Who we are

We are experts in healthcare services. Dedicated to improving the health of our population, we provide joined-up services with partners that meet everyone's needs, nearer to home.

NHS
Worcestershire Acute Hospitals
NHS Trust

Why we exist
Our Purpose

Helping people to live healthier, more fulfilling lives

What we do every day
Our Mission

Being the best team we can be for our patients, each other and our partners

Where we want to get to
Our Vision

Everyone is proud of the difference we make. We are more than a hospital, we bring care together for people

How we will get there
Strategic Priorities

By being better connected with what matters

People
Nurturing a culture people want to be a part of

Patients
Meeting the needs of our patients and communities

Collaboration
Building strong connections and pathways

Excellence
Focusing on continuous improvement

Effectiveness
Enhancing our efficiency and effectiveness

Guided by our Values

Being open and honest • Ensuring people feel cared for • Showing respect to everyone

Our Strategy 2025-30

Strategic Narrative- draft territories for development by May 25

HOW WE WILL GET THERE

Strategic Priorities

By being better connected with what matters

PEOPLE

Nurturing a culture people want to be a part of

- *Culture & values*
- *Staff basic needs*
- *People strategy*
- *People development*

PATIENTS

Meeting the needs of our patients and communities

- *Safe, high-quality care*
- *Home first*
- *Patient voice*
- *Patient experience*
- *Health inequalities*

COLLABORATION

Building strong connections and pathways

- *Within the trust*
- *Within the system*
- *Within community*
- *Across specialisms*
- *Prevention*

EXCELLENCE

Focusing on continuous improvement

- *Clinical best practice/R&I*
- *Tech and digital*
- *Sharing best practice*
- *Using data intelligence*
- *Population health*

EFFECTIVENESS

Enhancing our efficiency and effectiveness

- *Financial*
- *Governance*
- *Sustainability*
- *Buildings & infrastructure*

Strategic Narrative- *example* depiction of priorities

COLLABORATION

Building strong connections and pathways

Within the trust	Within the system	Within community	Across specialisms	Prevention
The outcomes we are working towards:	*The outcomes we are working towards:*	*The outcomes we are working towards:*	*The outcomes we are working towards:*	*The outcomes we are working towards:*
Key commitments for 2025:	*Key commitments for 2025:*	*Key commitments for 2025:*	*Key commitments for 2025:*	*Key commitments for 2025:*

Trust Strategic narrative- next steps

- Share the Trust Strategy document with staff, partners and our community.
- Allocate Executive Directors to each of the ‘pillars’ of Strategic Objectives
- Agree the detail of each Strategic Objective
- Use those objectives to guide delivery of the annual plan for 2025-26
- Build on the Trust Strategy by helping clinical teams create individual Clinical Strategies guided by the principles agreed today.

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Our Strategy 2025-30

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Minutes for Quality Governance Committee

Thursday 30th January 2025 at 10.00 am
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director (Chair)	**Y**
Required Attendees	Sarah Shingler	Chief Nursing Officer	**Y**
	Rachel Dunne	Deputy Chief Nursing Officer - ICB	**Y**
	Justine Jeffery	Director of Midwifery	**Y**
	Baylon Kamalarajan	Consultant Paediatrician and POSCU Lead	
	Chris Douglas	Interim Chief Operating Officer	**Apols**
	Simon Murphy	Non-Executive Director	**Y**
	Michelle Lynch	Associate Non-Executive Director	**Y**
	Edwin Mitchell	Associate Divisional Director - SCSD	
	Nicholas Purser	Surgery Governance Lead	**Y**
	Stephen Collman	Managing Director	**Apols**
	Alison Robinson	Deputy Chief Nursing Officer	**Y**
	Rosemary Smart	Public Patient Forum	**Y**
	Susan Smith	Deputy Chief Nursing Officer	
	Sue Sinclair	Associate Non-Executive Director	**Y**
	Jules Walton	Acting Chief Medical Officer	**Y**
	Jo Ringshall	Healthwatch	
	Gwenny Scott	Company Secretary	**Y**
	Tracey Cooper	IPC	**Apols**
	Rebecca Brown	Chief Digital Information Officer	**Y**
	Chrisy Bryne	Healthwatch	**Apols**
	Emma King	Deputy Director of Estates and Facilities	
Attending			
	Samantha Bucknall	EA to Sarah Shingler (minutes)	**Y**

Item	Title
QGC/25/1	**Welcome and Apologies for Absence**
	Dame Julie welcomed all present at the meeting. Apologies from Stephan Collman and Chris Bryne
QGC/25/2	**Declarations of Interest**
	There were no new declarations of interest raised.

