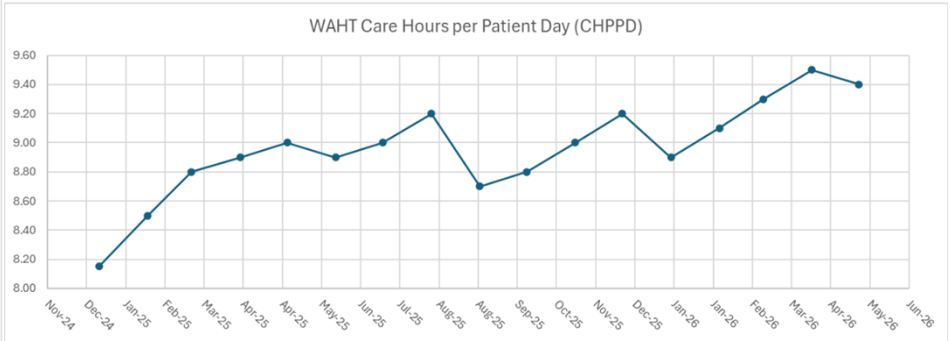
3.1.3 Electronic Rostering (Health Roster and SafeCare)

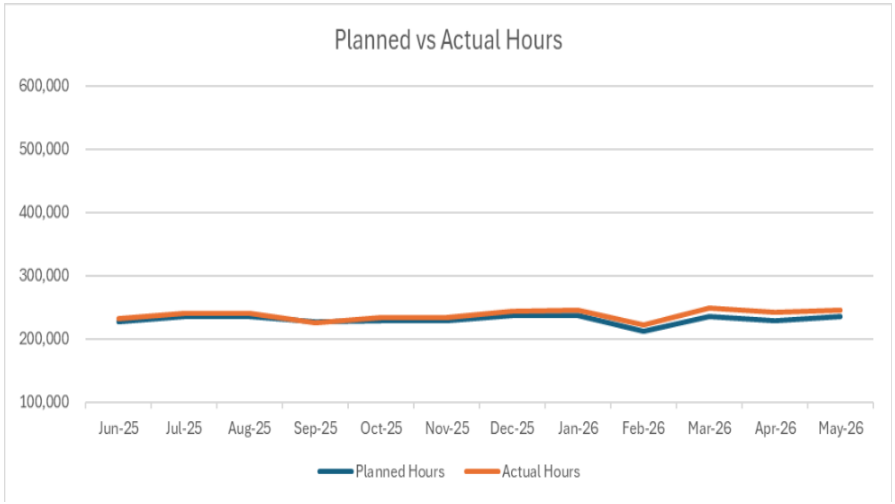
- LOOP application is in full operation with no issues reported
- E-Rostering KPIs are monitored through the Nursing, Midwifery and AHP Advisory Working Group and demonstrate good compliance

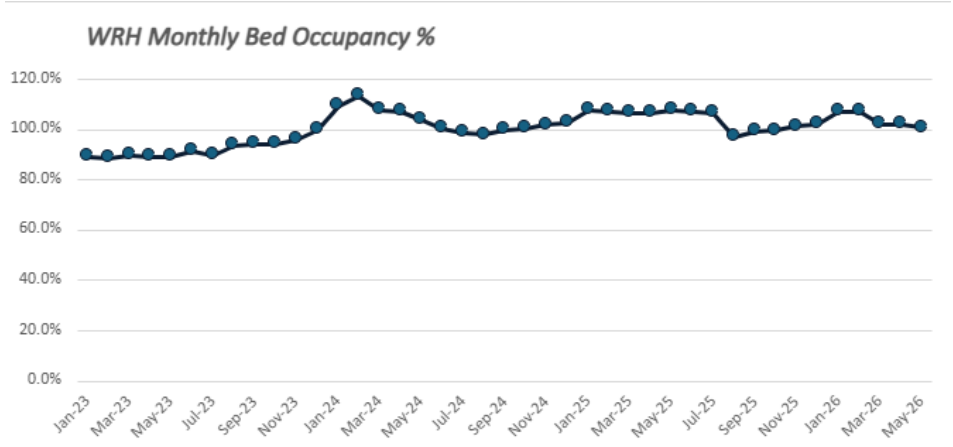
3. Expectation 1: Right Staff

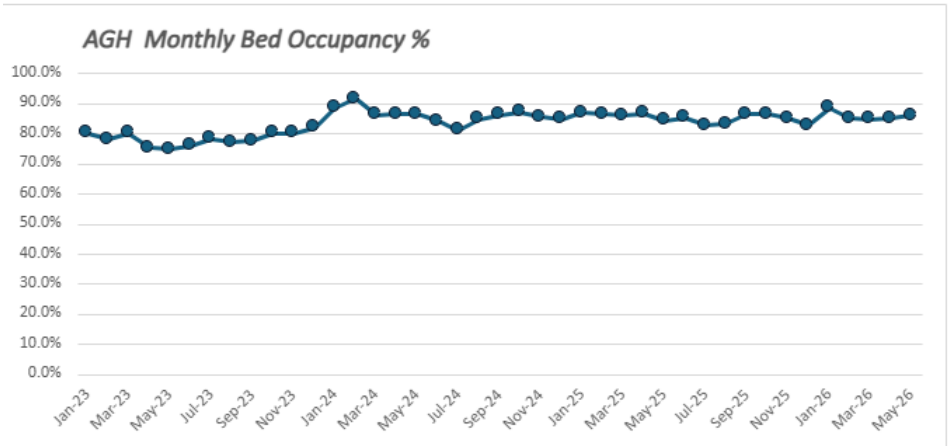
3.2 Safety performance metrics (WAHT)











Narrative:

- RN average fill rate is slightly reduced from last month but remains above 100% (101% / 103% day and night respectively), HCA fill on nights has also settled in May to 117% from 122% in April.
- Reviewing locations and themes in areas reporting utilisation above 100%, the registered nursing variance in May was primarily associated with the use of RMNs in Avon 2 and Avon 4, PDSA's on SAU and AMU, (ASA and AMA), and changes to the patient profile within PDU.
- For unregistered nursing, the main outlier areas were Beech Trauma and ASU. In Beech Trauma, changes to the patient profile resulted in a temporary uplift to the staffing template through the use of additional shifts. However, a substantive review is not currently possible due to a lack of clarity at Trust level regarding the ward's ongoing specialty. In ASU, the Division has confirmed that the current staffing template remains appropriate; however, a recent cohort of patients requiring enhanced levels of support has necessitated the short-term use of additional shifts.
- CHPPD in May 2026 is stable at 9.4 (from 9.5 in April) and above the lower Division have been approached and have confirmed that their template is correct but due to recent co-hort of patients requiring additional support this has necessitated short term additional shift usage) national advised range of 6.3
- No area fell below the 6.3 lower advised limit in May 2026.

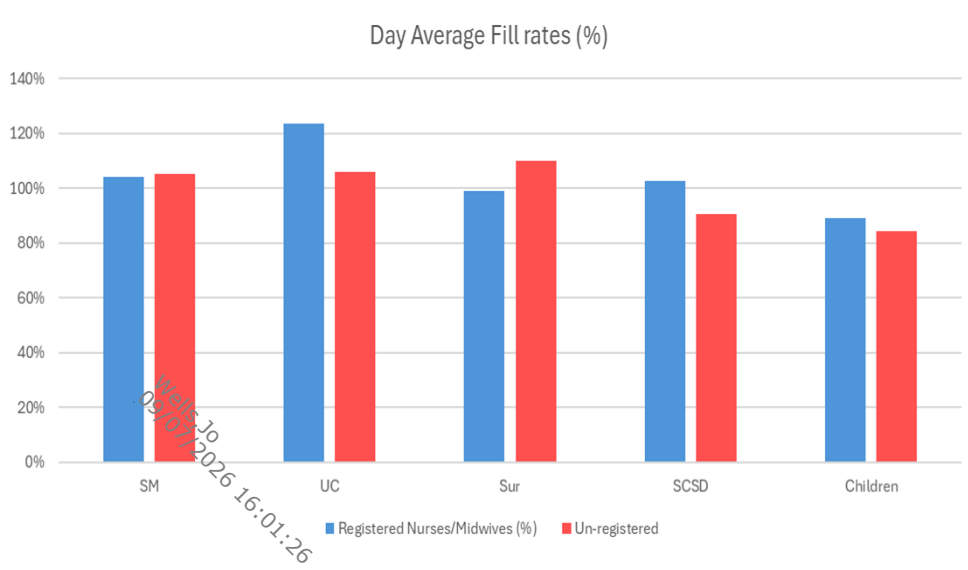
Wells Jo 09/07/2026 16:01:26

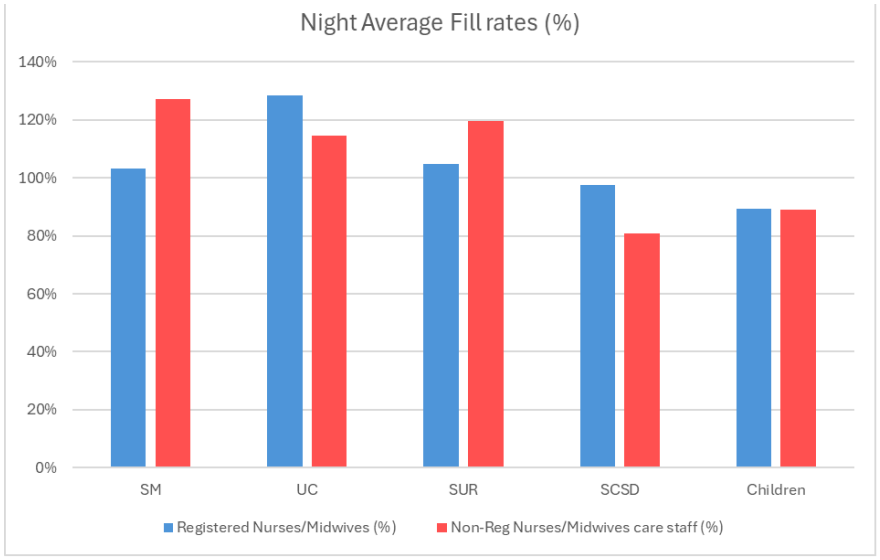
3. Expectation 1: Right Staff

3.2 Safety performance metrics

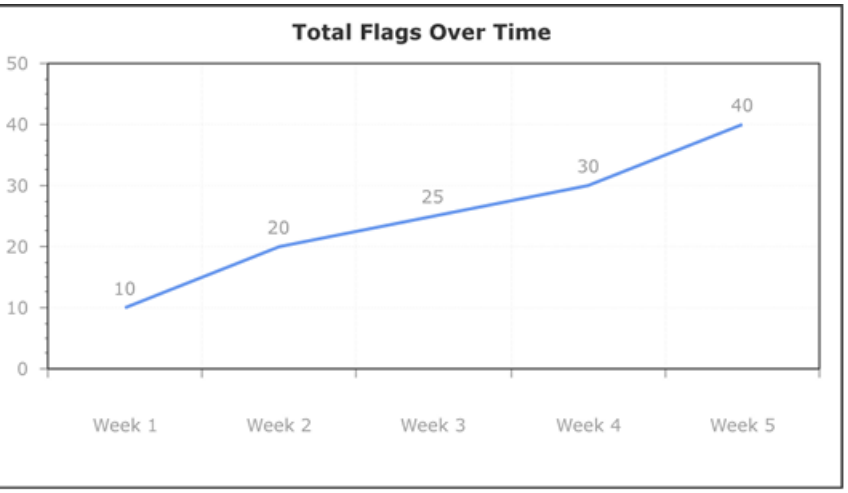
Narrative

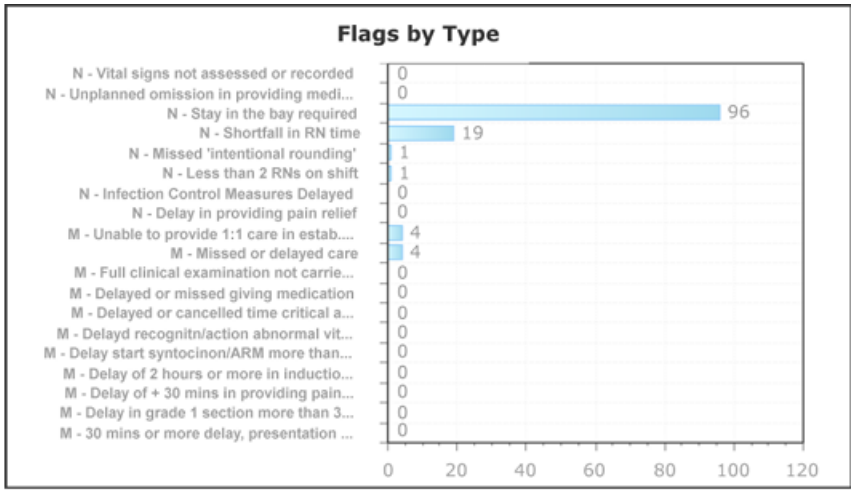
- Day and Night average fill rates analysis shows consistent fill across days and nights. ≤95 % only evident in SCSD and children's which is indicative of variations in acuity and dependency with CHPPD remaining stable in these areas and no specific safety concerns.
- 1-2-1 care and Enhanced therapeutic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

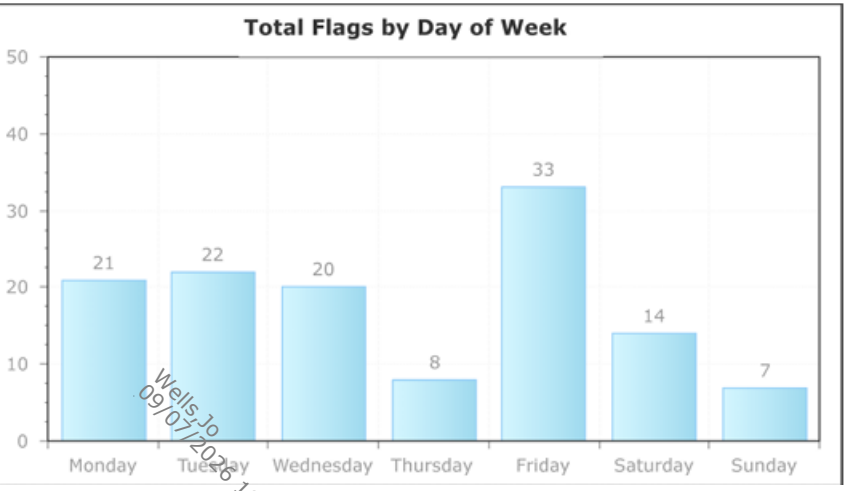


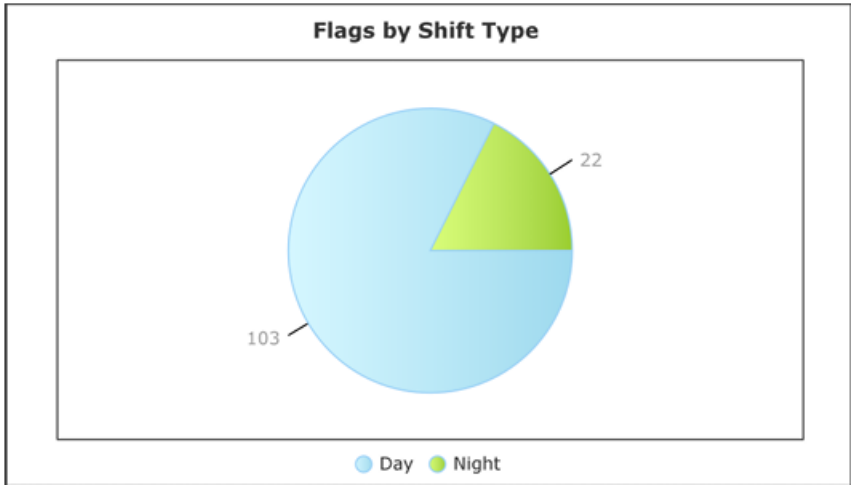


Expectation 1: Right Staff
3.4 Red flag data for May 2026









Narrative

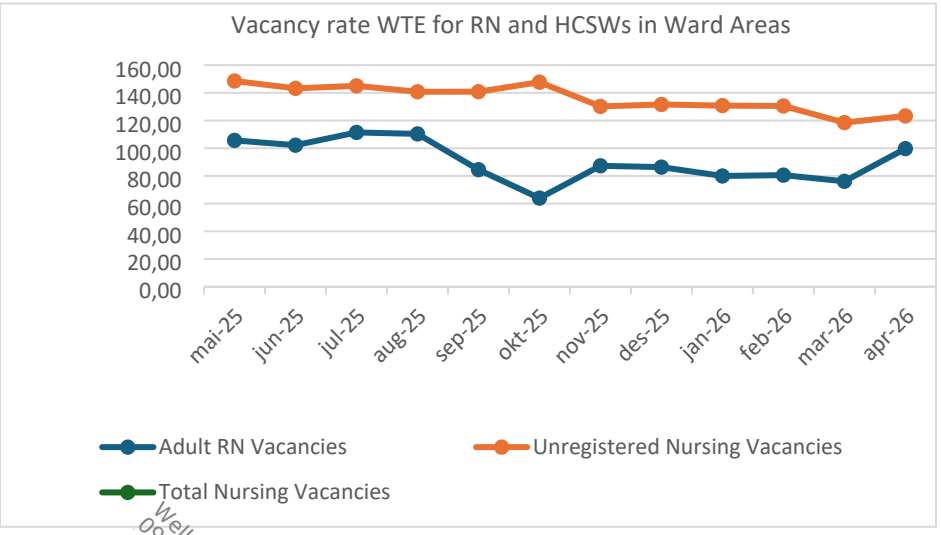
- May 2026 saw 124 (from 59 in April) red flags raised; 96 were for stay in the bay, 19 shortfall in RN time, 1 missed intentional rounding, 4 unable to provide 1:1 care, 4 missed or delayed care. In the coming month a process for active and contemporaneous review of red flags at the 10:30 and 15:30 escalation meetings will be looked at. So issues can be highlighted in real time.
- Monitoring and reporting of red flags raised via safe care will be a focus in 2026 and has been added to both NWAG reporting and the CEA ward accreditation process. This has been supported by additional training for Matrons, Ward Managers and ward staff via the Work force bitesize in May 26.

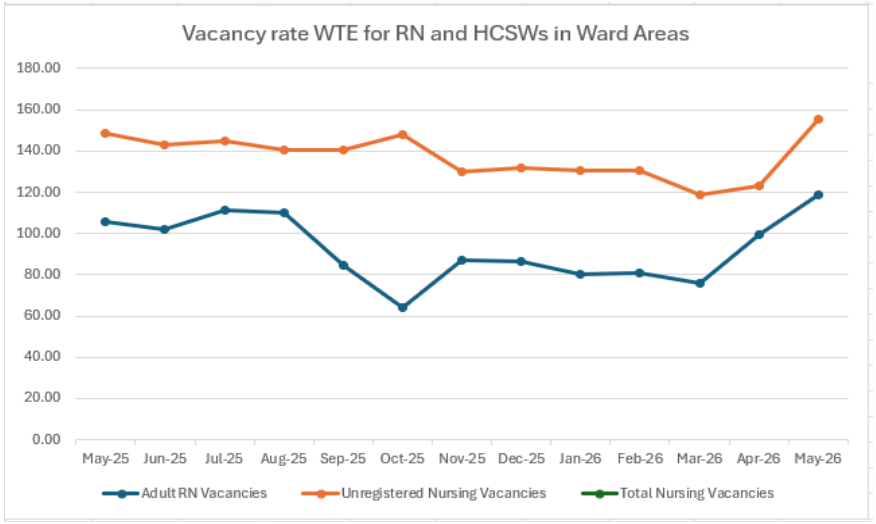
3. Expectation 1: Right Staff

3.5 Vacant posts

(Nursing)

Month	Vacancy Rate % Adult Nurse	Vacancy Rate % HCA	Adult Registered Nursing Vacancies (WTE)	Unregistered Nursing Vacancies (WTE)	Total Nursing Vacancies
May - 26	5.02%	12.77%	118.96	155.6	274.56
Apr-26	4.26%	10.49%	99.7	123.31	223.01
Mar - 26	3.28%	10.08%	76.11	118.5	194.61
Feb - 26	3.47%	11.11%	80.58	130.51	211.09
Jan – 26	3.44%	11.14%	79.96	130.76	210.72
Dec - 25	3.72%	11.21%	86.35	131.59	217.94