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QGC/25/3	**Minutes of the last meeting**
	The minutes of the meeting held on the 28th of November 2024 were confirmed as a factual representation of the meeting and approved.
QGC/25/4	**Action Schedule**
	Progress on the outstanding actions were reviewed and updates received.
QGC/25/5	**Escalations from Chief Medical Officer and Nursing Officer for items outside of standard report / not on the agenda**
	Ms. Walton wanted to bring to the committee's attention the decision to pause open prostatectomies. During the ongoing review of the service, it is anticipated that this will not lead to any issues with waiting lists. Mitigations are in place, including the use of alternative providers and interim support, to ensure the continuation of care.
QGC/25/5.1	**Mandalite Update**
	Ms King reported on the Fire Safety Update. • August 2023: A letter of deficiency regarding the fire detection system was received. Following this, an interim fire risk assessment was conducted, and surveys revealed issues with the mandalite system and its implementation. • July 2024: A formal letter from the fire department advised that fire compartmentation should be classified as nil based on intrusive surveys. This was escalated to the Chief Operating Officer, and mitigation measures were put in place. The risk rating was increased to 20. The head of fire safety at NHSE was informed due to concerns raised by the fire service. • October 2024: A meeting was held with the fire service, where it was agreed their safety team would conduct further inquiries on-site. • November 2024: The fire service surveyed the ground and first floors of Hospital Street. Ms. King took over her role in December and took initial actions in response to significant concerns. RBL was re-employed as project manager. • December 2024: An update was given regarding fire alarm escalations. Initial enabling works on Hospital Street began and were signed off by the fire engineer. A contractor was onboarded to undertake these works. Processes for procuring a new authorising engineer and site caretaker to support incident response were initiated. Challenges continued with the installation of the fire detection system, managed by SSG. Ms. King confirmed the scope and input were fit for service, though issues with the contractors persisted. Additional internal patrols, staff safety awareness, fire audits, and a change to evacuation procedures were implemented. Ms. Moore asked if there were penalties for contractors failing to deliver. Ms. King confirmed there are no penalties, but payments would be withheld. Work was planned to finish by May to support the evacuation process, with potential for earlier completion. • January Update: A fire risk assessment was received, and notes were returned.

	The fire detection company was finally engaged, confirming that 40% of the system is L1 compliant, with 60% requiring further surveys. The audit from 2023 is still outstanding. Verbal information on enforcement was received on January 14, 2025. Ms. King assured the Board that a framework is being drafted to address these Ms. King discussed the potential delays from bringing a new team into play. Ms. Moore asked about the budget. Ms. King clarified that the initial enabling works were budgeted at £6.9 million to improve evacuation routes. Mr. Murphy asked about the fire detection survey in 2023. Ms. King explained she hadn't done a retrospective review and is currently focused on risk assessments and resolving existing issues. Ms. Smart raised concerns about the delay in escalating issues to the MD and whether serious issues in other areas would be escalated appropriately. Ms. King acknowledged the concern and stated that the process is being reviewed. Mr. Murphy asked if the KTC site was being investigated due to outstanding actions at AGH. Ms. King confirmed that a similar review is being conducted at KTC.
QGC/25/6	**Best Services**
QGC/25/6.1	**Perinatal Safety Report**
	Ms Jeffery reported that positive trends in KPIs for safety, with a 90% KPI achieved due to the ability for women to self-refer into services. Blood booking procedures are on track and where they should be. Mortality rates continue to be lower than the national average, though the stillbirth rate is contributing to the trend. Ms. Jeffery, with HR's support, will implement confirmatory challenges forward managers and matrons to ensure they receive the same support as midwives over the past 18 months. Training KPIs are now in the green and in a strong position, with optimism about meeting the requirements outlined in the new MIS scheme for Year 7. The main focus is now on mandatory training and PDRs (Personal Development Reviews). Ongoing work to recruit obstetricians, with interviews scheduled for a maternal medicine position. Sickness within the consultant group is decreasing. Positive developments with neonate consultants now meeting BAPM standards. The BAPM action plan will be updated and presented to the committee as part of the CNST evidence. BAPM compliance is still in progress. Improvements should be visible in Q4, with a sustained position currently.
	Resolved that: The report was noted for assurance.
QGC/25/6.1.2	**Perinatal Incident Report**
	Ms Jefferey stated no PSIs were reported. One unavoidable stillbirth occurred. The case involved a 31-week pregnant woman with known placenta previa who experienced significant antepartum haemorrhage at home. Upon arrival at the hospital, no foetal heartbeat was detected, and a stillbirth was confirmed. This case will be reviewed through the Perinatal Mortality Review Tool. One neonatal death occurred in a baby born at 28 weeks with heart block. Foetal medicine colleagues are involved for shared learning, and the case will also be reviewed through the Perinatal Mortality Review Tool and shared across regional and LMS colleagues. Two congenital abnormality births were reported. One involved a baby born with a forearm missing in a twin birth, and the family has been supported. There has been a reduction in open actions, which will remain a focus for the Directorate's PRMS.
	Resolved that: The report was noted for assurance.
QGC/25/6.1.3	**CNST Report MIS Year 6**

	Ms. Jeffery's Report on CNST Compliance and Evidence Ms. Jeffery informed the committee that all CNST evidence is stored in a separate folder within AdminControl, accessible for committee members to review. There are 10 safety actions within the scheme, covering 89 elements in total. Ms. Jeffery reported achieving in her opinion gold standard evidence for 88 of the 89 elements. The one area of weakness was identified in the Perinatal Mortality Review Tool. The recommendation is to submit compliance for 9 out of the 10 safety actions and provide additional evidence to assure that the 89th action has been met. The declaration will be taken to the trust board for sign-off and then submitted to the LMNS by the beginning of March.
	Resolved that: The report was noted for assurance.
QGC/25/6.1.4	**Midwifery Safe Staffing Report**
	Ms Jefferey reported that there is a seasonal increase in sickness within the midwifery team, primarily due to cold and flu. 16 midwives are set to be recruited in February. No red acuity days have been reported. There have been some internal escalations and staff movements, but no additional support from community teams has been necessary. Ms. Lynch inquired if the 16 recruits are internal or external. Ms. Jeffery confirmed that these are internal staff who have progressed from student midwives.
	Resolved that: The report was noted for assurance.
QGC/25/6.1.5	**Nursing Safe Staffing**
	Ms Shingler reported staffing levels are positive across paediatrics, neonates, and all adult inpatient areas, maintaining safe staffing levels throughout December. Avon One was opened on November 20th as part of the winter pressure plan. The PDU (Paediatric Department Unit) reopened and remains at full capacity. The Medical SDEC is now accommodating up to 8 patients overnight with golden discharges. These changing requirements have led to an increased need for temporary staff, which in turn is contributing to higher agency costs to maintain safety. The vacancy rate is at its lowest, standing at 2.6%, with further reductions expected next month. Ms. Shingler welcomed 21 RCN cadets, with over 50% of them being offered HCA roles, with the potential to progress into nursing roles. Ms. Moore asked whether nurses are trained in how to manage boarding. Ms. Shingler confirmed that the standard of treatment should remain the same, whether in a corridor or in an overcrowded department.
	Resolved that: The report would be presented at the next meeting.
QGC/25/6.1.6	**Safeguarding Report**
	Ms. Shingler assured the committee that the trust is meeting all legislative and statutory requirements related to safeguarding adults, children, and young people accessing services, as part of a review. A Non-Executive Director has joined the safeguarding committee. internal Audit will review safeguarding governance and compliance with national frameworks in March 25, as a review has not been undertaken for several years. Ms. Shingler reported high risks such as outdated Policies: A trajectory is in place to review and complete all outdated safeguarding policies. The transition from Oasis to PAS is being managed, and alerts are in hand. Safeguarding compliance issues with the medical workforce are being addressed with the divisions.

	Recruitment is underway for vacancies in the safeguarding team. Ms. Shingler highlighted the Protection of Premises Bill (Martins Law), which aligns with the Counter-Terrorism Strategy. The trust is tracking this, and no concerns have been raised. There is an increasing number of older patients declared homeless. The safeguarding team is working on earlier identification of these patients and addressing safeguarding issues. Ms Shingler noted a gap around assurances of DBS's the CMO and safeguarding governance team have taken action to address this, and it will be covered in the internal audit review. Ms. Walton confirmed that the complex care MDT (Multidisciplinary Team) has been instrumental in identifying complex patients and improving outcomes. Ms. Sinclair suggested that the Better Care Fund could be better utilized for homeless patients. Mr. Purser noted that many homeless patients refuse care home placements due to no-drink and no-drug policies in these homes. This usually relates to younger patients. **Action:** • Ms. Dunne is to report back to the committee regarding the trust's current position on care home beds, including how many are empty, whether funding from the Better Care Fund is available, and how it can be utilised.
	Resolved that: The report was noted.
QGC/25/6.1.7	**Medicines Optimisation Report & Controlled Drugs Report**
	Ms. Carruthers reported that the pharmacy workforce is improving and is hopeful that they will reach level 6 by Q3. E-learning for medicine management has been successfully implemented. Divisions now provide a monthly report, indicating the level of assurance within those reports. There was an increase in the number of reported medication incidents, but no new themes were identified. Additionally, the percentage of medication incidents causing harm also met the KPI for the three-month period. Assurance around SASH audits will be included in the Q4 report. Many senior positions within the pharmacy workforce have now been filled. The long-standing risk related to E-learning for medicines management was addressed, with implementation starting in December 2024. There has been improvement in anti-microbial stewardship, heading into Q3. Discussions are ongoing regarding the EPMA (Electronic Prescribing and Medicines Administration), and the project plan is being reviewed and shared. Ms. Sinclair enquired whether the team is seeing better divisional medical attendance at EPR meetings. Ms. Carruthers confirmed a plan for divisional engagement, including participation from medical, nursing, and other health professionals in EPR. **ACTION:** Ms. Brown asked whether the committee would like to see progress on planning documents related to EPMA deployment. The committee confirmed that this would be greatly appreciated. Ms. Walton offered assurance that the clinical teams are now more engaged, and momentum has been gained. Ms Carruthers presented Q2 Controlled Drugs Report. No escalations have been reported. However, there has been a significant increase in the number of incidents reported during the quarter.
	Resolved that: The report was noted for assurance.
QGC/25/6.1.8	**Patient Safety Incident Investigation (PSII Report)**