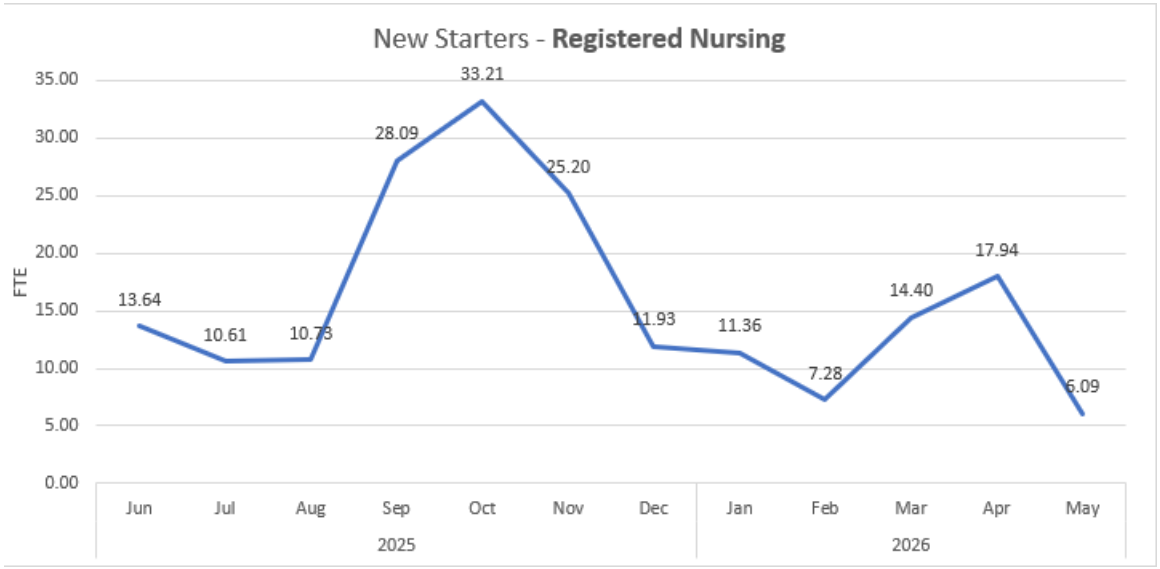


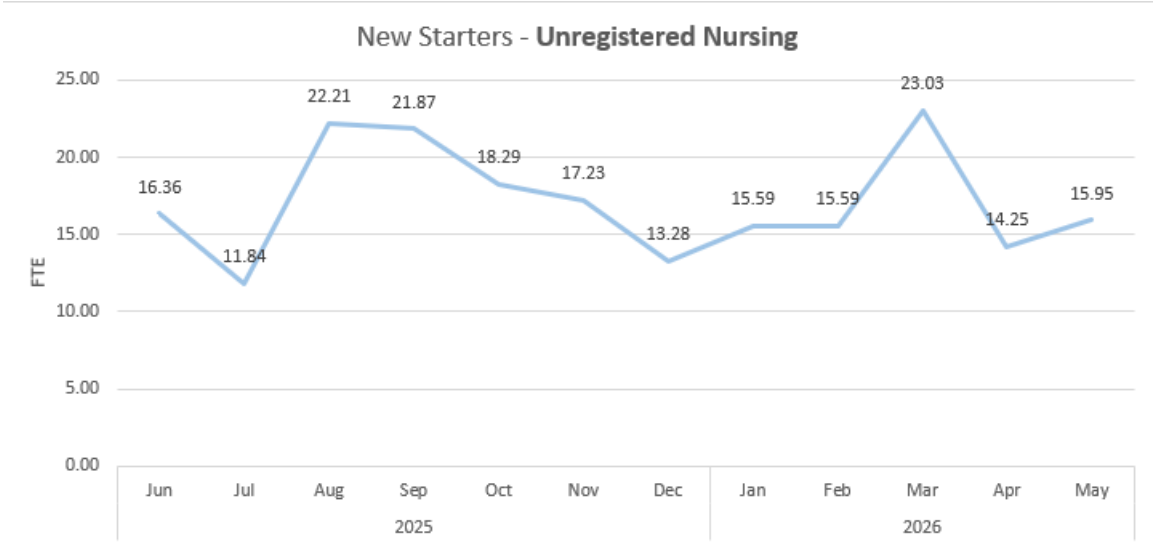


Narrative

- RN vacancies for May 2026 are currently at 118.96 WTE (5.02%) and show a further rise following the addition of 23 WTE RNs to funded establishment in month 2. This remains below the Model Health system level of 5.4%. Looking to the future pipeline a further Newly Qualified recruitment event took place on May 16th 2026 with 113 candidates being interviewed. 12 offers have already been made, and divisions will be asked in June to commit to the number of offers we are able to support to enable final decisions (including reserve list) to be communicated to candidates.
- HCA vacancies remain a focus for ongoing work across divisions / workforce and HR jobs team. Interviews took place on May 22nd with 20 offers being made. Following the recent pay rise, the entry level of Band 3 is now eligible for certificate of sponsorship and several offers made will trigger for this. It is noted that under the UK current immigration plans, HCAs will stop being eligible for new sponsorship applications after December 2026.

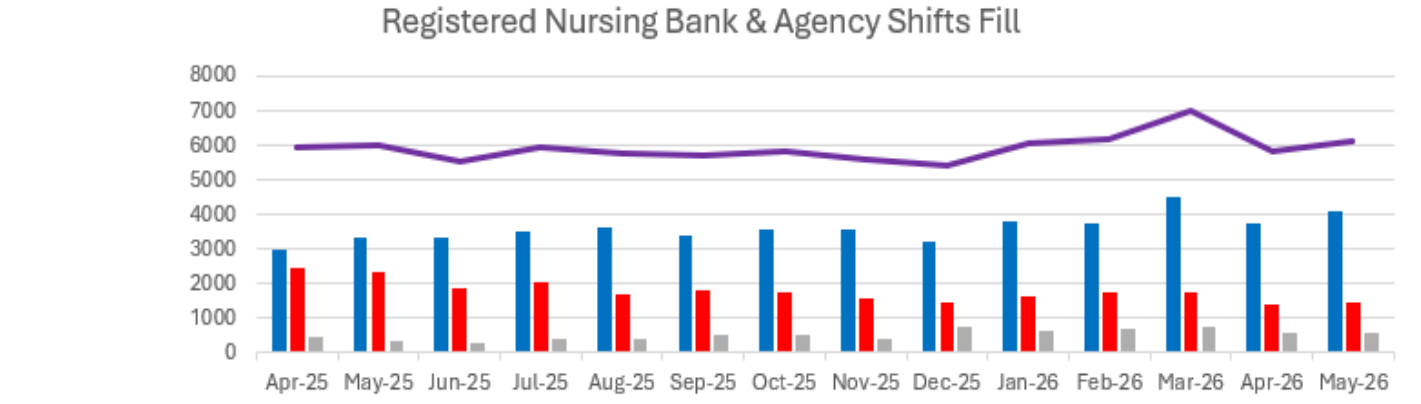
3. Expectation 2: 3.6 Right Skills





3. Expectation 3: Right Places

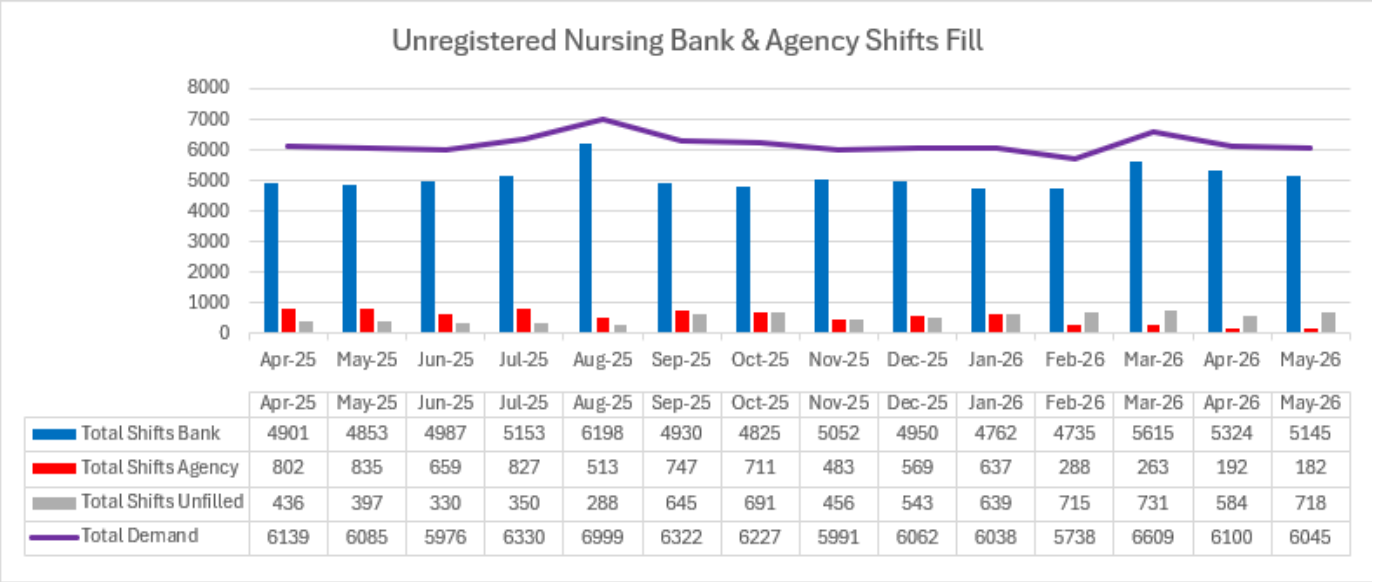
3.7 Effective Employment (Registered Temporary Staffing)



	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	May-26
Total Shifts Bank	3004	3309	3341	3514	3635	3398	3567	3583	3202	3807	3728	4495	3767	4076
Total Shifts Agency	2485	2313	1881	2060	1723	1806	1764	1577	1460	1613	1768	1737	1428	1438
Total Shifts Unfilled	447	363	285	396	429	503	497	407	730	663	685	781	612	585
Total Demand	5936	5985	5507	5970	5787	5707	5828	5567	5392	6083	6181	7013	5807	6099

3.Expectation 3: Right Places

3.7 Effective Employment (Unregistered Temporary Staffing)



	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	May-26
Total Shifts Bank	4901	4853	4987	5153	6198	4930	4825	5052	4950	4762	4735	5615	5324	5145
Total Shifts Agency	802	835	659	827	513	747	711	483	569	637	288	263	192	182
Total Shifts Unfilled	436	397	330	350	288	645	691	456	543	639	715	731	584	718
Total Demand	6139	6085	5976	6330	6999	6322	6227	5991	6062	6038	5738	6609	6100	6045

Narrative

- The safer staffing escalation meetings continued twice daily Mon-Fri throughout May 2026 to include the break glass for the removal of HCSW agency cascade in February 2026 across all departments / wards
- The overall usage of temp HCAs fell in month whist RN hours increased by 19.23 WTE driven partly by increase in RMN demand in month, increased use of MSDEC overnight and increased sickness level.
- As per NHSE targets WAHT removed agency HCSW from automatic cascade on Feb 9th 2026 with use being restricted to a 'break glass' process. In line with this the safer staffing escalation meeting has been increased to twice daily with a handover to the on-call team incorporated to ensure safe staffing and escalation points. Agency HCSW usage fell further in month to 6.6 WTE total usage.

Additional Capacity used / open in May 2026:

Ward	Month	Registered		Unregistered		Registered	Unregistered
		Hours	Cost	Hours	Cost	WTE	WTE
Worcestershire Heart Centre	May	0	0	0	0	0	
Discharge Lounge WRH	May	0	0	257	£5,541.00	0.0	1.6
Discharge Lounge AGH	May	342	£8,930.56	296	£5.601.62	12.1	1.8
AMA	May	1,028	£30,095.00	690	£14,040.00	6.9	4.6
PDU	May	2801	£80,127	2699	£56,055	18.67	17.99
Ward 12 flip bays	May	330	£11,644.18	207	£5,400.58	2,0	1.3
ASA	May	966	£26,711.06	644	£11,228.31	5.9	4.0
Medical SDEC WRH	May	345	£8.001.32	150	£3,662.00	2.1	0.9
	May **Totals**	**5,812**	**£165.509**	**4,943**	**£101,528.51**	**47.67**	**32.19**

Health Care Scientists

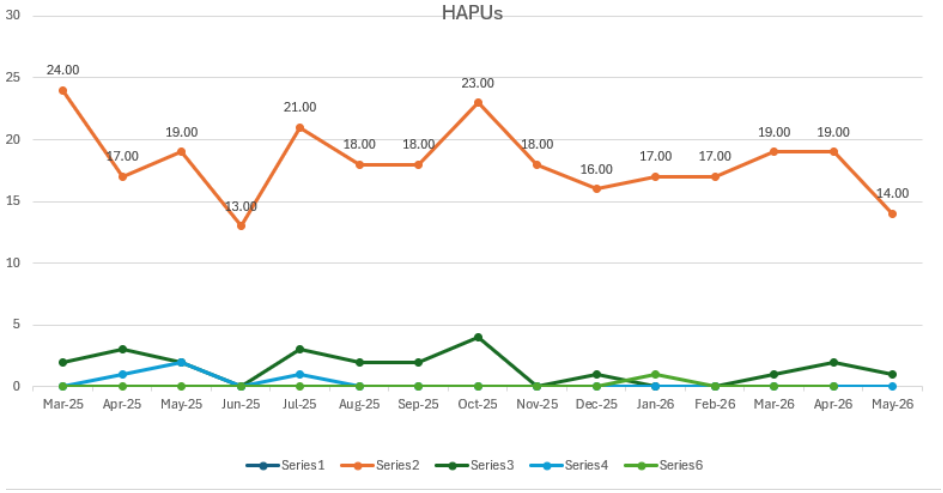
As part of work being undertaken via Agency Program board, Nursing has taken on the support of temporary staffing reduction in Health Care Scientists.