	Ms. Shingler shared learning from a recent PSI, which was also a coroner's case. The inquest, held on 12th December, concluded that the patient died of natural causes but developed sepsis from a deteriorating pressure ulcer while under ongoing care from health services. The coroner commended the report for being well-documented. The key findings from the case are being taken through ISAG (Incident and Safety Action Group). Some learning has emerged regarding how the pressure ulcer was managed. The patient was discharged to the reablement team, but the pressure ulcer was reported significantly worse than reported at admission. The wound was swabbed but labelled incorrectly, delaying antibiotic therapy. The patient's deterioration was not escalated to a GP. On re-admission, the patient's skin was not assessed, and a necrotic pressure ulcer was missed. Signs of sepsis were also missed. The patient subsequently developed pneumonia and showed further deterioration. Ms. Shingler confirmed that there is learning from this case. As a result, the GRAT process was immediately reviewed across both sites. Pressure areas are now checked upon ambulance arrival, and compliance with this is audited daily. Ms. Smart asked whether the GRAT nurse on re-admission checked the patient's history and previous admission notes. Ms. Shingler confirmed that this is not the role of the GRAT nurse at that point in the process. Ms. Smart enquired if medical cover would be in place during the holiday period to ensure proper medical oversight. Ms. Walton assured the committee that the medical workforce is ongoing. Mr. Purser discussed the need to change the strategy and system design. Ms. Walton assured the committee that a review of the clinical workforce is ongoing, with current work on End-of-Life Care.
QGC/25/6.1.9	**Emergency Department Quality & Safety Report**
	Ms. Shingler stated that this assurance report will be presented to the committee on a monthly basis. She explained that the report is based on the 12 fundamentals of care and outlines the efforts made by all divisions to support UEC Ms. Shingler confirmed that the ED team is working hard to maintain standards in the department despite current pressures. She also discussed the harm reviews included in the report. These reviews are conducted for every patient who has been on the back of an ambulance for 8 hours or longer, and they are signed off by the Chief Nursing Officer CNO or CMO team. Additionally, the report includes reviews for patients who have been in the department for 24 and 48 hours to assess whether any harm has been caused. The report also covers the number of TES spaces.
QGC/25/6/1.10	**Audiology Thematic Review**
	Ms. Walton informed the committee that the final report has now been approved. The report details the investigation into the circumstances, the investigation process, and the outcomes for the patients involved. Ms. Walton assured the committee that all patients involved in the review have now received the appropriate care. Ms. Walton highlighted that the team did exceptional work, and as a result, the Patient Safety Lead was invited to present at the National Patient Safety Conference on the trust's management of this case. Ms. Walton reported that the Bronze Incident Cell has now been stood down.
QGC/25/6.2	**Article 3 Human Rights Act**
	Ms. Shingler informed the committee that a review took place at WRH by the Head of the safeguarding team to look at compliance with Article 3 of the Human Rights

	Act, which includes maintaining dignity, respect, and preventing serious physical or psychological abuse in a healthcare setting. However, she confirmed that the review concluded we are not in breach of the Human Rights Act, providing assurance that we are doing everything possible to uphold these standards. While there are areas for improvement concerning privacy and dignity, the Director of Nursing for UEC is taking forward the recommendations, and some have already been actioned.
QGC/25/6.3	**Learning Disability Q3 Report**
	Ms. Shingler reported that the main risks identified in the Q3 report are related to the support provided by our learning disability specialist liaison nurse. Currently, we have less than one whole-time equivalent from the Health and Care Trust across our two sites. A review is underway to determine the appropriate level of support required. Ms. Shingler also mentioned that Oliver McGowan training had a 63% compliance rate in November, with an additional 12% improvement expected by the end of December. Furthermore, Ms. Shingler noted that the learning disability report highlighted several areas requiring improvement, but an action plan is already in place to address these issues.
QGC/25/7	**Best experience of Care and Best Outcomes for Patients**
QGC/25/7.1	**Learning from Deaths**
	Ms. Walton reported that mortality rates have remained stable, which is a positive indicator, but there are still cases that need attention, like the one related to electrolyte and fluid management. A case was highlighted regarding electrolyte and fluid management. A Regulation 28 was issued, which is a recommendation for improving care. This is being handled by the ISAG (Incident, Safety, and Audit Group). An outlier in a diagnostic group has been renormalised, which likely means they have adjusted the data or findings to better align with expected norms. The SJR process is under review. There is acknowledgment that the current process is not effective, and work is underway to improve it with input from the learning from death leaders. Changes in legislation regarding desertification came into effect in September 2024, which could impact healthcare policies or guidelines in areas affected by desertification. All Regulation 28s will be reviewed through ISAG, and there's a clear focus on closely monitoring these cases to ensure improvements are made.
QGC/25/7.2	**Research & Development**
	Ms. Walton highlighted that the research and innovation team is undertaking excellent work.
QGC/25/7.3	**Improving safety Action Group**
	Ms. Shingler has no further escalations to report, apart from those already discussed in today's meeting.
QGC/25/7.4	**Health & Safety Update**
	Ms. King informed the committee that the Q2 report is intended to provide assurance regarding our legal compliance, following the discussions in the Health and Safety Committee. She also confirmed that she will be taking over as the chair of the Health and Safety Committee.

QGC/25/7.5	**Management of PFI Contract: Delivery Suite Window Issue**
	Ms. King confirmed that temperature monitoring was initially reported in January 2024 but was not properly monitored until November 2024. She explained that the monitoring was not conducted in a controlled environment, as the room was still in use, and clinical teams had access to temperature controls to support patient care. To address this, additional temperature monitoring was set up in a room provided by the maternity team, which was not going to be used. The monitoring was installed in line with contract standards, placed 1.5 meters high in the middle of the room. Despite expectations that it would fail, the temperature reading came in at 20.8°C with the thermostat set to the midpoint. This suggested that raising the temperature by three degrees would meet the required standard. However, when monitoring was reset and repeated on December 19th and 20th, this time placed next to the resuscitaire in the cot where it needs to be, the temperature did not meet the required standards. This led to a challenging conversation with SPC. Ms. King informed the committee that a discussion with SPC resulted in an agreement with Equans to install secondary glazing to get through the winter, with a full window replacement planned for spring or summer. In summary, while the immediate issue has been resolved, Ms. King highlighted that there are still a number of long-standing issues to address, which will be discussed in upcoming workshops. If these issues are not resolved, formal notice will be given to negotiate, as stipulated in the contract. Ms. Moore and Ms. Sinclair expressed their gratitude to Ms. King for her commitment and the hard work she has put in since taking on her post.
QGC/25/7.6	**Medical Devices**
	Ms. King reported that she has reviewed the previous minutes and actions from the medical device's tracker. She stated that she feels assured by the technical services team and the contracts we have with Siemens regarding the management of our equipment. However, Ms. King expressed that her biggest concern is the training for both permanent and temporary clinical staff in relation to medical devices and other medical equipment. To address this, she has requested the formation of a dedicated task and finish group to review education, learning, and development in this area. While Ms. King noted that there has been an improvement in providing assurance, she acknowledged that significant improvements are still needed. This ongoing work is part of her broader governance review. Ms. Shingler informed the committee that a formal response was submitted to HSE within the required timescales in relation to two improvement notices served to the Trust and notification of contravention of Health and Safety Law following an investigation by the Health and Safety Executive (HSE) into a RIDDOR report regarding inoculation injury. there has been HSE assurance regarding two warning notices related to inoculation injuries, and a formal submission has been made. She also noted that the inoculation policy will be added to the risk register.
QGC/25/7.7	**Integrated Performance Report**
	Mr. Douglas reported that while risks remain around waiting times, progress is being made from an elective perspective. He informed the committee that most specialties across the divisions are on track to meet the 52-week wait target by the end of the year. He highlighted challenges in general surgery, ENT (which is a national regional challenge), and maxillofacial surgery. Additionally, there are concerns regarding patients waiting for corneal transplants.

	Mr. Douglas confirmed a small dip in the Faster Diagnosis Standard in December 2024, mainly due to staffing levels of histopathologists and pathology reporting turnaround times. However, the standard is still above the national target. He expressed concern about the 31-day and 62-day cancer treatment standards, particularly in terms of the time it takes for patients to see an oncologist before starting treatment. There are ongoing waiting list initiatives, and an additional locum is in place. However, there are longer-term plans being developed to address significant workforce challenges, with business cases currently going through internal governance. Another issue raised was around SARB treatment for lung cancer patients, which is being investigated by the SCSD division team. Mr. Douglas noted that skin cancer treatment remains a particular area of concern due to the lack of recovery in that service. Challenges are also present in gynae oncology, tertiary providers, delayed surgeries, and the provision of breast cancer services, specifically for patients undergoing DIEP surgery. The trust has been unable to secure additional support in this area, and this issue has been escalated to the ICB and the West Midlands Cancer Alliance, which plays a role in ensuring the appropriate tertiary support is in place. Overall, the number of patients waiting 65 or 104 days for treatment is decreasing. He discussed the challenges faced during the winter period, particularly with walk-ins and increased handover delays caused by an overcrowded ED. In response, a "pit stop" streaming system has been introduced for ambulances into SDEC. Mr. Douglas also mentioned the introduction of the "Executive of the Day" system and confirmed that the trust will be going into Tier 1, with a visit scheduled for 28th February 2025. Ms. Smart inquired about tracking the amount of time a patient waits in the back of an ambulance. Mr. Douglas confirmed that this is being tracked as part of the overall wait time in ED.
QGC/25/8	**Governance**
QGC/25/8.1	**Risks**
	Ms Shingler reported that there are 9 risks rated at 15 and above, which are included in the paper. Ms. Shingler raised her main concern regarding the need to vacate the space currently being used by the PDU, as it needs to be closed to prepare for the Cath lab. There has been a delay due to the ongoing use of the space, but conversations are underway to determine how to manage this situation moving forward.
QGC/25/8.2	**Clinical Effectiveness**
	Ms. Walton highlighted those 19 clinicians attended this month's meeting, indicating good progress. She reported one escalation from the group: typically, there has been strong compliance and engagement with national audits, often reporting 100% compliance. However, the number of national audits is increasing significantly, and the effectiveness lead raised a concern that there may not be sufficient resources to engage with all of them moving forward. This is a topic that will be discussed further within the group.
QGC/25/8.3	**GIRFT**
	Ms. Walton highlighted the good work being done and encouraged the committee's continued engagement. She also informed the committee that a new clinical lead has been appointed to the GIRFT programme.
QGC/25/9	**Committee Escalations**
	No escalations noted.