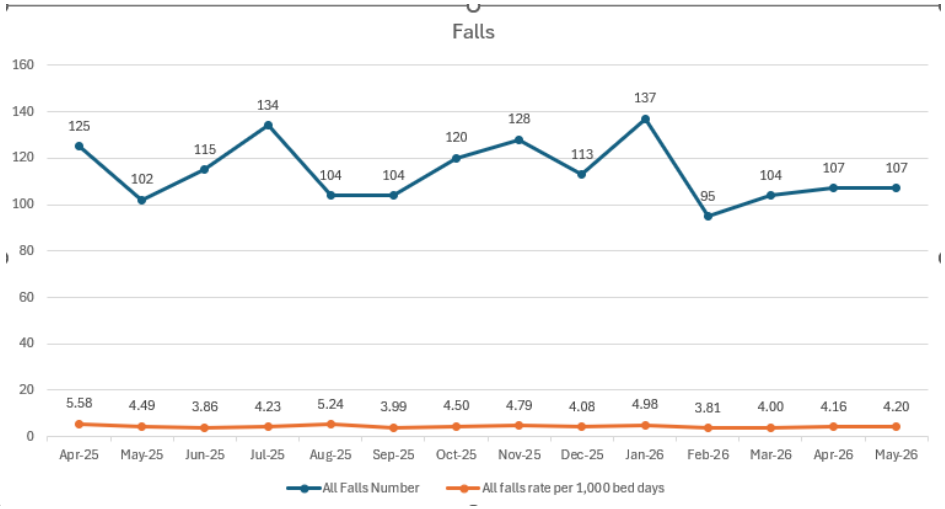
In the financial year 25/26 agency usage in this professional group was seen to reduce by 69% from month 1 to month 12. This represents a 3,500 hrs. per month reduction in usage and was accompanied by a 900 hr. per month increase in bank usage.

Moving forwards monthly updates will be shared with relevant D'OPS to allow further improvements to be made and increase overall visibility in this staff group.

4.Measure and Improve

4.1 Patient outcomes

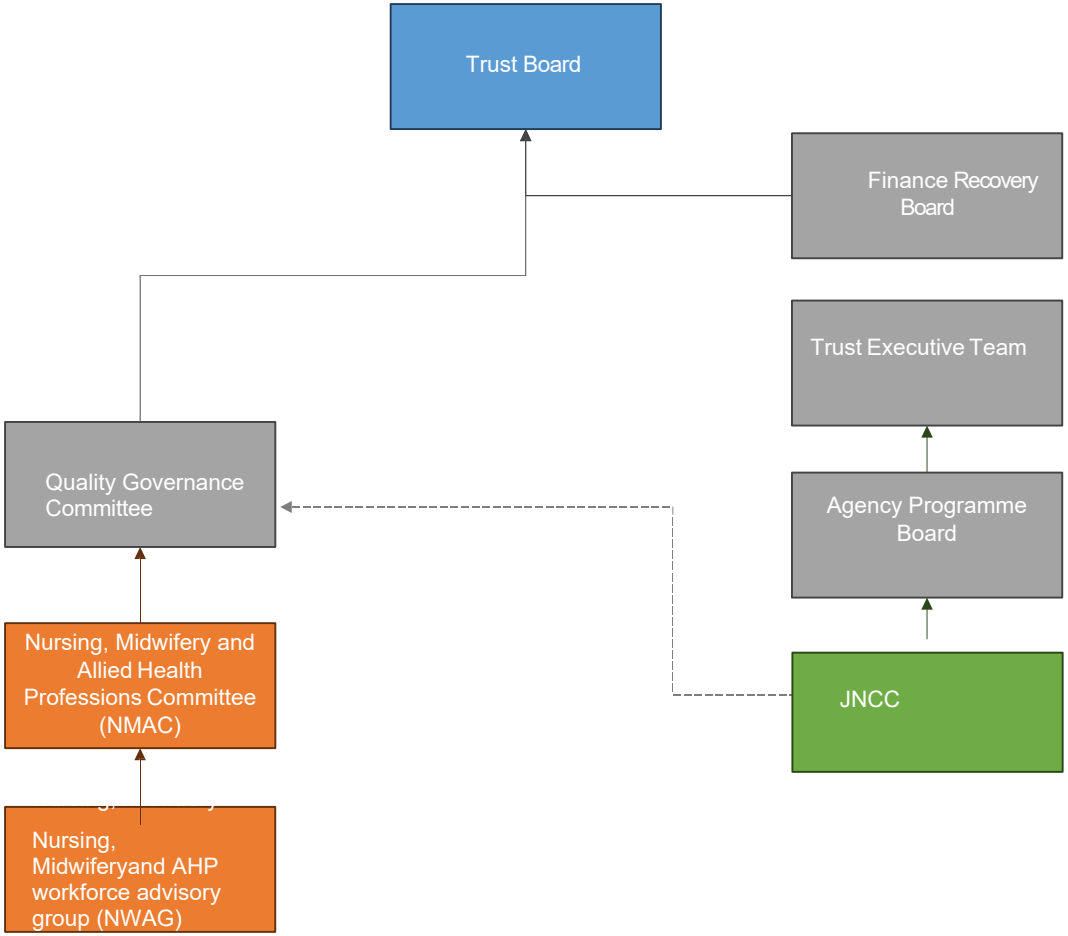




Narrative

- The total number of falls is stable from last month (107). While Hospital acquired pressure ulcers (HAPUs) have fallen.
- Unable to draw parallels to falls and HAPUs to safer staffing metrics at this current time.
- There are initiatives taking place across WAHT in relation to falls and patient safety, including the introduction of roles which are intended to focus on education and assessments to proactively reduce the number of Nurse Sensitive Indicators.

APPENDIX	
CHPPD PER WARD – May 2026	Care Hours Per Patient Day Appendix



Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	14 July 2026
Title of Report:	Maternity Assurance Overview
Lead Executive Director:	Chief Nurse
Author:	Hayley Flavell, Chief Nurse
Reporting Route:	Quality Governance Committee
Enclosures included with this report:	a. CNST Quarter 4 Report b. Preparation for the Publication of the Independent Review into Maternity Services Report c. NHSE letter: Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

Enclosures a and b were reviewed by the Quality Governance Committee on 2 July 2026 and are provided as additional assurance to the Board.

The CNST quarter 4 report (enclosure a) provides assurance that the Trust achieved full compliance with all ten CNST Maternity Incentive Scheme Year 7 safety actions.

Enclosure b provides assurance regarding the Trust's progress in implementing the seven Immediate and Essential Actions (IEAs) recommended following the publication of the Independent Review into Maternity Services at Shrewsbury and Telford NHS Trust (2020).

The attached letter from NHSE dated 26 June 2026 (enclosure c) relates to the recent Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust. The Board will review these findings in detail in its workshop prior to this Board meeting.

The letter asks Trust Boards to complete and return to NHSE by 31 July 2026 a Board Assurance Statement relating to care for the deceased, including its progress against relevant recommendations made by the Fuller Inquiry (2025).

In view of timescales, the Board will be asked to delegate its authority to the Quality Governance Committee to review and approve the Board Assurance Statement at its meeting on 30 July 2026.

Recommended Actions required by Board or Committee

The Board is asked to:

Note the assurance provided by the two reports considered by the Quality Committee.

Note the NHSE requirements regarding the Fuller Inquiry recommendations and delegate authority to the Quality Governance Committee to approve the Board Assurance Statement prior to submission.

Executive Director Opinion[1]

[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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Public Trust Board
Date of Meeting:	14 July 2026
Title of Report:	CNST Q4 report MIS Year 7
Lead Executive Director:	Chief Nursing Officer
Author:	Justine Jeffery – Director of Midwifery Jane Wardlaw – Lead Assurance and Compliance Midwife
Reporting Route:	Quality Governance Committee
Enclosures included with this report:	Appendix 1 - MIS Year 8 Letter to Trusts Appendix 2 - Q4 PMRT case report 25-26 Appendix 3 - SBL Summary Q4 25-26 Appendix 4 - January MNVP Highlights report Appendix 5 – March MNVP Highlights report Appendix 6 - NOTES - MNSChampions 23rd January 26 Appendix 7 - NOTES- MNSChampions 27th Feb 26 Appendix 8 - NOTES - MNSChampions 27th March 26 Appendix 9 - Claims and incidents Q3 2025-2026 – Final *Available in Additional Reading folder or by request*
Purpose of report:	☒ **Assurance** ☒ **Approval** ☒ **Information**

Brief Description of Report Purpose

MIS Year 7

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

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

MIS Year 8

A letter was received from NHS Resolution on 19th Feb 2026 embedded below. The MIS Year 8 briefing outlines a significant redesign of the national incentive scheme, with a clear shift from process-driven compliance to outcome-focused assurance. The revised model introduces six streamlined safety actions, increased local flexibility, and a stronger emphasis on demonstrable improvements in safety outcomes for women and babies. There are enhanced expectations for Board oversight, including scrutiny of governance, workforce capacity, training compliance, and evidence of learning translated into improvement. The framework also strengthens requirements around service user voice, equity, and system-wide learning, with more explicit expectations for regular reporting and assurance to Trust Boards. See Appendix 1

Safety Action	Evidence
1	**Compliant - PMRT** Q4 25-26 *See Appendix 2 – Q4 25-26 PMRT case report*
2	**Compliant - MSDS** data set complete
3	**Compliant - TCU** QI project commencement, TCU provisions confirmed with ODN
4	**Compliant – Medical Staffing** - Compliance of engagement according to the RCOG long term locums (6-month Audit Presented in Q2 CNST report) **Compliant** – RCOG 'Roles and Responsibilities' (3-month Audit Presented in Q2 CNST report) – 80% minimum compliance standard.
	Compliant – Action Plan produced for BAPM Neonatal Nursing and Medical staffing standards (presented in Q3 CNST MIS Year 7 Report) Risk register ID 6031 & 5991 **Compliant** - BAPM QIS standards Neonatal Nursing staff *Neonatal Workforce updates due in Q1 26-27*
5	**Compliant - Midwifery Staffing** reports (Birthrate + tabletop Audit August 25) presented to trust board monthly
6	**Compliant – Saving Babies Lives** Elements 1-5 demonstrate full compliance; Element 6 requires the recruitment of a 0.6 WTE maternity specific dietician. *See Appendix 3 - SBL Summary Q4 25-26*
7	**Compliant – MNVP** Local engagement with the MNVP continues through the Patient Experience Group Meeting Bi-monthly. High lights report demonstrates community engagement. *See Appendix 4 – MNVP HLR Jan 2026 and Appendix 5 – MNVP HLR March 2026*

8	**Compliant – Training** Compliance 90% on 30th November 2025.
9	**Compliant - Perinatal Surveillance** NED Appointed, Quarterly Perinatal Safety Reports aligned with Perinatal Quality Oversight Model, Safety Champions meeting with at least one member of the PLT (Perinatal Leadership Team) every meeting and their culture improvement plan has been presented to Safety Champions *See Appendix 6 - NOTES - MNSChampions 23rd January 26, Appendix 7 - NOTES- MNSChampions 27th Feb 26 and Appendix 8 - NOTES - MNSChampions 27th March 26*
9	**Compliant** Trust Claims Score Card Q3 25-26 discussed with Safety Champions (March 26) *See Appendix 9 - Claims and incidents Q3 2025-2026 - Final*
10	**Compliant** MNSI / EN reports – Q4 – Jan/Feb/March 26 Families have received information on the role of MNSI and NHS resolution's EN Scheme and that the duty of candour was performed. Screen shot below from the Perinatal Safety Report confirming the four cases in the quarter had appropriate information sent to them.