QGC/25/9.1	**Trust Board**
	Non
QGC/25/9.2	**Committee Escalations**
	No Escalations
QGC/25/10	**Any Other Business**
	No other Business
QGC/25/10.1	**Next Meeting Date 27th February 2025**
QGC/25/11	**Reflections on the meeting**
	Ms Moore thanked the committee for all the hard work being addressed and especially thanked Ms King for her contribution to the changes implemented and discussed today.
QGC/25/12	**Closed at 14:20**

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AUDIT AND ASSURANCE COMMITTEE

Minutes of the Meeting held on Thursday 9 January 2025 at 09.00am held via MS Teams

PRESENT:		
CHAIR:	Colin Horwath	Non-Executive Director
MEMBERS:	Simon Murphy	Non-Executive Director
	Tony Bramley	Non-Executive Director
IN ATTENDANCE:	Neil Cook	Chief Finance Officer
	Emma Masters	Internal Audit
	Lynne Walden	Associate Director of Finance (Financial Services & Coding)
	Paul Westwood	Counter Fraud
	Kristina Woodward	Internal Audit
	Gwenny Scott	Company Secretary
	Stephen Collman	Managing Director
	Zoe Thomas	External Audit
	Jules Walton	Acting Chief Medical Officer (for item 5/1/25)
APOLOGIES:	Leanne Hawkes	Internal Audit
	Karen Martin	Non-Executive Director

1/1/25 **WELCOME AND APOLOGIES FOR ABSENCE** **ACTION**

Mr Horwath welcomed all to the meeting. There were no further items of business identified.

2/1/25 **DECLARATIONS OF INTEREST**

There were no new declarations of interest. Declarations are available on the Trust's website.

3/1/25 **MINUTES OF MEETING HELD ON 14 NOVEMBER 2024**

The minutes of the meeting held on 14th November 2024 were approved.

4/1/25 **Matters Arising and Action Schedule**

The action schedule was reviewed and updates were noted.

5/1/25 **Bank & Agency and Job Planning Update**

Little progress was being made with job planning. A review of the process is underway. Ms Walton authorised all bank and agency requests but the process requires updating.
The actions put in place do not appear to be delivering.

The timescale for progress was queried. Ms Walton informed that at least 1 deputy should be in post soon to assist. The issue is a priority to address but there were challenges.

Mr Collman added that Michael Parr was to work closely with Ms Walton with priority areas.

Mr Horwath stated that the issue should be escalated to Trust Board.

Job Planning is progressing relatively well. A number of actions were modified recently and are now complete. Compliance is improving and now stood at 73%. A couple of hotspots remained such as urgent care, where the team were working with the Divisional Director.

Mr Horwath stated that it was appropriate that job planning is reviewed regularly at the People & Culture Committee. The potential financial impact of the over 12 PAs was queried. Mr Cook confirmed that it is included within financial reporting as a risk.

Internal Audit

6/2/25 **Progress Report**

The finance and payroll controls draft report had been issued.
UEC report had been responded to.
1 Terms of Reference for expenses had been issued.
An audit of pre-employment checks for doctors was underway.
Meetings were taking place with Executives and NEDs to discuss areas for next year's plan.

Page 3 of the report detailed the outturn and recommendation tracker, which had improved since the last meeting.
Appendix A outlined the Internal Audit Plan.
Appendix B was the ToR.
Appendix C detailed the KPIs and action tracker.

It was highlighted that there was now weak assurance rather than zero assurance. Management response within 10 days performance had dipped in Q3 and Q4. Ms Masters informed that this was due to an Executive Director leaving or changing. This year's plan is behind expectation, though it was hoped that the plan would still deliver, staff needed to be made available. A further update would be provided in April.

Mr Horwath summarised that there were no concerns and that a number of reports were in a planning and development phase.

Counter Fraud

7/1/25 **Counter Fraud Progress Report**

Mr Westwood informed that contracted performance exceeded plan due to referrals bought forward and the 8 received this year.
Minor recommendations had been made with procurement colleagues.

There were 2 open investigations which are progressing long term.
1 new investigation was reported, relating to private work. Information was being obtained but the individual has resigned from the Trust. An invoice will be sent in regard to earnings.

Page 8 of the report detailed the closed investigations.
A couple of minor investigations are underway which are likely to be closed.

Appendix A detailed benchmarking data.

Mr Murphy queried if there was a policy for due diligence of third party suppliers and a timeline. Mr Cook replied that he would discuss the matter with Mr Narwal. The checks are completed but there was no formal Standard Operating Procedure in place.

It was observed that planned and actual days was quite large and the plan for next year was queried. Mr Westwood informed that referrals to be addressed with Mr Cook and Ms Walden. Reviews took place on a case by case basis. 15 days of reactive work was reported in 2022/23 and 10 days in 2023/24.

A procurement review in next year's plan was encouraged.

The report was noted for assurance.

External Audit

8/1/25 **External Audit Progress Report**
External Audit would visit during February for initial planning interim work.
Planning was underway for a stocktake to take place at the end of March.

The report was noted.

9/1/25 **UEC Closure Report**
The report related to the UEC build and lessons learnt.
It was noted that the scheme was implemented during the pandemic, pressures at the front door, PFI and supplier issues all played a part.
The build costs were over optimistic.
Lack of project arrangements were in place. A Strategic Programme Group had now been created and stronger governance in place.
Cost leakage and PFI will still remain a challenge going forward.
Having the right professional support is required.
Revenue impact of the headcount was largely due to covid and the change of demand. 36 additional spaces had been created and ambulatory care hours extended.
Testing the market was underway for a VFM review.

Ms Masters informed that there is a robust internal audit response with evidence attached. A review of the actions and recommendations would take place.

Under resourcing and a lack of skill in estates was observed and going forward, it was recommended that the function is well resourced and well led. Mr Collman informed that a review of the structure had taken place and there was more assurance now than previously but agreed that there was a need to ensure that going forward there needed to be capacity and capability.

Mr Murphy stated that the short timeframe and budget was always going to be problematic and suggested that the report is presented to Private Trust Board.

There was a subsequent business case around revenue of staffing which had been shared with the ICB and is funded. There was confidence in the arrangement of SPG going forward.

Mr Horwath welcomed the helpful and insightful report and Committee received assurance that procedures and control mechanisms are now in place.

The report was noted.

10/1/25 **Accounts and Annual Report Timetable**
Draft accounts to be submitted on 25th April.
A meeting had been arranged on 23rd June to review accounts.
The annual report and annual accounts are submitted together.

The report was noted.

11/1/25 **Audit Committee Terms of Reference**
The ToR would be presented to the Foundation Group Board.
Minor changes were recommended to ensure that they were in line with the Code of Governance.

Mr Horwath welcomed a review of effectiveness at the end of the year.

12/2/25 **VFM Action Plan**
Responses to recommendations for VFM were outlined.
The evidence is being captured separately.
The Financial Strategy and alignment with the ICS strategy is still emerging.
The Trust was on track to achieve the plan this financial year.
Support had been strengthened with the introduction of the Financial Improvement Director.
There is expectation to align to a 3 year plan.

13/1/25 **Going Concern**
It was recommended that the Trust is still a Going Concern.
Cash is sufficient to ensure that creditors can be paid.

The Going Concern was approved.

For Information

14/1/25 **Any Other Business**
There was no other business.

15/1/25 **Committee Escalations**
UEC Closure Report
Progress on job planning and bank and agency.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**31/03/2025**
Title of Report:	Proposal for a PFI Exit Committee
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Choose an item.
If Other, provide details:	
Lead Chief Officer/Director:	**Stephen Collman, Managing Director**
Author:	Tony Bramley, Non-Executive Director
Documents covered by this report:	PFI Exit Committee Terms of Reference

1. Purpose of the report

To propose the establishment of a PFI Exit Committee to oversee preparations for exiting the PFI scheme on the Worcester Royal Hospital site at the end of its term in December 2031.

2. Recommendation(s)

To approve the draft terms of reference for the new Committee.

3. Chief Officer/Executive Director Opinion[1]

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

☐ ***Focus on Flow***	☐ ***Think/Act as a Lead Provider***
☐ ***Governance***	☐ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☒ ***Strategic 'Big Moves'***

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

Worcestershire Acute Hospitals NHS Trust

PFI Exit Committee

Terms of Reference

1.0 Purpose

1.1 The PFI Contract Expiry Committee is a formal sub-committee of the Board, formed to oversee the hand-back of the Worcester Royal Hospital PFI Contract to the Trust. The Committee will provide assurance to the Board on all issues related to PFI contract expiry but not replicating existing and ongoing PFI contract management arrangements. The committee will effectively form a project board for all issues related to PFI expiry.

1.2 The end of the PFI contract in 2031 is strategically important and a major risk for the organisation in terms of:

a) Ensuring a smooth process for contract hand back, ensuring continuity of service provision
b) Ensuring that assets are handed back in the appropriate condition at the end of the contract
c) Approving the future arrangements for the Worcester Royal Hospital facilities management post-PFI hand back.