Recommended Actions required by Board or Committee

- Review the 10 safety Actions below and acknowledge continued compliance with each element for YR 7 safety actions.
- Review the changes to MIS year 8 – Core standards and Supplementary guidance expected publication 1st April 2026

Executive Director Opinion[1]

The report provides strong assurance that the Trust has achieved full compliance with all ten CNST MIS Year 7 safety actions, supported by clear evidence of sustained governance oversight, workforce monitoring, and embedded safety processes. Performance is consistent and demonstrates a mature approach to perinatal safety, with effective multidisciplinary engagement and patient involvement.

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

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Quality Governance Committee
Date of Meeting:	02/07/2026
Title of Report:	Preparation for the Publication of the Independent Review into Maternity Services
Lead Executive Director:	Chief Nursing Officer
Author:	Justine Jeffery – Director of Midwifery Rebecca Fox – Deputy Director of Midwifery Jane Wardlaw – Lead Assurance and Compliance Midwife
Reporting Route:	
Enclosures included with this report:	Appendix 1 – Ockenden Assurance Template May 23 – March 25 Appendix 2 - Process of benchmarking guidelines against NICE / Evidence
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

This report provides the Trusts current position in respect of the seven Immediate and Essential Actions (IEAs) recommended by Donna Ockenden following the publication of the Independent Review into Maternity Services at Shrewsbury and Telford NHS Trust (2020). It summarises current compliance, key areas of assurance, and any identified gaps.

The review has been undertaken in response to a request from NHS England Midlands Regional Team in preparation for the publication of the Independent Review into Maternity Services at Nottingham University Hospitals Trust expected on 24th June 2026 and will be presented by the Chief Nursing Officer at the Regional Provider Review Meeting in June.

Appendix 1 outlines the latter historical journey (commenced 2021) of Ockenden IEA completion from May 2023 – March 2025 when tracking was discontinued through the COSMOS platform. This also provides the questions in full for each IEA.

This report provides a high level of assurance for the 7 IEAs however the following areas require further development as many of the recommendations have been superseded with updated guidance/publications: (1)neonatal medical workforce compliance to BAPM standards (2) consider increasing %uplift for midwifery staffing to include maternity leave (3) work with the MNVP to support whilst capacity is reduced and a system level redesign of services is completed and (4) recognise and address service delivery inequity for MDT AN diabetic clinic.

Recommended Actions required by Board or Committee

It is recommended that the Board accept the report for assurance and note the Immediate actions where further improvement is required.

Executive Director Opinion[1]
Worcestershire Acute Hospitals NHS Trust (WAHT) demonstrates a high level of overall compliance with the 7 Ockenden IEAs, with strong governance, embedded safety processes, and validated alignment with Maternity Incentive Scheme (MIS) safety actions. Assurance is largely evidenced through robust reporting mechanisms (e.g., Perinatal Safety Reports), LMNS validation, and sustained outcome improvement The Trust is well positioned ahead of the forthcoming national review publication, with most requirements embedded and validated. However, targeted action is required in workforce (particularly neonatal), service equity, MNVP capacity, and full compliance with risk assessment standards to ensure sustained and fully assured compliance.

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

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Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

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Section 1

Immediate and Essential Action 1: Enhanced Safety
Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:
(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
		system and trust level?				
Q1 Dashboards – LMNS PQS meeting quarterly Q2 MNSI Q3 Perinatal Safety Report Quarterly Q4 PMRT Joint meeting Q5 MSDS compliant Q6 MNSI Q7 PQSM (PSOM) implemented – Guideline live Q8 SI's presented in Perinatal Safety Report which is presented to Board by the DoM.	• Clear escalation routes • Closed-loop governance • Real-time quarterly surveillance • 7 pillars of governance encompassed • Learning and mitigation opportunities transparency	Trending the data within the Perinatal Safety Report collates Q1-8 this equates to reduction in harm. • Able to demonstrate sustained improvement in SB reduction and HIE • Able to demonstrate areas of focus	ICB / regional restructuring within the PSOM framework	ICB/ regional leads Timeframe currently unavailable due to changes in assurance oversight plans.	ICB / regional direction	Continue with reporting cycles
Further Notes Position June 2026 • PSOM - Perinatal Clinical Quality Surveillance Model now revised – The Perinatal Surveillance Oversight Model. WAHT COMPLIANT in its implementation MIS years 5,6,7 Safety Action 9 – LMNS validated Dec 25 • PMRT - process with Joint oversight, SOP and TOR. WAHT COMPLIANT with MIS years 5,6,7 Safety Action 1 – LMNS validation Dec 25 • LMNS/ ICB and regional structural changes/reform equates to some changes in the quarterly Perinatal Safety Report surveillance pathway. • MNSI – reporting process WAHT COMPLIANT with MIS years 5,6,7 Safety Action 10 – LMNS validation Dec 25 • MSDS – all data uploads WAHT COMPLIANT with MIS year 5,6,7 Safety Action 2 – LMNS validation Dec 25 • SI's framework changed to PSIRF adopted by the trust Mid 2024						

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named nonexecutive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

Q11 NED Safety Champion appointed Q12 PMRT tool standards met Q13 MNVP coproduction process Q14 Monthly Safety Champions Q15 MNVP Patient experience meetings bi-monthly Q16 NED and Safety Champions working together	• Meeting CNST MIS safety Actions 1, 7, 9 • WAHT met these safety actions in MIS years 5,6 & 7. LMNS Validated • Safety Champion minutes (Obs and Midwife attendance)	• MNVP and NED roles strengthen assurance and ensure patient and public voice are embedded for independent challenge. Effectiveness demonstrated through clear impact on improvement actions, sustained oversight and evidence of influence at both trust and system level. • ICB redesign of MNVP establishment. service redesign underway	Completion of MNVP team redesign	ICB	n/a	Maintain meetings/relationship with Strategic Lead recognising limitation in capacity.

Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Q17 MDT training (PROMPT and SBL) Q18 Am/Pm Cons Led MDT ward rounds Q19 Funding for training ringfenced	• Monthly booking meetings with Maternity DM • Compliance with BR+	• Within the Perinatal safety report – presented to, Maternity Governance, QGC, LMNS, Safety	None	N/A	N/A	N/A

Q21 90% staff trained on PROMPT Q22 Ward Rounds Q23 MDT Schedule	• Partial compliance with BAPM standard (medical) • Funding secured to develop/release faculty • Funding secured to increase uplift to 24% to enable release for training • Review of Dashboard monthly • Guideline/TNA • ESR upload of staff attendance • CNST MIS year 5,6,7 compliant on Safety Actions 4 & 8 • Ward rounds have signatory documents of attendance – audited quarterly	Champions, MIS (CNST), Directorate • Safe staffing report tracks midwifery workforce KPIs				

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
requirements of IEA 4?						
Q24 Maternal Medicine Centre referral system in place Q25 Named Cons for every patient 100%	• AN Care Guideline • Audit / Dashboard • SBL Validation quarterly with LMNS	• SBL Validation meetings • Safety Champions meetings • Maternity Governance	To achieve 100% in SBL - a one stop diabetes clinic is required. Current issue is the onsite endocrinologist (over 3 sites).	LMNS Lead to determine if mitigation equals compliance to meet 100%	Regional confirmation requested. If mitigation not accepted further funding needed to enable	Endocrinologist contactable during clinics via on phone or teams to discuss patient care.

Q26 Early invention with complex pregnancies achieved Q27 SBL Compliance 99% (named specialist midwives for diabetes, EFM, and Preterm) Q28 Complex named consultant >99% Q29 BWH named Maternal Medicine specialist centre (4x maternal in-house medicine clinics per wk, 2x maternal medicine consultants)	• Monitor incidents relating to any maternal medicine concerns	• Perinatal Safety Report Quarterly	Possibility that in person may be mitigated by available on phone or teams.		equitable service across 3sites	

SBL V2 was replaced by the most up to date version SBL V3.2 - NHS England » Saving babies' lives version three: a care bundle for reducing perinatal mortality

WORCESTERSHIRE

Area	Framework	Indicator Description	Type	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	12 Month Rolling Total
Management	Ockenden	% High risk women assigned a named Consultant - within 7 days	%	99.6%	99.8%	99.7%	100.0%	99.6%	99.7%	100.0%	100.0%	100.0%	99.2%	99.8%	99.2%	99.3%	99.7%
	Ockenden	% High risk women assigned a named Consultant - at any time	%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	99.7%	100.0%	100.0%

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Q30 Risk assessment at every AN Contact > 90% Q31 Place of birth reviewing >80% Q32 SBL Compliance 99% Q33 PCSP recorded place of birth at every contact >90%	• Audit / Dashboard • SBL Validation quarterly with LMNS	• SBL Validation meetings • Safety Champions meetings • Maternity Governance • Perinatal Safety Report Quarterly	Improve compliance with AN risk assessment. See IEA 4 for SBL actions	DDoM	Staff engagement	Onset of labour risk assessment mandatory completion

Saving Babies Lives benchmarks are currently against V3 – see link NHS England » Saving babies' lives version three: a care bundle for reducing perinatal mortality

	A	B	C	D	G	H	I	J	K	L	M	N	O
1		WAHT SBL audits						April 2025 - March 2026					
2	E1		Requirement	Reporting	Mininum compliance	Stretch Ambition	LMNS Traget	Q1	Q2	Q3	Q4		Current Status
18		2.1	Aspirin Risk Assessment	Intervention				99%	99%	99.1%	100%		Fully
21		2.4	FGR Risk assessment by 14/40	Process indicator 2a	80%	90%		100%	100%	100%	100%		Fully
24	E2	2.7	High risk women that have a UtAD	Intervention				60%	58%	70.0%	75.0%		Fully
26		2.9	Risk pathway following scan	Intervention			N/A	Compliant	Compliant	Compliant	Compliant		Fully
30		2.13	Increased risk of FGR	Intervention			N/A	Compliant	Compliant	Compliant	Compliant		Fully
45	E4	4.2	Onset of labour fetal monitoring risk assessment	Intervention				95%	See audit	See audit	86%		Fully
55		5.3	Preterm risk assessment	Intervention			N/A	100.0%	100.0%	100.0%	100%		Fully
58	E5	5.6	Risk assessment and management of multiple pregnancies	Comply with NICE			90%	Compliant	Compliant	100%	100%		Fully
66		5.14	Awareness for women at increased risk	Intervention			N/A	Compliant	Compliant	Compliant	Compliant		Fully

Area	Framework	Indicator Description	Type	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	12 Month Rolling Total
	Saving Babies Lives	% Women with CO reading of 4 ppm or more at booking	%	8.6%	6.5%	8.9%	8.1%	5.6%	8.8%
Risk Management	LMNS	Women with BMI of 30 and over at booking	Integer	153	103	149	124	138	1539
	LMNS	% Women with BMI of 30 and over at booking	%	32.6%	24.6%	29.5%	31.6%	28.2%	28.6%
	Better Births	% Antenatal personalised care plan completed	%	100.0%	99.8%	99.8%	99.8%	99.5%	99.8%
	Better Births	% Intrapartum personalised care plan completed	%	18.9%	19.7%	25.9%	28.9%	28.9%	21.0%
	LMNS	% Portal Access - Women who registered and logged in	%	99.8%	99.3%	99.6%	99.7%	100.0%	99.6%
	Ockenden	% High risk women assigned a named Consultant - within 7 days	%	100.0%	99.2%	99.8%	99.2%	99.3%	99.7%
	Ockenden	% High risk women assigned a named Consultant - at any time	%	100.0%	99.7%	100.0%	99.7%	100.0%	100.0%
	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	%	96.5%	96.5%	96.7%	96.5%	97.4%	96.1%
	Ockenden	% Contacts where place of birth suitability was recorded	%	82.2%	82.9%	81.9%	82.8%	83.1%	81.7%
	Ockenden	% Women who delivered with the Trust where a place of birth suitability was recorded before delivery	%	97.4%	94.2%	98.4%	97.0%	97.9%	96.8%

Immediate and essential action 6: Monitoring Fetal Wellbeing
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Q34 M/W and Obs Cons EFM Leads in place	• Audits results • Training evaluations • Local survey's	• ATAIN • Perinatal mortality rates	See IEA 4 for SBL actions	As above	As above	n/a

Q35 Expertise demonstrated through JD and national level teaching/implementation of physiological interpretation. Q36 SBL 99% Compliance Q37 >90% attended PROMPT Q38 = to Q35	• Service user experience • Outcomes related to fetal monitoring • SBL LMNS Validations • Job Plans • Rosters	• HIE rates • Apgar's • Cord Blood Gases • IIA transfers from Meadow				

Implementation Progress

Worcestershire Acute Hospitals NHS Trust

Intervention Elements	Description	Element progress	% of interventions fully implemented (LMNS Validated
Element One	*Smoking in Pregnancy*	Fully Implemented	100%
Element Two	*Fetal Growth Restriction*	Fully Implemented	100%
Element Three	*Reduced Fetal Movements*	Fully Implemented	100%
Element Four	*Fetal Monitoring in Labour*	Fully Implemented	100%
Element Five	*Preterm Birth*	Fully Implemented	100%
Element Six	*Diabetes*	Partially Implemented	83%
All Elements	*Total Compliance for Quarter Two 2025/2026*	Partially Implemented	99%

May 2026 - LJH

How will the 90% attendance compliance be calculated?	*The training requires 90% attendance at two pre-determined points during the MIS Year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, at the following training where applicable dependant on staff group:*	*Staff group*	*Compliance 3rd June 26*
	1. Fetal monitoring training	Midwives Band 5,6,7,8	97.65%
		Obstetrician Consultants (that contribute to rota)	100%
		All other Obstetrician Doctors (that contribute to rota)	100%
	2. Multi-professional maternity emergencies training	Midwives 5,6,7,8	99%
		Anaesthetists Consultants (that contribute to rota)	100%
		All other Anaesthetists (that contribute to the rota)	96%
		Maternity Support workers and Maternity Care Assistants	96%
		Obstetrician Consultants (that contribute to rota)	93%
		All other Obstetrician Doctors (that contribute to rota)	97%
	3. Neonatal resuscitation training	Neonatal nurses	92%
		Medical staff (Pead's / Neonatal)	92%
		Midwives 5,6,7,8	99%

NHS
Worcestershire Acute Hospitals NHS Trust

99% compliance across all the interventions within SBL

Saving Babies Lives

Quarter Four 25/26

January February March

Element One
Smoking in Pregnancy

100% compliant

- 92% are CO monitored at booking
- 87% are CO monitored at 36 weeks
- Smoking status is updated 100% of the time
- 90% of our smokers are referred
- 84% that see a TDA set a quit date
- 83% setting a quit date achieve a 4 week quit
- 80% are smoke free at 36 weeks

Element Two
Growth Surveillance

100% compliant

- 99% have a risk assessment for aspirin at booking
- 95% have Vitamin D recorded
- 100% have a risk assessment for FGR at booking
- 75% of high risk women have a UtAD
- 86% of babies with an EFW of below the 3rd centile were delivered in a timely manner
- 58% overall detection rate for SGA/FGR

Element Three
Fetal Movements

100% compliant

- 100% of those attending with reduced fetal movements have a cCTG where appropriate
- 72% of those with recurrent reduced fetal movements have a scan within 24 hours
- 0.9% of Inductions are documented with the only reason as reduced fetal movements

Element Four
Fetal Monitoring

100% compliant

- 98% of staff that care for women in labour have in date training and assessment
- 1 babies with HIE or brain injurys in Q4
- Documented assessment for most appropriate form of fetal monitoring = 86%
- Excellent documentation has been reported when reviewing CTG's

Element Five
Preterm Birth

100% compliant

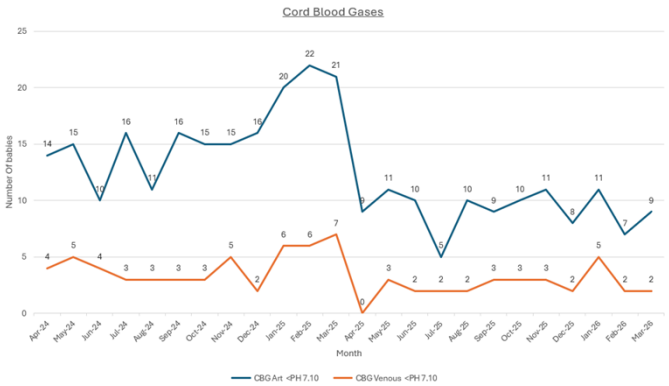
- 0.1% rate of preterm 16 – 24 weeks
- 5.7% rate of preterm birth 24 – 37 weeks
- 100% have an assessment for risk of preterm birth at booking
- 99.6% of preterm babies documented as "born in the right place"
- 35% of babies had a full course of steroids within 7 days of birth
- 6% had steroids more than 7 days before birth
- 35% delivered before a second dose of steroids could be given
- 86% of babies <30 weeks received magnesium sulphate
- 95% had delayed cord clamping
- 80% had first temperature in required range
- 95% received their own mothers milk in a timely manner
- *NB percentages reported here are for singleton births as timings for multiples is not required for SBL due to numerous factors.*

Element Six
Diabetes

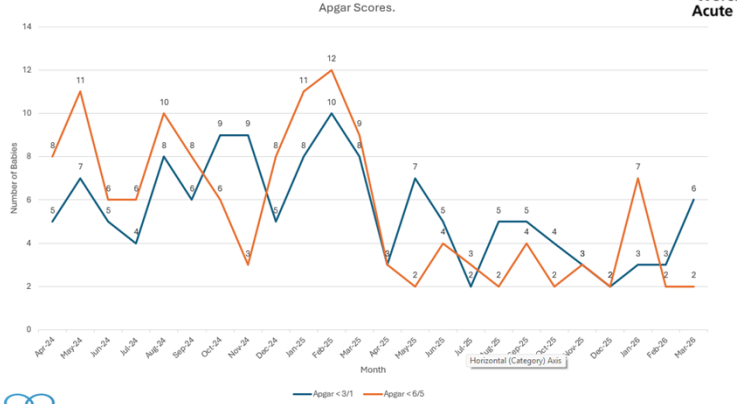
83% compliant

- 100% of those with Type 1 Diabetes are offered pregnancy specific HCL
- 80% use pregnancy specific HCL
- 50% of those with type 1 & 2 Diabetes have their HbA1C taken in required time frame

The Measurable Outcomes. Cord Blood Gases

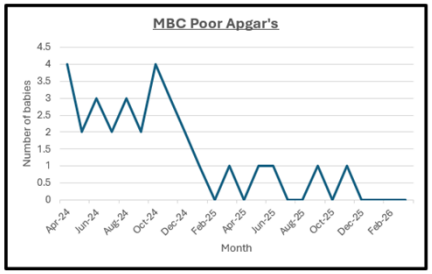


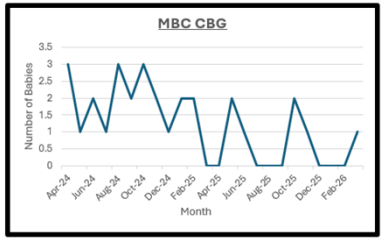
The Measurable Outcomes Apgar's



Meadow Birth Centre Impact of Physiological CTG interpretation and IIA. Transfer V Intervention

MONTH	MBC Poor Apgar 6/5	MBC CBG	Transfers	Intervention
Mar-26	0	1	3	3
Feb-26	0	0	2	2
Jan-26	0	0	1	1
Dec-25	0	0	2	2
Nov-25	1	1	2	2
Oct-25	0	2	3	3
Sep-25	1	0	0	0
Aug-25	0	0	2	2
Jul-25	0	0	1	1
Jun-25	1	1	4	3
May-25	1	2	2	2
Apr-25	0	0	4	3
Mar-25	1	0	5	2
Feb-25	0	2	4	1
Jan-25	1	2	6	3
Dec-24	2	1	7	4
Nov-24	3	2	3	1
Oct-24	4	3	2	2
Sep-24	2	2	1	3
Aug-24	3	3	0	0
Jul-24	2	1	2	0
Jun-24	3	2	3	1
May-24	2	1	1	1
Apr-24	4	3	2	3





Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Q39 Info for choice of birth – BadgerNet leaflet Q40 Website and Leaflets Library Q41 Informed choice supported by BRAINS tool Q42 Guidelines for care across maternity pathway compliant with	• CQC Maternity Survey Action Plan • MNVP feedback in safety champions and bimonthly patient	• CQC Maternity Survey results • MNVP quarterly highlights reports • Patient experience meetings	Awaiting Personalised care toolkit	Foundation Group - Consultant Midwives (awaiting new lead for workstream)	New lead appointment	Consultant Midwife clinic appointments.

NICE and out of guidance care Q43 MNVP bimonthly patient experience meetings/ Coproduction with CQC Action Plan, guidelines/Leaflets Q44 Trust Website	• experience meetings • ARM / LCSC/ IOL choice for procedure	• PALs feedback				

Patient Information Leaflets - Worcestershire Acute Hospitals NHS Trust

Maternity

- Restrictive Frenulum (Tongue Tie)
- Latent Phase of Labour
- Pain Relief Options in Labour
- Epidural Leaflet
- Homebirth
- Starting Insulin when you have Gestational Diabetes
- Tongue tie post procedure
- Low PAPP-A
- Gestational Diabetes Dietary Information
- Oral Glucose Tolerance Test (OGTT)
- What you need to know about Antenatal Hand Expressing
- After your Caesarean Section
- Managing your Type 1 or Type 2 Diabetes in Pregnancy
- Planned Caesarean Birth at Worcestershire Royal Hospital with Enhanced Recovery – Information Guide for Mothers, Birthing People and Birth Partners
- Dietary Information for pregnant in-patients with Diabetes
- Assisted Vaginal Birth
- Postnatal exercises and advice

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Q45 Safe staffing report, Birth rate+ Q46 Birthrate+ compliant (2025) Q47 DOM responsible to Exec Director Q48 DOM & DDOM, lead midwives, consultant midwife, research team, leadership development available to all (Trust Education Academy). Q49 Standard Template used to inform of any non-evidence-based	• Consider substantive recruitment to maternity leave • CNST MIS year 6, 7 compliant with SA 4,5 • JD • Funding	BAPM action plan reviewed and escalated quarterly Safe staffing reports quarterly - workforce KPIs detailed within report	Recruit to vacancies timely Identify funding to meet BAPM standards (medical)	Director of midwifery Clinical Director	Funding	No mitigation available

guidelines/ Outside of NICE						

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

Job Description and organisation chart demonstrates that DOM reports to Executive Director and Chief Nurse.
All roles outlined in the manifesto are in post and confirmed via LMNS insight visits and recorded on the regional heatmap.

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
See Appendix 2 Powerpoint presentation. Template attached to every guideline. GAP analysis dashboard maintained for tracking of which guidelines have been assessed.	Within a 3-year period all guidelines will have been reviewed and therefore all compliant. All guidelines are reviewed prior through a two-layer approval system and any	Template attachment to beginning of guideline – monitored via maternity guideline group which reports into maternity governance.	None	N/A	N/A	N/A

Questions are displayed below	guidelines not following national guidance is discussed in detail and documented within the cover sheet.					

Ockenden Maternity Guidelines Assessment

1. Is there National Guidance Available for this guideline?
(Yes/No – specify source e.g. NICE, RCOG)

2. National Guidance used to inform guideline
(List guidance references – NICE / RCOG / other)

3. Does the guideline follow National Guidance if available?
(Yes/No)

4. If no, what rationale has been used?
(Explain deviation)

5. If no national guidance available OR not followed, what evidence has been used to inform guideline?
(List evidence sources)

Appendices

Appendix 1 Ockenden Assurance Template May 23 – March 25	Ockenden Assurance Template
Appendix 2 Process of benchmarking guidelines against NICE / Evidence	National Guidance Process for Maternit

Skipton House
80 London Road
London
SE1 6LH

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21 December 2020**. The priorities are:

1) **Enhanced Safety**
   a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
   b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
   b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) **Staff Training and working together**
   a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
   b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
   c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) **Managing complex pregnancy**
   a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
   b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) **Risk Assessment throughout pregnancy**
   a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) **Monitoring Fetal Wellbeing**
   a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) **Informed Consent**
   a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by **31 January 2021** confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, **by 21 December**. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which will be published shortly and draws together elements including:

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) compliance against the CNST safety actions, and
4) a current workforce gap analysis

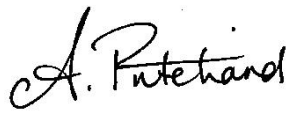
Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15 January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely



Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

Ruth May
Chief Nursing Officer, England

Professor Steve Powis

National Medical Director

NHS England and NHS Improvement

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

		system and trust level?				

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

requirements of IEA 4?						

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

NHS England

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. **NHS Premises Assurance Model (PAM)** (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. **Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services** (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. **Insightful provider board guide** (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)
The full text of these recommendations can be found in the Phase 2 Report (pp.264-265).
Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).
Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)
The full text of these recommendations can be found in the Phase 2 Report (p.265).
Supporting guidance
Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
The Insightful provider board guide (see entry 3 in Annex 1).
Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the Phase 2 Report (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Public Trust Board
Date of Meeting:	14th July 2026
Title of Report:	Lord Mann Review: NHS England Requirements and Trust Response
Lead Executive Director:	Chief People Officer
Author:	Ali Koeltgen, Chief People Officer
Reporting Route:	Trust Board
Enclosures included with this report:	Appendix 1: NHS England letter, Lord Mann Review and required actions, 4 June 2026
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report updates the Board on the Lord Mann Review into antisemitism and other forms of racism in the NHS, the actions requested by NHS England, and the Trust's current position. It provides assurance on work already underway through the Trust's Anti-Racism Charter, WRES reporting, EDI governance, staff experience work and Board oversight arrangements.

Recommended Actions required by Board or Committee

The Board is asked to:

- Note the publication of the Lord Mann Review and the NHS England requirements issued on 4 June 2026.
- Note the strong alignment between the Review recommendations and the Trust's existing Anti-Racism Charter commitments.
- Support completion of the required organisational response to NHS England by 31 July 2026.
- Agree to receive a further update on implementation and any further actions identified through the self-assessment process.

Executive Director Opinion[1]

The Lord Mann Review is a significant national report for NHS organisations. It is evident that racism, antisemitism, Islamophobia, anti-Muslim hostility and all forms of discrimination affect both staff and patients. This is therefore a matter of culture, inclusion, workforce experience and patient safety.

The Trust has already made clear commitments through its Anti-Racism Charter and associated programme of work. The next step is to complete a formal self-assessment against the Review recommendations, confirm any further governance decisions required, and submit the organisational assurance response to NHS England by 31 July 2026.

Wells,Jo
09/07/2026 16:01:26

[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.

1.0 Introduction

On 4 June 2026, NHS England issued a letter from Sir Jim Mackey, Chief Executive, and Danny Mortimer, Director General for People, following publication of the Lord Mann Review into antisemitism and other forms of racism in the NHS. The letter asks NHS organisations to demonstrate local action and provide an organisational response to confirm the adoption of key definitions by 31 July 2026.

The Review concludes that racism, antisemitism, Islamophobia, anti-Muslim hostility and other forms of discrimination continue to affect staff and patient experience across the NHS. It calls for stronger leadership accountability, clearer organisational standards, improved staff protection, mandatory education and training, better use of data, and more consistent action by employers.

This paper provides an overview of the key requirements arising from the Review, assurance on actions already underway within Worcestershire Acute Hospitals NHS Trust, and confirmation of the Trusts response to NHS England.

2.0 Background

The Lord Mann Review was commissioned to examine how the NHS, NHS employers and healthcare regulators recognise, report and respond to antisemitism and other forms of racism. The Government has accepted the Review's recommendations and NHS England has set out expectations for provider organisations.

- Adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles.
- Strengthened Board accountability and oversight.
- Implementation of forthcoming NHS Staff Standards.
- Consideration and adoption of relevant national definitions, including the Government definition of anti-Muslim hostility.
- Delivery of mandatory equality, diversity and human rights learning, with additional anti-racism content when issued nationally.
- Enhanced action to prevent and respond to racism and discrimination.
- Greater use of workforce and patient data to identify and address inequalities.
- Clear communication and engagement with staff, patients and communities.

The Trust is required to submit its response to NHS England by 31 July 2026 to confirm adoption of the recommended definitions for antisemitism, Islamophobia, anti-Muslim hostility.

3.0 Key Messages for the Trust Board

Racism is a staff and patient safety issue. Discrimination affects wellbeing, confidence, inclusion, retention and staff experience. It can also affect patient trust, access, experience and quality of care. Tackling racism is therefore integral to safe, compassionate and inclusive care.

Antisemitism must be addressed alongside all forms of racism. The Review is clear that antisemitism should be recognised and tackled as a form of racism. NHS organisations are expected to take a balanced and inclusive approach that addresses antisemitism, Islamophobia, anti-Muslim hostility and all forms of racial discrimination.

Leadership accountability is essential. The Review places strong emphasis on visible leadership, Board ownership and organisational accountability. Boards are expected to understand local data, monitor progress and ensure action is taken where inequalities exist.

4.0 WAHT Position and Board Oversight

The Trust has already taken significant action which aligns with many of the requirements of the Review. This includes the adoption of the Trust Anti-Racism Charter and anti-racism programme of work,

established WRES reporting, , mandatory Equality, Diversity and Human Rights learning, and regular Board oversight of EDI, staff experience and Freedom to Speak Up themes. Assurance regarding this work and staff experience is governed by the People and Culture Committee , with WRES and WDES reports being shared historically through the Foundation Group Board.

The Board receives regular updates relating to equality, diversity and inclusion, including the EDS22, WRES performance, Freedom to Speak Up themes and staff experience measures. These arrangements provide an existing mechanism for overseeing delivery against the Review recommendations.

4.1 Workforce Race Equality Standard

The Trust reviews and reports WRES data annually through to the People and Culture Committee and Trust Board. Workforce data is monitored to identify disparities in recruitment, career progression, disciplinary processes and staff experience.

4.2 Anti-Racism Programme

The Trust has established a structured programme of work, including leadership sponsorship, staff engagement through equality networks, awareness activity, review of workforce policies and practices, and continuous monitoring of staff experience indicators.

4.3 Learning and Development

The Trust currently delivers mandatory Equality, Diversity and Human Rights learning. The Trust will review and implement any additional national anti-racism training requirements when released by NHS England

5.0 High Level Gap Analysis Against NHS England Requirements

NHS England requirement	WAHT position
Adoption of NHS Race and Health Observatory Anti-Racism Principles	Broadly aligned through the Trust Anti-Racism Charter. Formal sign-up to be completed and publicised.
Violence Prevention and Reduction Standard	Currently monitored through Health and Safety Committee, stronger alignment to staff experience needed and alignment to new NHS staff standards.
Adoption of antisemitism definition	Adopted in EDI Policy from November 2025.
Adoption of anti-Muslim hostility definition	Policy under formal review to incorporate new term (ratification process in progress– July 2026)
NHS Staff Standards	Awaiting publication. The Trust will assess compliance and implement requirements.
Equality, Diversity and Human Rights training	Existing mandatory training programme in place.
National anti-racism training	The Trust will implement when nationally available.
Board anti-racism training	To be incorporated into the Board development programme when national materials are released.

Communication and engagement	Existing communication and engagement in place, including anti-racism charter working group, however opportunity to strengthen as work progresses.
Data review and Board oversight	Established WRES and workforce reporting arrangements are in place.

6.0 Next Steps

- Progress a more detailed self-assessment against the Lord Mann Review recommendations, with oversight through the People and Culture Committee.
- Confirm adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles.
- Ratification of revisions to the Trust EDI policy to include the definition of anti-Muslim hostility.
- Assess readiness for implementation of the forthcoming NHS Staff Standards.
- Develop any additional actions arising from identified gaps.
- Submit the required organisational assurance return to NHS England.

A further update will be provided to the Board via the People and Culture Committee escalation report as implementation progresses.

7.0 Recommendations

The Trust Board is asked to:

- Note the publication of the Lord Mann Review and the NHS England requirements.
- Note the significant alignment between the Review recommendations and the Trust's existing Anti-Racism Charter commitments.
- Support completion of the NHS England response by 31 July 2026.
- Receive a further update on implementation and any additional actions identified through the self-assessment process via P&CC Committee escalation reports.

Appendix 1 (in Additional Reading Pack)

NHS England Letter: Lord Mann Review and Required Actions, 4 June 2026

NHS England

To:
- NHS chief executives

cc.
- Chief people officers
- Chief nursing officers
- Medical directors
- Communications directors
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 June 2026

Dear colleagues,

Lord Mann Review

Today Lord Mann has published his review into tackling racism and antisemitism within the NHS with recommendations to support our shared goal of making our services safe for all patients, communities and colleagues.

Some of the events we see at home and abroad – not least of all the distressing events surrounding the death of Henry Nowak – can polarise opinions and harden division, going against the values that make the NHS what it is.

As the NHS, we can – and often do – create an environment where every person, patient or colleague feels treated with dignity, compassion and respect.

Today's review demonstrates that we are not achieving that consistently and as effectively as we should be. Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia), discrimination and inequality, and we all have much more to do.

These recommendations will help us strengthen the way we drive change, and our focus should be ensuring that we are a place of compassion, care and unity – not conflict or discrimination, every day, on every site, in every home we visit, in every shift. Achieving this requires us all to be honest about the challenges we face and take strong action to address them.

Lord Mann's review set out a range of recommendations for NHS England, NHS organisations and leaders, the Department of Health and Social Care, as well as arm's-length-bodies (ALBs) and regulators. Collectively, these measures aim to:

- strengthen leadership and accountability,
- improve understanding and capability through training and development,
- set clear expectations regarding political identifiers and inclusive practice,
- improve and standardise support and protection for staff who experience racism,
- improve the consistency, quality and application of data relating to racism.

As NHS England, we welcome the recommendations and we accept the recommendations for us in full. As an immediate set of actions, we will:

- sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles
- set clear Staff Standards relating to experience of racism
- support NHS improvement and assurance through the NHS Oversight Framework
- strengthen accountability for racial inclusion through our appraisals
- consult on adding Jewish and Sikh to NHS protected characteristic datasets
- develop bespoke eLearning for NHS PALS and complaints handlers
- ensure all NHS boards and system leaders complete regular anti-racism training

We also know the display of politicised badges and symbols has been a matter of debate and concern for staff and patients. We will complete engagement and publish the long-awaited national uniform guidance in short order.

Tackling all forms of racism within the NHS will require a joined-up, concerted effort at every level – we should all be acutely aware of the racial abuse and harassment our colleagues and patients are subject to. Our own staff surveys give clear voice to some of the unacceptable discrimination and abuse faced within our organisations. In addition, it is just as concerning when we see evidence of discrimination in our services or hear testimony from patients who have experienced unequal treatment or antisemitic or racial abuse when interacting with the NHS. We also know that we must better support staff when they experience racism in their interactions with the public.

We have set out a series of immediate actions we are asking you to take within your own organisations:

- To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.

- Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework.
- Prepare to implement the forthcoming NHS Staff Standards.
- Adopt the new government definition of anti-Muslim hostility.
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).
    - Ensure Board agreement to undertake new anti-racism training when it becomes available.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.
- Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

In addition, following on from our communications in October 2025, please can you confirm whether your organisation has adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility. Please respond to this request, once for each organisation, by Friday 31 July 2026.

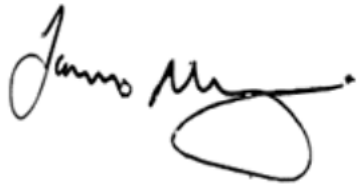
We know many organisations are already taking clear action, working in partnership with patients, community, trade unions and colleagues with lived experience – acknowledging and seeking to understand that experience is crucial to making the improvements we all want to see.

There are some fantastic examples of the work you are doing to tackle issues of racism and unequal access to services, and we'll work with you to share these widely across the system whilst encouraging you to use and support the delivery of the NHS equality, diversity and inclusion improvement plan.

Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace. The Lord Mann review gives us the opportunity to raise our standards and expectations about what we will accept and put our professional values –

care, compassion and clinical excellence first. It is part of every leader's role to actively begin to dismantle the structural discrimination which exists. We are grateful for your support in delivering the actions set out.

Yours sincerely,



Sir Jim Mackey
Chief Executive
NHS England

Danny Mortimer
Director General for People
NHS England

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 17 June 2026
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**Annual Report 2025/26**
Summary	The Committee reviewed the Annual Report and Annual Governance Statement for 2025/26. The report presented a balanced and candid account of a challenging year, including sustained operational pressures in urgent and emergency care and a year-end financial deficit. The latter was more significant than expected and as a result the Trust had been required by NHSE to set out its learning and improvement plans. This was reflected in the Annual Governance Statement. The Committee noted areas of progress, including improvements in elective recovery, strengthened financial controls, and continued development of governance arrangements. The Annual Governance Statement was considered consistent with both internal and external audit findings and reflected the Trust's systems of governance, risk management and internal control.
Outcome	The Committee: • Considered the Annual Report to be fair, balanced and understandable and consistent with the views of the Committee; • Confirmed that the Annual Governance Statement appropriately reflects the Trust's control environment; and • Recommended the Annual Report to the Board for approval.
Item/Topic	**Annual Accounts 2025/26**
Summary	The Committee reviewed the Annual Accounts for 2025/26, noting the Trust's reported deficit for the year and the challenges in achieving the breakeven duty. The changes made to the draft unaudited accounts previously reviewed were noted. The accounts were prepared in accordance with NHS requirements and were subject to external audit. The Committee noted the tightening liquidity position and the Section 30 referral arising from the breach of the breakeven requirement.
Outcome	The Committee: • Commended the finance team for finalising the accounts within tight timescales. • Noted the year-end financial position and associated risks • Took assurance from the external audit process that no material misstatements were identified • Recommended the Annual Accounts to the Board for approval subject to the final, confirmed audit position as below.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 17 June 2026
Report to: Trust Board

Item/Topic	External Audit Findings for year ending 31 March 2026
Summary	An unqualified audit opinion was issued on the financial statements, providing assurance that no material misstatements were identified. The majority of audit adjustments were minor, low-level disclosure or presentational matters. The external auditor reported continued improvement in the quality of working papers and constructive engagement from the finance team, with remaining issues considered isolated rather than systemic. Two matters were highlighted: • Revenue recognition for partially completed patient spells was confirmed as a judgemental, non-material issue. The Committee was satisfied with the Trust's accounting treatment, noting the issue in the context of the transition from block to activity-based payment arrangements. • Lease accounting remains subject to ongoing technical review. This was escalated as a significant unresolved issue due to the potential for material adjustment, rework across prior and current years, and possible implications for approval timelines or the audit opinion if not resolved. The Committee also noted the Section 30 referral to the Secretary of State arising from the breach of the Trust's break-even duty and the significant VFM findings (below).
Outcome	The Committee: • Took assurance from the unqualified audit opinion and the absence of material misstatements • Confirmed it was satisfied with the Trust's treatment of the non-material patient spells issue • Agreed to escalate the unresolved lease accounting matter to the Board, noting the potential impact on the financial statements, approval timeline and audit opinion • Noted the Section 30 referral arising from the breach of the break-even duty • Agreed to receive a future deep dive report on the relevant lease arrangement to support further scrutiny.
Item/Topic	**Management Letter of Representation**
Summary	The Committee considered the Management Letter of Representation, confirming that it reflects management's responsibilities in respect of the preparation of the financial statements and disclosure of relevant information to the external auditors. The Committee was satisfied that the representations made were appropriate and consistent with its understanding of the Trust's financial position and governance arrangements. A change might be required depending on the conclusion of the continuing review of the technical issue.
Outcome	The Committee: • Reviewed and supported the Management Letter of Representation; and • Recommended approval to the Board (subject to the above)
Item/Topic	**Auditor's Annual Report for year ending 31 March 2026**
Summary	The Committee considered the Auditor's Annual Report, which provides a wider assessment of the Trust's arrangements for securing economy, efficiency and effectiveness. The report highlights pressures in financial sustainability, operational performance and delivery of savings, consistent with other reports received by the Committee. Three significant weaknesses were highlighted. Two were continuations of weaknesses in previous years and the third was new: • Financial sustainability • Level of bank and agency spend (though noting the latter had reduced significantly) • Trust performance, particularly on UEC. Regarding the latter, the auditor acknowledged that improvement actions are underway; however, these are recent and not yet fully embedded, and therefore assurance remains limited for the year under review. Governance was rated green and the auditor was comfortable with the governance framework. However, there was a need to strengthen organisational grip, pace and execution, particularly in financially and operationally challenged areas.

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

Escalation and Assurance Report

Report from: Audit and Assurance Committee
Date of meeting: 17 June 2026
Report to: Trust Board

Outcome	The Committee: • Noted the seriousness of the findings of the Auditor's Annual Report; and • Confirmed that the key risks identified are aligned with the Trust's strategic and operational priorities. • Agreed to review the management responses in detail at the next meeting. • Agreed to review the financial governance arrangements to ensure they are as robust as possible.
Item/Topic	**Head of Internal Audit Opinion and Annual Report 2025/26 (final)**
Summary	The Committee received the final Head of Internal Audit Opinion (having received an earlier draft), which provides significant assurance over the Trust's governance, risk management and internal control arrangements. The Committee noted areas of limited assurance, including discharge processes and consent, and the ongoing development of the Board Assurance Framework. All high and medium actions were reported as delivered in-year. Two reviews from 2025/26 plan had not been concluded and had been transferred to the 2026/27 plan.
Outcome	The Committee: • Took assurance from the overall positive audit opinion. • Noted the areas requiring further improvement. • Was satisfied that management actions are being appropriately tracked and delivered.

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

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	14 July 2026
Title of Report:	Board Assurance Framework
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Company Secretary
Reporting Route:	Audit and Assurance Committee
Enclosures included with this report:	Board Assurance Framework
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

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

The attached Board Assurance Framework (BAF) comprises:

- A headline summary of all BAF risks
- The current Trust objectives to which the BAF risks are aligned.
- A risk heat map and a reminder of the Board risk appetite statement
- A separate summary of each BAF risk.

No significant changes to the BAF risks are proposed. Routine changes to each risk are shown in red font for ease.

Recommended Actions required by Board or Committee

The Board is asked to note and accept the BAF updates for assurance.

Executive Director Opinion[1]

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

The Audit and Assurance Committee will review the BAF prior to the Board meeting and consider its assurance regarding the effectiveness of the management of the risks and the BAF process.

[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.