1.3 To work closely with the Wye Valley Trust PFI Contract Expiry Committee to maximise the benefits of collaboration for both organisations.

2.0 Membership

2.1 Membership of the Committee will comprise:

- Up to 3 Non-Executive Directors
- Chief Operating Officer
- Director of Estates and Facilities
- Chief Clinical Strategy Officer
- Chief Finance Officer
- Foundation Group Financial Advisor or nominee
- Company Secretary

2.2 The Group can co-opt further members as need arises. This is likely to include the Trust's legal advisors, PFI advisors, regional and national NHS representatives including the IPA and PFU.

3.0 Attendance

3.1 It is expected that all members will attend every meeting. When a member is unable to attend a meeting their deputy or nominated deputy will attend on their behalf.

3.2 Other representatives may be asked to attend as required.

4.0 Chair

The Chair of the Committee will be a non-executive director of the WAHT Board

5.0 Secretary

The Secretary to the Committee shall be provided by WAHT and their duties in this respect will include:

a) Agreement of agenda with Chair
b) Ensuring accurate minutes are taken & keeping a record of matters arising and issues to be carried forward
c) Ensuring the agenda, papers, and corresponding minutes reflect confidential items.

6.0 Quorum

The quorum for the meeting shall consist of one half of the total membership, including a non-executive and executive director.

7.0 Frequency of Meetings

The Committee will meet quarterly until the completion of the PFI hand back.

8.0 Notice of Meetings

8.1 Unless otherwise agreed, notice of each meeting, including venue, time, date, agenda and supporting papers, shall be provided to members using AdminControl no later than five working days prior to the date of the meeting.

8.2 The Chair shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly

9.0 Minutes of Meetings & administration

9.1 The minutes of all meetings of the Committee shall be formally recorded by the WAHT Executive Assistant.

9.2 The Executive Assistant will also be responsible for the collation of reports for distribution via AdminControl.

10.0 Duties

10.1 The Committee is responsible for:

a) Oversight of the expiry of the PFI contract, considering issues that arise from the hand back process
b) To oversee the road map towards expiry and manage risk relating to the process
c) Responding to the issues highlighted by the Trust's condition survey and ensuring that the buildings are handed over in the appropriate condition
d) Responding to the IPA Health check of the Trust's hand back arrangements, ensuring that recommendations are implemented
e) Planning and implementation of the future contract arrangements for the facilities management of the Worcester Royal Hospital
f) Receive and provide support and advice on all matters related to PFI contract hand-back
g) Identify all risks and constraints associated with the project and establish a risk register for regular review and mitigation.
h) To oversee and make recommendations for the engagement of consultants, contractors and subject-matter experts required to successfully deliver the project, in accordance with Trust Standing Financial Instructions and finance policy
i) To decide upon any remedial actions required, both operational or contractual, to ensure the delivery of the project.
j) To propose short and long-term budget provision for the associated costs of preparing to exit the PFI and to monitor financial spend on the project and any revenue and capital consequences, providing reports to the Trust Board of any emerging financial risks.
k) To coordinate the production of regular delivery reports to the Trust Board to describe progress with the project and escalate any areas of concern that require support to remedy.
l) To work with the Wye Valley Trust PFI Contract Expiry Committee in order to: Share expertise; learn lessons; and (where appropriate) share resources, in order to maximise the benefits for both organisations.

11.0 Authority

11.1 Committee is a formal sub-committee of the Trust and will report back on a quarterly basis.

12.0 Review

13.1 The Terms of Reference shall be reviewed by member and approved by the Trust Board at regular intervals, but at least annually.

13.0 Approval

Date of approval: Approving Body:

Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
ATAIN	Avoidable Term Admissions into Neonatal Units
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CCOSMOS	CNST, CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2 and Saving Babies Lives
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
CNST	Clinical Negligence Scheme for Trusts
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council

HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
HIE	Hypoxic-Ischaemic Encephalopathy
HSE	Health & Safety Executive
HFMA	Healthcare Financial Management Association
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LAT	Looked After Team
LMNS	Local Maternity and Neonatal System
LocSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
MASD	Moisture Associated Skin Damage
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MEWS	Maternal Early Warning Scores
MCA	Mental Capacity Act
MCA	Maternity Care Assistant
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIS	Maternity Incentive Scheme
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MNSI	Maternity & Newborn Safety Investigations
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MSW	Maternity Support Worker
NEWS	National Early Warning Scores
NEWTT	Newborn Early Warning Trigger and Track
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NHSR	NHS Resolution
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
OBC	Outlined Business Case
OOC	Out Of County
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PID	Project Initiation Document

PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PMR	Perinatal Mortality Rate
PROMs	Patient Reported Outcome Measures
PROMPT	PRactical Obstetric Multi-Professional Training
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review
RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SDP	Single Delivery Plan (maternity)
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur