WALSALL HEALTHCARE NHS TRUST

TRUST BOARD MEETING TO BE HELD IN PUBLIC

WEDNESDAY 7 JUNE 2023

MEETING PACK B (READING ROOM)

Item 14.1

Walsall Healthcare
NHS Trust

Trust Board Report	
Meeting Date:	7 June 2023
Title of Report:	Chief Executive's Report
Action Requested:	**To receive and note.**
For the attention of the Board	
Assure	• Assurance relating to the appropriate activity of the Chief Executive Officer.
Advise	• None in this report.
Alert	• None in this report.
Author and Responsible Director Contact Details:	Tel: 01902 695950 Email: gayle.nightingale@nhs.net
	Links to Trust Strategic Aims & Objectives
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care d) Deliver the priorities within the National Elective Care Strategy e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care
Resource Implications:	None.
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Responsive: Well-led:**
Equality and Diversity Impact	None in this report.
Risks: BAF/ TRR	None in this report.
Risk: Appetite	None in this report.
Public or Private:	Public
Other formal bodies involved:	As detailed in the report.
References	As detailed in the report.

Walsall Healthcare
NHS Trust

NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Chief Executive Report to Board	
1.0	**Review**
	This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.
2.0	**Consultants**
	There has been three Consultant Appointments since I last reported: **General Surgery** Dr Syed Kabir **Emergency Medicine** Dr Waseem Hassan Dr Mohammed Aslam
3.0	**Policies and Strategies**
	Policies for April 2023 • Policies, Procedures and Guidelines – Quarter 1 Report • CP931 V4 - HIV Post Exposure Prophylaxis Policy • IP975 V3 - Middle East Respiratory Syndrome (MERS-COV) Policy • OP979 V3 - Management of External Agency Visits, Inspections, Accreditations and External Reports Policy • OP980 V6 - Security Policy • Trust Guidelines V4 - Genital Injuries in Children (previously known as the Accidental Genital Injuries in Children Guideline) • Standard Operating Procedure V2 - Emergency Marriage **Policies for May 2023** • Policies, Procedures and Guidelines - Quarter 2 Report • OP981 V6 - Safeguarding Patients and staff from Domestic Abuse • OP983 V2 - Safe and Effective Use of Bed Rails Policy
4.0	**Visits and Events**

	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • 20 March 2023 – participated in an NHS Providers Integration virtual workshop • 21 March 2023 – chaired the virtual West Midlands Cancer Alliance Board • 22 March 2023 - chaired the virtual Joint Staff Briefing • 23 March 2023 – participated in a virtual quarterly Black Country System Review meeting • 3 April 2023 - participated in the virtual Black Country Collaborative Executive Group meeting • 6 April 2023 - met with Pat Usher and Jane Wilson, Joint Staff -side Leads and participated in a virtual Walsall Council Overview and Health Scrutiny Committee • 11 April 2023 – met with the Chair, Vice Chair of the Walsall Health Scrutiny Panel Committee • 17 April 2023 - virtually met with Mark Axcell, Chief Executive – Integrated Care System (ICS) • 18 April 2023 – attended a ICS Financial 2023/24 Planning meeting • 19 April 2023 – attended Amanda Pritchard's – Chief Executive, NHS Leadership event • 20 April 2023 – chaired the virtual Joint Negotiating Committee (JNC) and participated in a virtual ICS Financial 2023/24 Planning meeting • 21 April 2023 – attended an NHS Urology Clinical Senate meeting for RWT/ WHT • 25 April 2023 – met with Suleman Jeewa, Freedom to Speak Up Guardian • 27 April 2023 – attended the Institute of Health and Social Care Management (IHSCM) National Conference • 28 April 2023 – undertook a site visit at the newly renovated Compton Hospice, Wolverhampton • 3 May 2023 – attended a West Midlands Cancer Alliance – Cancer Priorities and Future Delivery in the West Midlands Workshop • 4 May 2023 – attended a RWT/WHT – Joint Strategy Research Development session • 10 May 2023 – met with John Raftery, Interim Vice Chancellor – University of Wolverhampton and participated in a Walsall Proud Partnership meeting • 11 May 2023 – met with Val Ferguson, Freedom to Speak Up Guardian and participated in a virtual Local Negotiating Committee (LNC) • 12 May 2023 – hosted a visit from Lord Patrick Carter • 16 May 2023 – participated in a virtual NHS Assurance/Oversight meeting for WHT and RWT and participated in a Research Road show with Aston University. • 18 May 2023 - - participated in a virtual Joint Negotiating Committee (JNC). • 19 May 2023 – hosted a visit from Matthew Taylor, Chief Executive – NHS Confederation
5.0	**Board Matters**
	There were no Board Matters to report on.

Walsall Healthcare
NHS Trust

Trust Board Report	
Meeting Date:	7 June 2023
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 25 May 2023 – to note this was a virtual meeting
Action Requested:	**To receive and note.**
For the attention of the Board	
Assure	• None in this report.
Advise	• Matters discussed and reviewed at the most recent TMC.
Alert	• None in this report.
Author and Responsible Director Contact Details:	Tel: 01902 695950 Email: gayle.nightingale@nhs.net
	Links to Trust Strategic Aims & Objectives
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care d) Deliver the priorities within the National Elective Care Strategy e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care
Resource Implications:	As per the agenda item.
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None identified.
Risks: BAF/ TRR	None identified.
Risk: Appetite	None identified.
Public or Private:	Public.
Other formal bodies involved:	Executive Team Meetings, Staff Briefing
References	As per the agenda item.

Walsall Healthcare
NHS Trust

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Brief/Executive Report Details	
Executive Summary Title:	Chair's report of the Trust Management Committee (TMC) held on 27 April 2023 – to note this was a virtual meeting
1.0	**Key Current Issues/Topic Areas/ Innovation Items:**
	• Fostering Friendly Presentation – Walsall Council.
2.0	**Exception Reports**
	• There were none this month.
3.0	**Items to Note – all of the following reports were reviewed and noted in the meeting**
	CQC Fundamental Standards of Care Compliance Report • Director of Nursing Report • Midwifery Services Report • Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report • Divisional Quality and Governance Report – Surgery Report • Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report • Divisional Quality and Governance Report – Community Services Report • Integrated Quality Performance Report (IQPR) • Trust Financial Position (Revenue and Capital) - Month 1 Report
4.0	**Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting**
	• Care Quality Commission (CQC) Fundamental Standards of Care Compliance Report • Infection Prevention Report • Safeguarding Report • Patient Voice Annual Report • Contracting and Business Development Verbal Update • Walsall Together Report • Workforce Metrics Report • Black Country Collaborative Report • Quality Improvement Report • Sustainability and Green Plan Report • Research and Development Report • Fire Safety Annual Report • Property Management Report

	• Emergency Planning, Resilience and Restoration (EPRR) Report • Covid-19 Recovery Plan Report • Corporate Risk Register Heat Map Report • Quality Account Report • Cyber Security Report
5.0	**Business Cases – approved**
	• There were no Business Cases presented this month.
6.0	**Policies approved**
	• Policies, Procedures and Guidelines - Quarter 2 Report • OP981 V6 - Safeguarding Patients and staff from Domestic Abuse • OP983 V2 - Safe and Effective Use of Bed Rails Policy
7.0	**Other items discussed**
	There were none this month.

Walsall Healthcare
NHS Trust

Trust Board Report

Meeting Date:	7 June 2023
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 27 April 2023 – to note this was a virtual meeting
Action Requested:	**To receive and note.**
For the attention of the Board	
Assure	• None in this report.
Advise	• Matters discussed and reviewed at the most recent TMC.
Alert	• None in this report.
Author and Responsible Director Contact Details:	Tel: 01902 695950 Email: gayle.nightingale@nhs.net
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Resource Implications:	As per the agenda item.
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None identified.
Risks: BAF/ TRR	None identified.
Risk: Appetite	None identified.
Public or Private:	Public.
Other formal bodies involved:	Executive Team Meetings, Staff Briefing
References	As per the agenda item.

Walsall Healthcare
NHS Trust

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Brief/Executive Report Details	
Executive Summary Title:	Chair's report of the Trust Management Committee (TMC) held on 27 April 2023 – to note this was a virtual meeting
1.0	**Key Current Issues/Topic Areas/ Innovation Items:**
	• Fostering Friendly Presentation – Walsall Council.
2.0	**Exception Reports**
	• There were none this month.
3.0	**Items to Note – all of the following reports were reviewed and noted in the meeting**
	• Director of Nursing Report • Midwifery Services Report • Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report • Divisional Quality and Governance Report – Surgery Report • Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report • Divisional Quality and Governance Report – Community Services Report • Integrated Quality Performance Report (IQPR) • Trust Financial Position (Revenue and Capital) - Month 12 Report
4.0	**Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting**
	• Infection Prevention Report • Patient Experience Report • Learning from Deaths Report • Seven Day Service Report • Patient Led Assessment of Care Environment (PLACE) Scores Report • Contracting and Business Development Verbal Update • Corporate Risk Register and Business Assurance Framework Report • Care Quality Commission (CQC) Action Plan Report • Walsall Together Report • Learning Management System Report
5.0	**Business Cases – approved**
	• Business Case for the funding of Replacement Endoscopy Stack Systems • Business Case for the Clinical Deployment of Emergency Preparedness and Resilience and Response (EPRR)

	• Business Case for Ockenden List of Priorities • Business Case for the Outpatients Improvement Programme • Business Case for Phase 3 of the Pharmacy Outpatients Development • Business Case for Ward 4 Nursing Establishment • Business Case for Frontline Digitalisation Programme • Business Case for Paediatric Nursing Establishment • Business Case for Endoscopy Capacity Suite Expansion • Business Case for Clinical Systems Team Staffing Establishment • Business Case for a 24 hr Phlebotomy Blood Culture Service • Business Case for Neurophysiology Capacity Staffing Establishment • Business Case for the Venous Thrombo Embolism (VTE) Service • Business Case for the Oncology Service • Business Case for the Clinical Fellowship Programme
6.0	**Policies approved**
	• Policies, Procedures and Guidelines - Quarter 1 Report • CP931 V4 - HIV Post Exposure Prophylaxis Policy • IP975 V3 - Middle East Respiratory Syndrome (MERS-COV) Policy • OP979 V3 - Management of External Agency Visits, Inspections, Accreditations and External Reports Policy • OP980 V6 - Security Policy • Trust Guidelines V4 - Genital Injuries in Children (previously known as the Accidental Genital Injuries in Children Guideline) • Standard Operating Procedure V2 - Emergency Marriage
7.0	**Other items discussed**
	There were none this month.

Item 14.3

Walsall Healthcare
NHS Trust

Trust Board Meeting	
Meeting Date:	Wednesday 7th June
Title of Report:	Black Country Provider Collaborative – Update Report
Action Requested:	Note the report
For the attention of the Board	
Assure	• A number of the executives (including the CEO) participated in the discussions around the next steps for the Provider Collaborative.
Advise	• The governance work to develop the Joint Committee and Scheme of Delegation will be presented to the Trust Board for approval prior to agreement
Alert	• Detailed work is underway to develop proposals for the corporate work programme
Author and Responsible Director Contact Details:	Simon Evans simon.evans8@nhs.net Group Chief Strategy Officer
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Prioritise the treatment of cancer patients b) Safe and responsive urgent and emergency care c) Deliver the priorities within the National Elective Care Strategy
Support our Colleagues	a) Improve overall staff engagement
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience
Resource Implications:	None as a result of this report.
CQC Domains	Safe: patients, staff and the public are protected from abuse and avoidable harm. Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Responsive: services are organised so that they meet people's needs. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	Health Equalities are considered are considered within the draft proposals.
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A

Walsall Healthcare
NHS Trust

Public or Private:	Public
Other formal bodies involved:	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Black Country Provider Collaborative – Update Report

The following are the key messages from the BC Provider Collaborative meeting May 2023.

1) New Collaborative work priorities (Outline Briefs)

The Collaborative Executive received Outline Briefs for a number of new work priority areas which include the following:

- BC Networked Service Solutions – *a general Outline Brief embracing all clinical fragile services for consideration in a phased way*
- BC Breast Radiology Alliance
- BC Reconstructive Plastics Surgery Unit
- Breast Unit Consolidation
- Centres of Excellence
- CQC
- Shared Consent Forms

Further discussions were held around assessment of fragile services and understanding the impact.

The Collaborative Executive were asked to discuss within their respective organisations and provide feedback to the BCPC Managing Director on the following:

- Provide feedback and comment on all of the Outline Briefs, and if appropriate how they may be strengthened
- Endorse the pursuit of all Outline Briefs
- Identify / confirm (nominate) leadership from the Collaborative Executive for each of the proposed priority areas (Outline Briefs)

An updated paper taking into account all feedback will be presented to the June Collaborative Executive meeting.

2) Colorectal – review of recent NBOCAP benchmarking

The Clinical Lead for the Colorectal Network recently presented a benchmark review of key clinical performance indicators from NBOCAP data. In short it highlighted no change (and at best very little movement) from a similar report conducted the year before. Some quality concerns have been identified and raised, with the BCPC CMO escalating the issue for discussion with all partner CMO's shortly.

The output of that discussion and resulting actions will be reported at the next Collaborative Executive in June.

3) Corporate Improvement Programme

The SRO for the Corporate Improvement Programme updated the Collaborative Executive (CE) on progress with the first three reviewed priorities as follows:

- HR – an Options Appraisal and updated position is scheduled to be brought forward to the June meeting of the CE
- Payroll – engagement with all partners is about to commence, with an Options Appraisal due to be presented at the June meeting of the CE
- Procurement – Further work is being finalised to bring a plan for agreement & execution to the June meeting of the Collaborative Executive.

As these three priority areas are well underway, and options being presented, it was suggested (and agreed in principle) that the next tranche of services for review be commenced. These are to include:

- Communications & Engagement
- Data, Digital & Technology
- Estates & Facilities

It is proposed that these commence imminently with an Options Appraisal for each of these three areas be presented in the early autumn (Sept / Oct time) with a final tranche (Legal & Governance, and Finance) commencing in early winter (around December / January time).

4) Governance (Collaboration Agreement & 'Joint Provider Committee')

The BCPC Managing Director gave an overview of work being undertaken to strengthen collaborative working across the four partners of the BCPC, through work on developing and establishing a 'Joint Provider Committee'.

A draft of two key documents has been shared with all four NHS Trust partners. They are:

- **Draft Collaboration Agreement (CA)** - This document is an agreement that sets out the 'legal framework' and various provisions that enable the establishment of the 'Joint Provider Committee'.
- Draft '**Joint Provider Committee'** (JPC) terms of reference. This sets out the specific details (Scope, membership, focus etc) for the JPC.

Both documents are 'work in progress' and all partners were asked to review and provide comment back to the BCPC Managing Director.

All comments will be reviewed and discussed with the Legal team, and a further (and hopefully) final draft of both documents will be presented to all organisation (with a cover Board paper) for review approval / sign off by early June.

5) Workforce – Bank rates

The workforce lead provided an update on the activities of the workforce, HR & OD workstream.

Agreement from the CE centred on the work around Bank Rates (aligning standard rates and aligning the rate for exceptional time limited enhancements). It was agreed to park the alignment of the standard

bank rates, however, it was agreed to support/align a £5 per hour for exceptional time limited enhancements.

Further work will continue in aligning Bank Rates for other bandings, and the issue of full implementation (as intended) will be revisited as the opportunity allows.

6) Surgical Robotics – update

The BCPC CMO provided a brief update on implementing the RAS. Both DGFT and SWBH have now received their Surgical Robots, with both sites now having undertaken clinical procedures successfully. Consequently, this stage of the work is now almost at a completion stage, with on-going training & education, together with the formal development of the 'Centres of Excellence' model now likely to be picked up in a subsequent stage.

7) NHS Partners – update from WM NHSE

The Deputy Director of Strategic Transformation, NHSE West Midlands shared some brief updates as follows:

- Maturity Matrix for Provider Collaboratives is now available. This is optional and not mandated but may provide some useful insights to support the BCPC in its on-going development / and strategic endeavours.
- The formal process of ICB to Provider delegations has been put on hold to 24/25. It was noted however, that in moving to the operating model scoping work will be commencing in the Black Country to support the development of a plan across the financial year of 23-24.

8) Presentation to NHS Providers

The BCPC Managing Director, CMO and SRO have been invited to present the Black Country Provider Collaborative experience at a number of national and regional events. This includes:

- The NHS Providers Workshop series. This has been recorded at available at the following link (shortly to be connected to the BCPC website)

  https://www.youtube.com/watch?v=w6A_uw76bTs&t=245s
- The NHS Confederation provider Collaborative workshop series
- Southwest Peninsula UAN
- Derbyshire ICB / Provider Collaborative
- BC ICS Health & Housing Training programme

Item 14.4

Walsall Healthcare NHS Trust

Walsall Healthcare Trust Board Meeting	
Meeting Date:	7th June 2023
Title of Report:	Care at Home Report: Activity in April 2023
Action Requested:	Note Contents
For the attention of the Board	
Assure	• ***Avoiding Hospital Admissions:*** Referrals were stable for services such as Care Navigation Centre, Rapid Response team and the Integrated Front Door service. • ***Virtual Wards:*** A range of pathways have been developed with the final virtual ward starting on 23rd January 2023. Since their inception the virtual wards have accepted 680 referrals for patients that have been stepped down from hospital • ***Medically Stable for Discharge:*** The level of patients awaiting discharge pathways 1-3 reduced to its lowest level since June 2021, at an average of 38 patients. The average length of stay whilst medically stable reduced to its lowest ever level of 2.5 days
Advise	• ***Virtual Wards:*** The adult virtual wards continued to offer 85 virtual beds covering respiratory, heart failure, palliative care, hospital at home and frailty pathways during April. Referrals into the service remained below the service capacity
Alert	• ***Intermediate Care Service:*** The sustained growth in demand for complex discharges and the implications for resourcing and mitigation plans in 2023/24 are still being considered by partners against a background of tighter funding. • ***Funding for out of hospital services:*** The funding allocation for 2023/24 has reduced further. The Trust and Walsall Together are revising service provision to match the allocated funding and prioritising those services to be reinstated as part of any surge capacity funds which may be released in the autumn. This will have a significant impact on services such as Integrated Front Door, Virtual Wards, Enhanced Care Home Support Team and Long Covid
Author and Responsible Director Contact Details:	Michelle McManus, Director of Transformation & Place Development Matthew Dodd, Director of Integration
	Links to Trust Strategic Aims & Objectives
Excel in the delivery of Care	**a) Embed a culture of learning and continuous improvement** b) Prioritise the treatment of cancer patients **c) Safe and responsive urgent and emergency care** d) Deliver the priorities within the National Elective Care Strategy e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standards

Improve the Healthcare of our Communities	**a) Develop a health inequalities strategy** b) Reduction in the carbon footprint of clinical services by 1 April 2025 **c) Deliver improvements at PLACE in the health of our communities**
Effective Collaboration	**a) Improve population health outcomes through provider collaborative** **b) Improve clinical service sustainability** **c) Implement technological solutions that improve patient experience** **d) Progress joint working across Wolverhampton and Walsall** e) **Facilitate research that improves the quality of care**
Resource Implications:	Bids have been submitted to NHSE around the development of virtual wards and hospital at home schemes related to the use of technology
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	The issue of health inequalities continues to receive growing prominence locally and nationally. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare.
Risks: BAF/ TRR	BAF Risk - Failure to deliver care closer to home and reduce health inequalities
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	WMBC ICB
References	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Walsall Healthcare NHS Trust

Brief/Executive Report Details	
Brief/Executive Summary Title:	Care at Home Report

Care at Home Executive Summary
April 2023

1. PURPOSE OF REPORT

This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain during April 2023.

Detailed discussions in these areas have been covered in the relevant Board Committees in previous months in addition to review by the Walsall Together Partnership Board.

2. BACKGROUND

Under the Communities strategic objective, WHT is the Host Provider for the integration of Walsall Together partners (formally established in April 2019), addressing health inequalities and delivering care closer to home.

The Health and Care Act (2022) formalised Integrated Care Systems (ICS) as legal entities with statutory powers and responsibilities. A key plank of ICS policy is that much of the activity to integrate care, improve population health and tackle inequalities will be driven by organisations collaborating over smaller geographies within ICSs referred to as 'places'.

WHT provides vehicle for governance by establishing a place-based Board (Walsall Together Partnership Board - WTPB) and management structure within the framework of its existing corporate structure. The WTPB has oversight of operational performance for community services.

3. PERFORMANCE, ASSURANCE AND RISK – COMMUNITY SERVICES

The key risks to community services and assurances around the level of service provision are included in **Appendix 1** and the Walsall Together Partnership Board members have been briefed on these risks in January.

The WT Partnership Management Team and WT Tactical Command continue to focus on the impact of operational performance and pressures on the citizens of Walsall and how it affects their health & well-being.

3.1 Demand: Demand for Community Locality Services and for non-elective acute community care remained stable during April.

3.2 Capacity:

Locality Teams: The Locality Community Teams delivered their highest amount of care at 6,608 hrs and met 97% of the demand in-month

Virtual Wards: The adult virtual wards continued to offer 85 virtual beds covering respiratory, heart failure, palliative care, hospital at home and frailty pathways during April. Referrals into the service remained below the service capacity. This is not unique to Walsall and across the ICB the Virtual Ward capacity remains underutilised. Plans to expand into step up care have been held due to the recovery actions required over funding levels which are identified in Section 4 below.

Discharge & Step-Up Pathways: The level of patients awaiting discharge pathways 1-3 reduced to its lowest level since June 2021, at an average of 38 patients. The average LOS as being medically fit reduced to its lowest ever level of 2.5 days. The central allocations for 2023/24 to fund discharge pathways are still being confirmed by the ICB, and in the meantime the joint planning and commissioning groups are considering options around demand management and outcomes for people with complex discharge needs.

4. Funding for out of hospital services:

The allocation of national funds via the Ageing Well, Service Development Fund and Community Infrastructure workstreams for 2023/24 was revised down in May. This has significantly exacerbated the shortfall that was previously notified to the Performance & Finance Committee in April. In response, WHT and partners are working on the following basis:

- Identifying the impacts on existing schemes and realigning/ceasing services to match the allocated funding. This will have a significant impact on services such as Integrated Front Door, Virtual Wards, Enhanced Care Home Support Team and Long Covid.
- Planning for and prioritising those services to be reinstated as part of (seasonal) surge capacity with any funds which may be released in the autumn

5. RISK REGISTER

The overall risk score on the Care at Home Board Assurance Framework (BAF) for the end of 2022/23 remains at level 8. All actions have now been completed, allowing for transfer of the Walsall Together element to be made across to a new BAF in line with the updated Trust strategy.

The following risk remains on the Corporate Risk Register at level 16:

- Risk 2370 – Delays in presentations for other, non-COVID, conditions may further exacerbate health inequalities and increase the risk of premature mortality.

Several mitigating actions are on track to be completed by the end of June, at which point the risk can be reassessed and is likely to be de-escalated.

6. PLACE-BASED PARTNERSHIP DEVELOPMENT

The ICB has approved an interim operating model for 2023/24, which includes the formal establishment of place-based commissioning arrangements. Delegation of responsibilities for services in scope will operate in shadow form for 2023/24 and place-based partnerships will be part of ongoing developmental work throughout the year to establish formal delegation in

advance of 1st April 2024. Each place-based partnership will receive £125k non-recurrent funding to support the continued development of place-based arrangements, a reduction of 50% on the funding received for the previous 2 years. This assumes that resources will be transferred from the ICB across to Place during the course of 2023/24, in proportion with the delegation of responsibilities.

Progress with establishing a partnership outcomes framework remains on track for review through partnership governance fora during June. This will support the transition to place-based arrangements, and potentially to population-based budgets. It will be used to finalise the high-level assurance metrics that will demonstrate how the partnership is delivering on the Trust strategic objective of *improving the health of our immediate communities*.

In May, we welcomed a visit from the CEO of NHS Confederation, alongside colleagues from One Wolverhampton. Partners from Walsall Council and whg presented alongside the Integration Director and Independent Chair on some of the key areas of success in Walsall Together. We have received excellent feedback about the work achieved and progress around our Outcomes Framework and governance arrangements. The Director of Transformation has since joined both the NHS Confederation Place Leaders Forum and a smaller advisory group that will shape the future of the place forum.

7. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.

APPENDICES

Appendix 1: Operational Performance Report for May 2023: Walsall Together

Walsall Together

Walsall Together Partnership Operational Update: May 2023

Matthew Dodd
Director of Integration

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

Tier	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services																				
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	6228.5	5210.5	5713.5	5495.25	6452.75	5871.5	5638	5688.25	5536	5784.25	6005	5957.75	6321	5589	6281.25	6608
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	860.50	920.00	1172.50	906.00	438.25	787.00	950.00	733.25	883.25	1043.25	622.75	643.25	377.25	370.25	390.25	188.00
	% of hours demand unmet	>23%	20%-23%	<20%	12.1%	15.0%	17.0%	14.2%	6.4%	11.8%	14.4%	11.4%	13.8%	15.28%	9.40%	9.74%	5.63%	6.21%	5.85%	2.77%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	26	23	25	25	26	28	27	27	26	30	31	22	30	24	29	12
	No. referrals received	<100	100-200	>200	25	24	22	19	30	39	25	29	24	17	26	11	26	15	19	17
	No. cases reviewed	<100	100-200	>200	108	89	117	83	102	142	129	107	110	86	90	68	82	68	87	61
Adult Social Care	1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	<100%		100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).				3.3%	3.3%	3.6%	3.8%	4.0%	3.9%	4.0%	4.0%	3.9%	3.9%	3.7%	3.7%	3.8%	3.8%	3.8%	
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).				84.9%	84.9%	85.1%	85.6%	85.7%	85.7%	85.5%	85.8%	85.5%	85.5%	85.3%	83.1%	83.6%	84.0%	84.3%	
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000	<9.1		>= 9.1	7.8	9.0	11.9	0.6	0.6	1.8	3.6	5.4	6.0	6.6	9.0	11.3	11.9	13.1	16.1	
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8	479.2	510.9	562.4	47.5	108.9	140.6	172.3	221.8	265.4	326.7	380.2	427.7	489.1	542.6	598.0	
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%	81.8%	80.4%	78.1%	84.6%	86.9%	79.3%	82.2%	77.7%	78.6%	77.2%	84.9%	79.4%	82.4%	89.2%	86.2%	
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				831	718	930	905	939	989	1063	1012	984	969	955	639	967	861	814	874
	Care and Support Assessments and 3 Conversations Completed - Total				296	429	316	280	327	358	285	355	297	352	357	283	316	352	356	243
	Monthly Adult contacts completed by Team				1,228	1,207	1,314	1,162	1,247	1,207	1,148	1,172	1,120	1,142	1,185	1,024	1,349	1,170	1,250	1,066

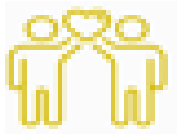
[Emergent] Score Card for WT Tiers – Tier 2 & 3

Walsall Together

Tier	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Tier 2: Specialist Community Services																				
ASC Safeguarding Concerns	Concerns received				291	336	323	284	381	354	322	388	338	321	342	308	375	355	321	303
	Concerns progressing to s42 eqnuiry				73	91	79	76	61	65	56	45	53	32	63	82	75	77	56	40
	% of concerns progressing to s42 enquiry				25%	27%	24%	27%	16%	18%	17%	12%	16%	10%	18%	27%	20%	22%	17%	13%
	Safeguarding cases in progress				34	86	63	80	84	129	97	120	82	97	99	36	44	70	52	58
Tier	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Tier 3 : Interimediate Care, Unplnanned Care & Crisis Services																				
Care Navigation Centre	Calls received	<435	435-512	>512	1225	1170	1338	1278	1270	1307	1323	1207	1171	1142	1310	1475	1463	1109	1232	1191
Rapid Response Team	Referrals received	<160	160-247	>247	260	254	294	281	294	242	277	245	250	285	307	339	313	245	325	269
	% admission avoidance	<73%	73%-87%	>87%	90.4%	91.3%	85.7%	91.9%	89.2%	98.0%	90.0%	90.2%	90.1%	90.2%	93.8%	90.3%	89.8%	88.6%	80.2%	83.3%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50-57.5	<50	48.00	45.88	52.67	50.28	46.40	50.10	54.10	52.10	51.30	50.59	49.17	50.53	52.40	41.50	42.40	38.00
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	3.4	3.5	3.8	4.3	4.0	4.0	4.0	4.6	4.6	4.0	3.4	3.5	2.7	2.8	2.6	2.5
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21-25	21<	32	26	28	28	27	25	27	26	27	25	34	27	31	32	30	31
	Domiciliary Pathways - Average service users				200.2	181.5	180.25	198.25	213.6	222.2	203.5	204.4	177	223.8	244.25	275.5	267.7	267.7	285	283.2
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	43	38	37	54	48	48	47	48	36	52	39	46	17	17	40	40
	Bed-based Pathways - Average beds in use				74	82.5	90	75	82	81	78	81	93.25	78	82	64	77.8	77.8	76.6	67.7
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	158	168	162	210	193	224	219	157	165	210	174	230	160	163	194	199
	Prevent Readmission	35<	35-50	>50	41	37	27	20	19	10	5	9	23	11	7	21	3	7	17	8
	Early Supported Discharge	40<	40-54	>54	35	44	45	29	31	48	85	49	52	61	40	55	54	57	28	43
	Assisted Discharge	35<	35-50	>50	54	40	35	56	68	76	44	74	86	82	109	99	63	59	64	34

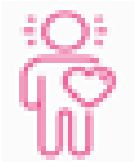
Tier 0 Resilient whg The H Factor Social Prescribing Programme .

332 Clever Conversations



51 sign up to the Social Prescribing programme

17 improving Warwick & Edinburgh Score

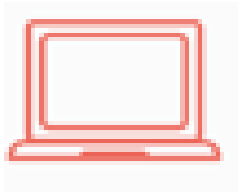


34 increased their confidence / self esteem

20 Referrals made to external support service Referrals

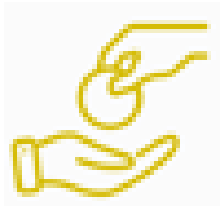
3 Completing training or education

24 Referral to whg Money Advice Service



7 Referrals to Clickstart Digital Support

15 Referrals for a fuel or Food voucher



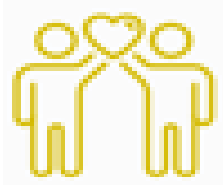
£377 requested from the Household Support Fund

9 Referral to whg Hardship Fund

December 2022

Tier 0 Resilient Communities Diabetes Matters

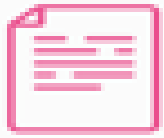
138 Clever Conversations



12 new customers were identified as needing support

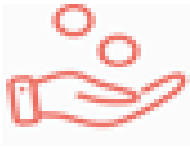
10 of these customers have completed sign up documentation with 2 still being supported and encouraged to engage

2 Hospital/GP appointments attended by the team



1 Medication review has been arranged by the team

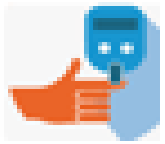
1 customer has reversed the blood sugar levels and is no longer considered diabetic



3 Referrals to whg Money Advice Service

3 Referrals to Aids and Adaptations

3 External Health Referrals made



2 Diabetes Pathway referrals made with customers needing specialised support who are not engaging with the diabetes pathway team.

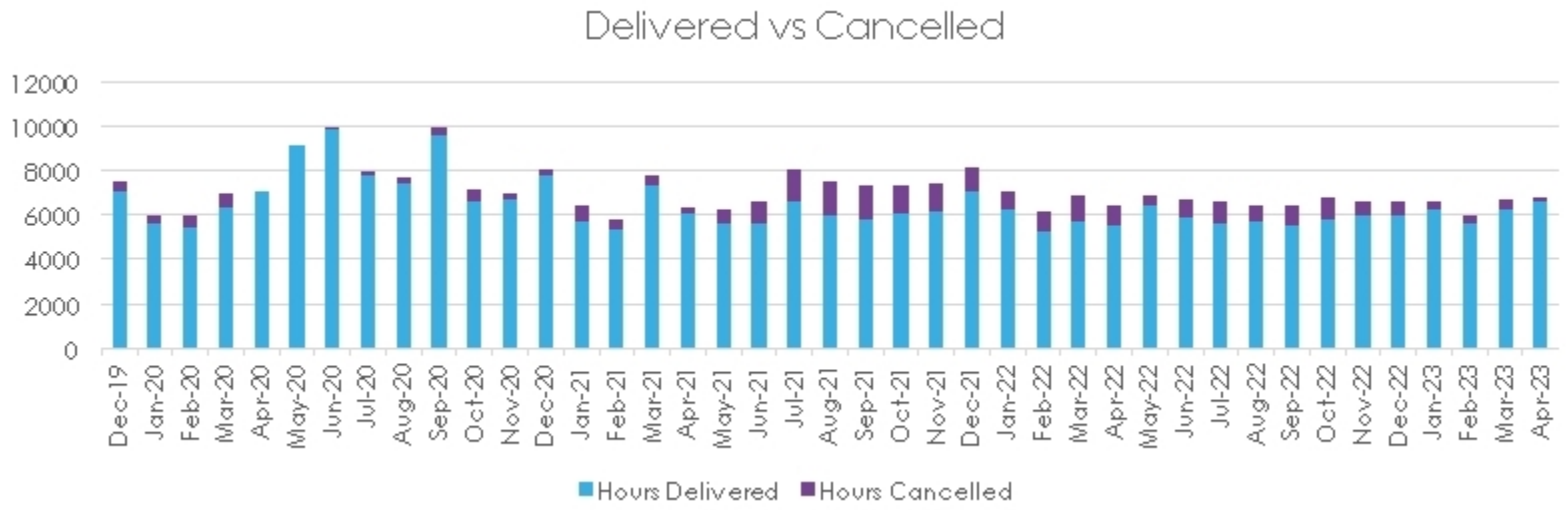
18 Community Events attended

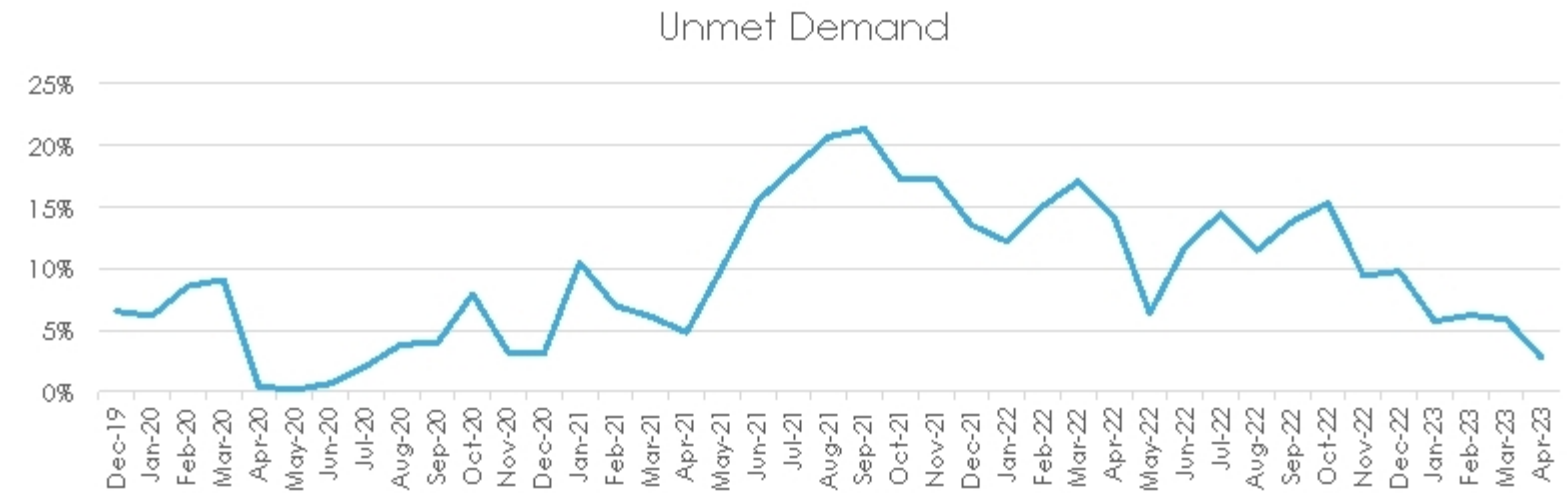
4 Community Organisations worked alongside

December 2022

Tier 1:

Community Nursing Capacity and Demand:





The Locality Teams delivered over 5,500 hours

Sickness absence increased during July impacting on the hours that the team were able to deliver.

Complexity of patients remains an issue and impacts on service delivery. During June, the Locality teams continued to see significant levels of complexity which included Palliative patients requiring syringe pumps and also complex social issues due to the late palliative diagnosis.

Additionally, complex wound care that required negative pressure and an influx in patients referred from the front door service and patients stepped down from the complex case managers.

These factors impacted on the number of hours that could be delivered and the number that were cancelled.

Last updated : May 2023

Tier 1: Primary Care Standard Operating Procedure (SOP)

- Primary care offering patients F2F appointments via patient choice, the appointment books are a blend of F2F, telephone calls and online offering

Current Pressures:

1. Access to appointments
    - LTC management backlog
    - Out patients backlog
    - Acute Covid appointments
2. Management of QoF and local commissioned services
3. Access to Out-patient services
4. Patient Demand
5. Zero Tolerance and abuse

Last updated on May 20212

Tier 1: Making Connections Walsall

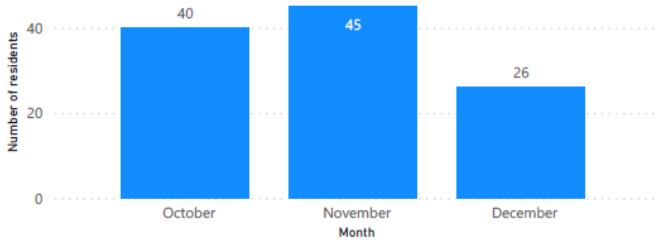
Making Connections Walsall - Client summary

Source: DCRS (Data Collection & Reporting Service)

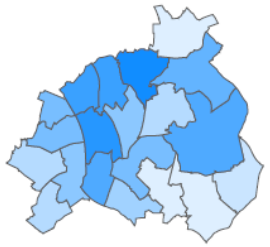
Referral date

01/10/2022 29/12/2022

Total residents



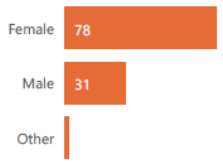
Electoral ward



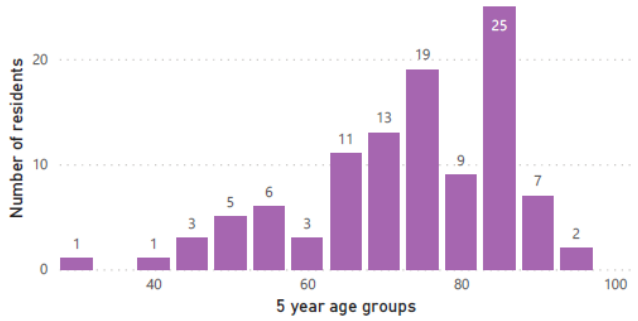
LSOA (Lower Super Output Area)

client_type	n	%
Making Connections	111	100.0%
Total	**111**	**100.0%**

Locality	n	%
East	34	30.6%
North	33	29.7%
West	23	20.7%
South	21	18.9%
Total	**111**	**100.0%**



Residents age



ethnicity	n	%
A: White _ British	79	71.2%
99: Not Known	14	12.6%
H: Asian or Asian British _ Indian	8	7.2%
Z: Not Stated	5	4.5%
B: White _ Irish	1	0.9%
G: Mixed _ Any Other Mixed Background	1	0.9%
I: Asian or Asian British _ Pakistani	1	0.9%
J: Asian / Asian British _ Pakistani	1	0.9%
N: Black / Black British _ African	1	0.9%
Total	**111**	**100.0%**

consider_themselves_disabled	n	%
Not disabled	54	48.6%
Disabled	33	29.7%
Not Known	24	21.6%
Total	**111**	**100.0%**

long_term_physical_health_condition	n	%
Yes	82	73.9%
Not stated	24	21.6%
Unknown	4	3.6%
No	1	0.9%
Total	**111**	**100.0%**

Total residents

111

Total contacts

342

Last updated - January 2023

Tier 1: Making Connections Walsall

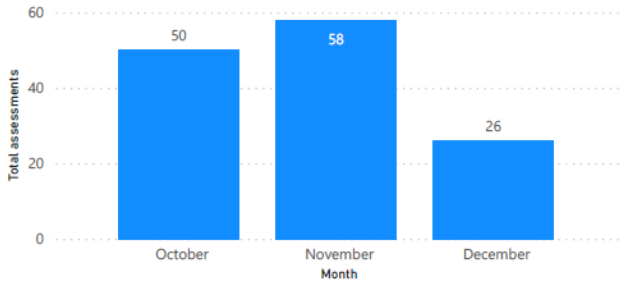
Making Connections Walsall - Assessment & Goals Summary

Source: DCRS (Data Collection & Reporting Service)

01/10/2022 21/12/2022

client_type
- COVID_19
- Making Connections

Assessments



Assessments 134

Locality_Name	n	%
East	30	22.4%
North	36	26.9%
South	29	21.6%
West	39	29.1%
Total	**134**	**100.0%**

local_issue	n	%
Not recorded	73	54.5%
Loneliness & isolation	51	38.1%
Emotional wellbeing	9	6.7%
Financial concerns	1	0.7%
Total	**134**	**100.0%**

referral_source	n	%
GP or other primary care services	65	48.5%
Local authority Services	44	32.8%
Community / voluntary services	10	7.5%
Self	7	5.2%
Intermediate care team	5	3.7%
Emotional wellbeing services	2	1.5%
Community & District Nursing	1	0.7%
Total	**134**	**100.0%**

employment_status	n	%
Retired	99	73.9%
Permanently Sick / Disabled	19	14.2%
Unemployed	9	6.7%
Response declined	4	3.0%
Employed: routine / manual	1	0.7%
Full time carer	1	0.7%
Temporary sick	1	0.7%
Total	**134**	**100.0%**

sign_off_reason	n	%
Not signed off	70	52.2%
Only wanted some information	21	15.7%
Not ready to make changes	11	8.2%
Could not contact client	9	6.7%
Other	8	6.0%
Signpost only	5	3.7%
Plan completed	4	3.0%
Chose an alternative service	3	2.2%
Client DNAs (Did not attend)	1	0.7%
Not eligible	1	0.7%
Plan part completed	1	0.7%
Total	**134**	**100.0%**

Goals 131

goal	n	%
Reduce anxiety/low mood	52	39.8%
Actions to enable goal achievement	30	23.1%
Connect more: Join a group	22	16.7%
Information required	13	10.1%
Be active: Find an enjoyable activity	8	6.0%
Build confidence/independence	3	2.3%
Learn something new: Take a course/Start new hobby	2	1.4%
Take more notice of the environment: Take time to enjoy the moment	1	0.6%
Total	**131**	**100.0%**

referral_to	n	%
Community / voluntary services	89	67.9%
Lifestyle change/support services	10	7.6%
Other (put details in 'Referral_other')	8	6.1%
Local authority services	7	5.4%
GP or other primary care services	5	3.8%
Emotional Wellbeing Services	4	3.1%
Advice and Guidance	2	1.5%
Citizens advice	2	1.5%
Lunch Club	2	1.5%
Bereavement Support	1	0.8%
Leisure activity	1	0.8%
Total	**131**	**100.0%**

Last updated - January 2023

Tier 1: Walsall Primary Care Mental Health Service (PCMHS) and Additional Role Reimbursement Scheme (ARRS) - Primary Care Mental Health Practitioners (PCMHP) May update

We had recruited 3 WTE of our 7 ARRS workers for year 1

ARRS Workers in Post

- West 2 – 0.4 WTE
- West 1 – 1 WTE
- East 1 – 0.6 WTE

ARRS workers due to start:

- South 2 -1 WTE

- Continuing with a rolling 3 month recruitment programme & we are working with workforce & development to explore initiatives to support recruitment due to lack of suitable candidates applying for the role

- Banding/NMP under review

- We have appointed a B5 to B6 Clinical Development Role with a view to preparing for B6 ARRS Worker/PCMH Nurse roles

Last updated : March 2023

PCMH Nurse PCN Alignment

- Due to the issues around recruiting to the ARRS roles we are moving forward to align PCMH nurses back with GP surgeries/PCNs
- We are returning back to F2F working offering telephone/video conferencing where this is patient preference and where indicated/appropriate
- The nurses have approached surgeries to determine room availability
- Where an ARRS workers is appointed the PCMH Nurse will receive referrals direct form the ARRS workers
- Number of referrals picking up again and coming through to the service

Last updated on April 2023

Tier 2:
Adult Social Care

ASC have received 303 concerns which a decrease in cases on the previous month.

The number of cases progressing to a s42 enquiry is lower to the previous period.

There are currently 40 opens S42 enquiries. This has been raised with managers to ensure the timely completion of enquiries which includes caused enquiries. Emphasis has also been placed on the need to inform people including referrers of outcomes following enquiries. This approach has caused a reduction.

Neglect & Psychological abuse remain the two highest categories of alleged abuse in this period.

Walsall Adult Social Care

Safeguarding concerns

Reporting period: 01/04/2023 30/04/2023

303
Concerns received

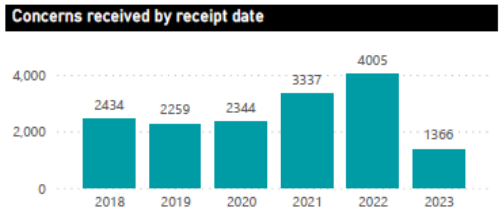
13.20
% leading to S42 enquiry

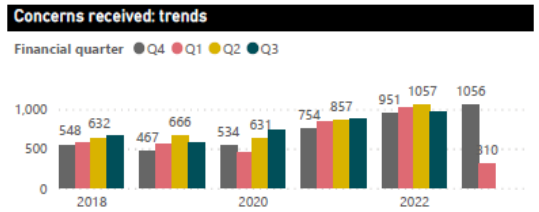
40
S42 enquiries

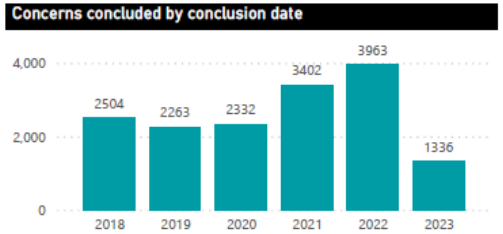
0
Non-S42 enquiries

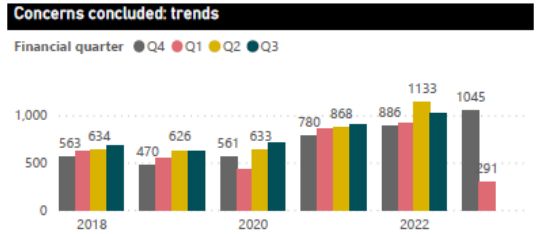
205
NFA

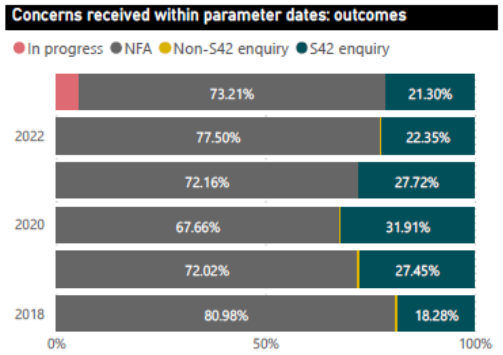
58
In progress

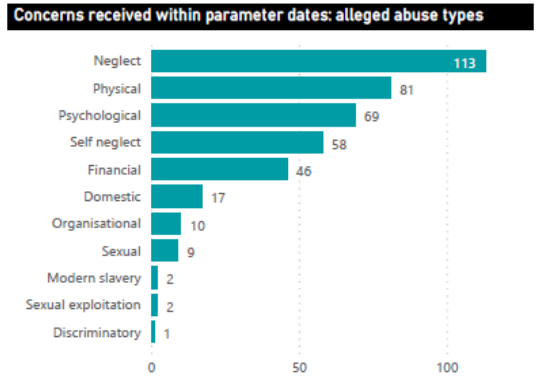












Last updated : May 2023

Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2022/23

Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	21/22 Result	April 22/23 Data	May 22/23 Data	June Q1 Data	July 22/23 Data	Aug 22/23 Data	Sept Q2 Data	Oct 22/23 Data	Nov 22/23 Data	Dec Q3 Data	Jan 22/23 Data	Feb 22/23 Data	Mar 22/23 Data	22/23 Target	Comments
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2183	2187	2181	2198	2197	2230	2234	2236	2270	2282	2270	2291	2275		
	AACM	1895	1951	1954	2045	2100	2188	2183	2187	2181	2198	2197	2230	2234	2236	2270	2282	2270	2291	2275		
	Jennie Pugh	91.3%	97.3%	98.4%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
1E: Proportion of adults **(aged 18-64)** with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	21	20	21	21	22	22	22	22	21	21	22	22	22	12	
	AACM	551	585	587	596	574	573	576	527	531	538	545	549	558	565	566	568	572	580	573		
	Jeanette Knapper	1.1%	1.7%	0.2%	1.2%	2.4%	3.3%	3.6%	3.8%	4.0%	3.9%	4.0%	4.0%	3.9%	3.9%	3.7%	3.7%	3.8%	3.8%	3.8%		
1G: Proportion of adults **(aged 18-64)** with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	490	451	455	461	466	471	477	483	483	472	478	487	483		
	AACM	551	585	587	596	574	573	576	527	531	538	545	549	558	565	566	568	572	580	573		
	Jeanette Knapper	85.8%	85.0%	86.0%	84.2%	86.1%	85.3%	85.1%	85.6%	85.7%	85.7%	85.5%	85.8%	85.5%	85.5%	85.3%	83.1%	83.6%	84.0%	84.3%	80.0%	
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	20	1	1	3	6	9	10	11	15	19	20	22	27	15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500		
	Jennie Pugh	4.4	6.8	13.4	6.0	14.5	10.8	11.9	0.6	0.6	1.8	3.6	5.4	6.0	6.6	9.0	11.3	11.9	13.1	16.1	9.1	
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	271	309	311	329	301	311	284	24	55	71	87	112	134	165	192	216	247	274	302	300	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	59500		
	Jennie Pugh	565.3	628.6	624.8	655.9	603.6	615.8	562.4	47.5	108.9	140.6	172.3	221.8	265.4	326.7	380.2	427.7	489.1	542.6	598.0		
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	79	93	106	96	111	115	125	88	96	85	89	115	106		
	Provider Services	317	130	266	73	91	125	103	110	122	121	135	148	159	114	113	107	108	129	123		
	TBC	80.1%	86.9%	82.7%	75.3%	83.5%	75.2%	78.1%	84.6%	86.9%	79.3%	82.2%	77.7%	78.6%	77.2%	84.9%	79.4%	82.4%	89.2%	86.2%	82.0%	

Tier 3:
Care Navigation Centre (CNC):

The CNC continued to receive a high level of referrals in July 2022.

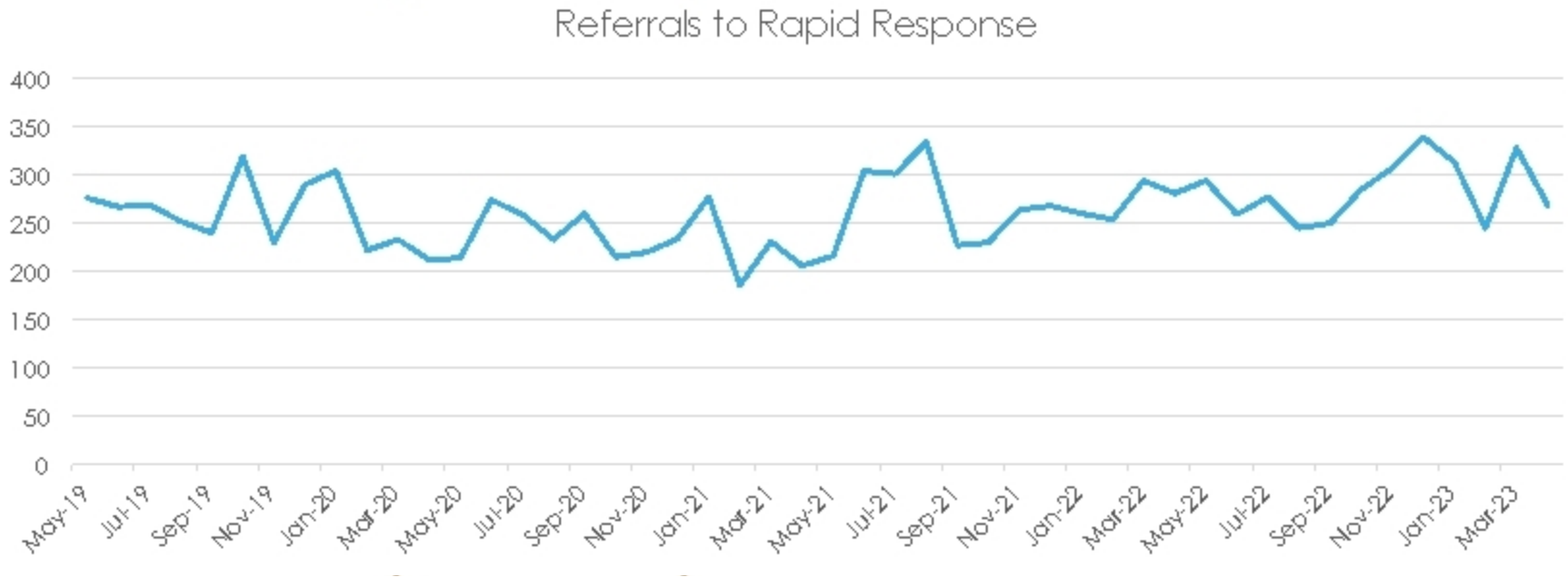
The expansion of capacity that has been embedded has enabled the CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

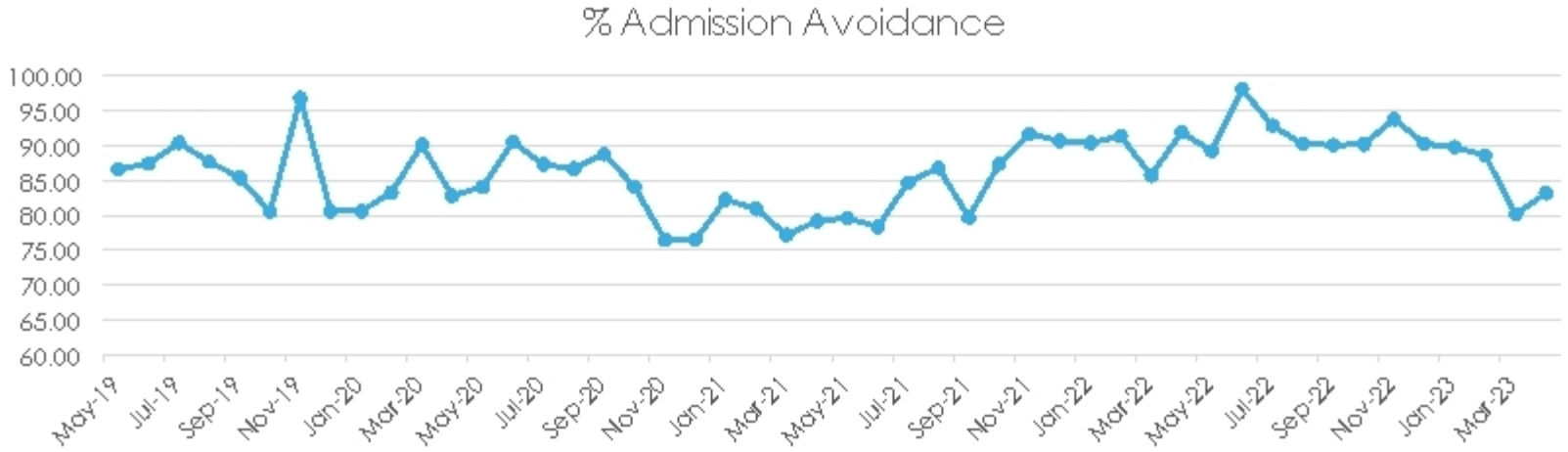
The high volume of calls are a result of the enhanced service that has been implemented. This includes a further expansion of CNC capacity, streaming patients directly from WMAS to Community pathways and services including a further strengthening of disposition pathways into Rapid Response and Integrated Front Door teams.

Additionally, a 999/111 SPA has been implemented through CNC for ED divert into FES, AEC, SACU and Gynae Early Pregnancy services. A direct push model from the WMAS CAD has been implemented so that more patients can be diverted into Community Services

Last updated : May 2023

Tier 3: Rapid Response



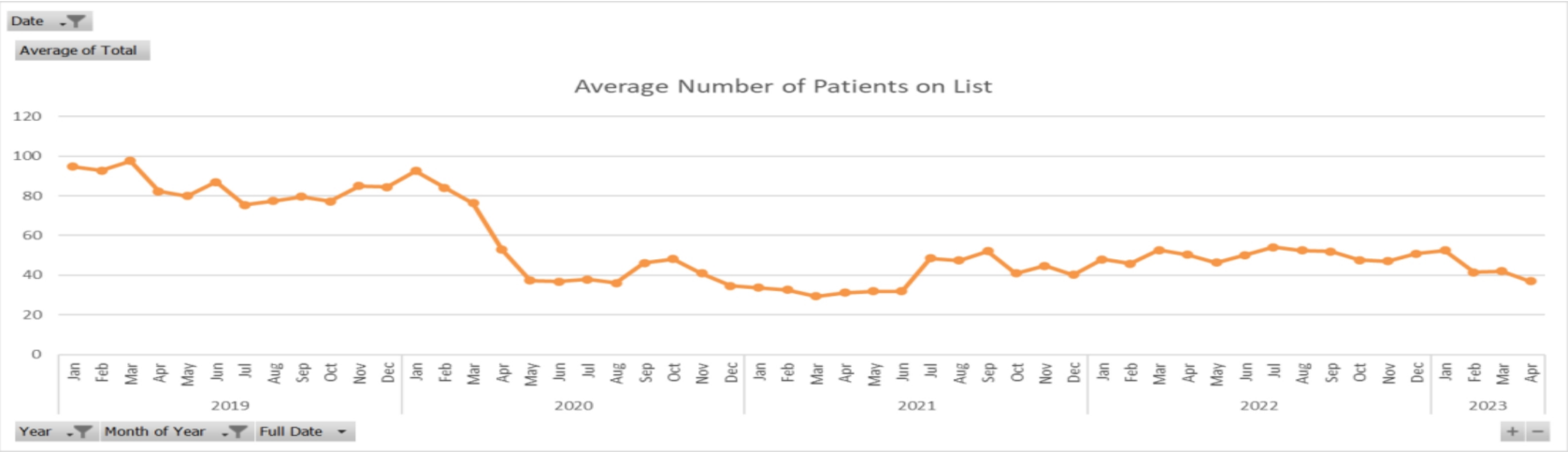


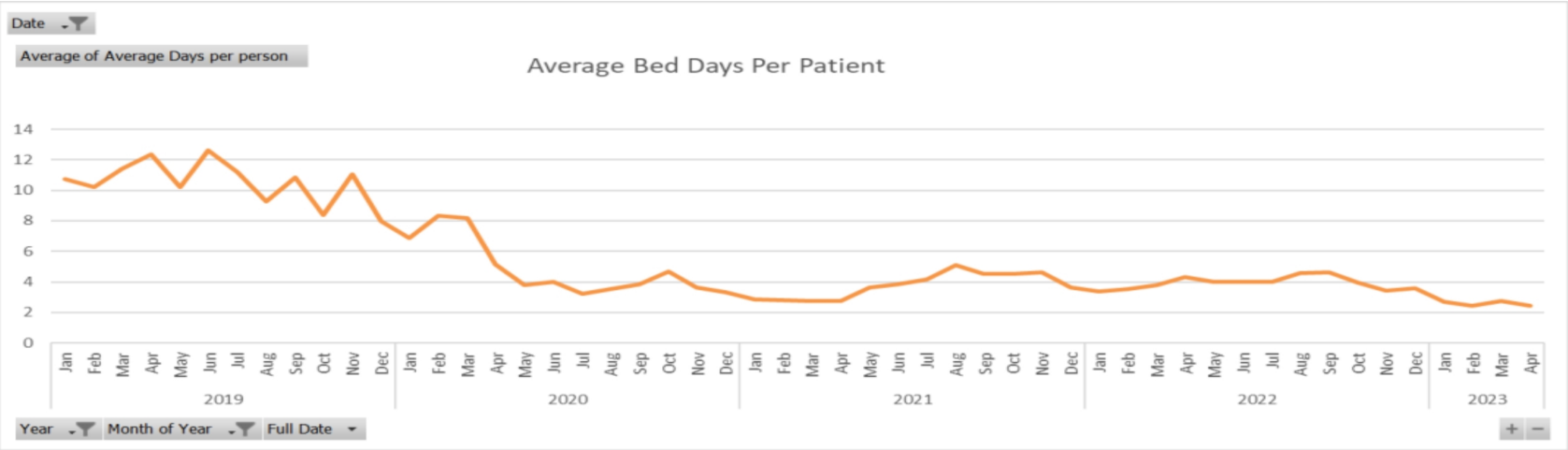
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present capacity of the service.

Plans to add more capacity and resilience for Rapid Response through Winter have been implemented in order to manage the increase in dispositions from WMAS and NHS 111.

Last updated : March 2023

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 38 patients during April 2023





The number of patients on the MSFD list averaged 55 patients during July 2022. This was due to high demand for the service. Despite the high numbers of patients, the average length of stay was maintained at 3.5 days.

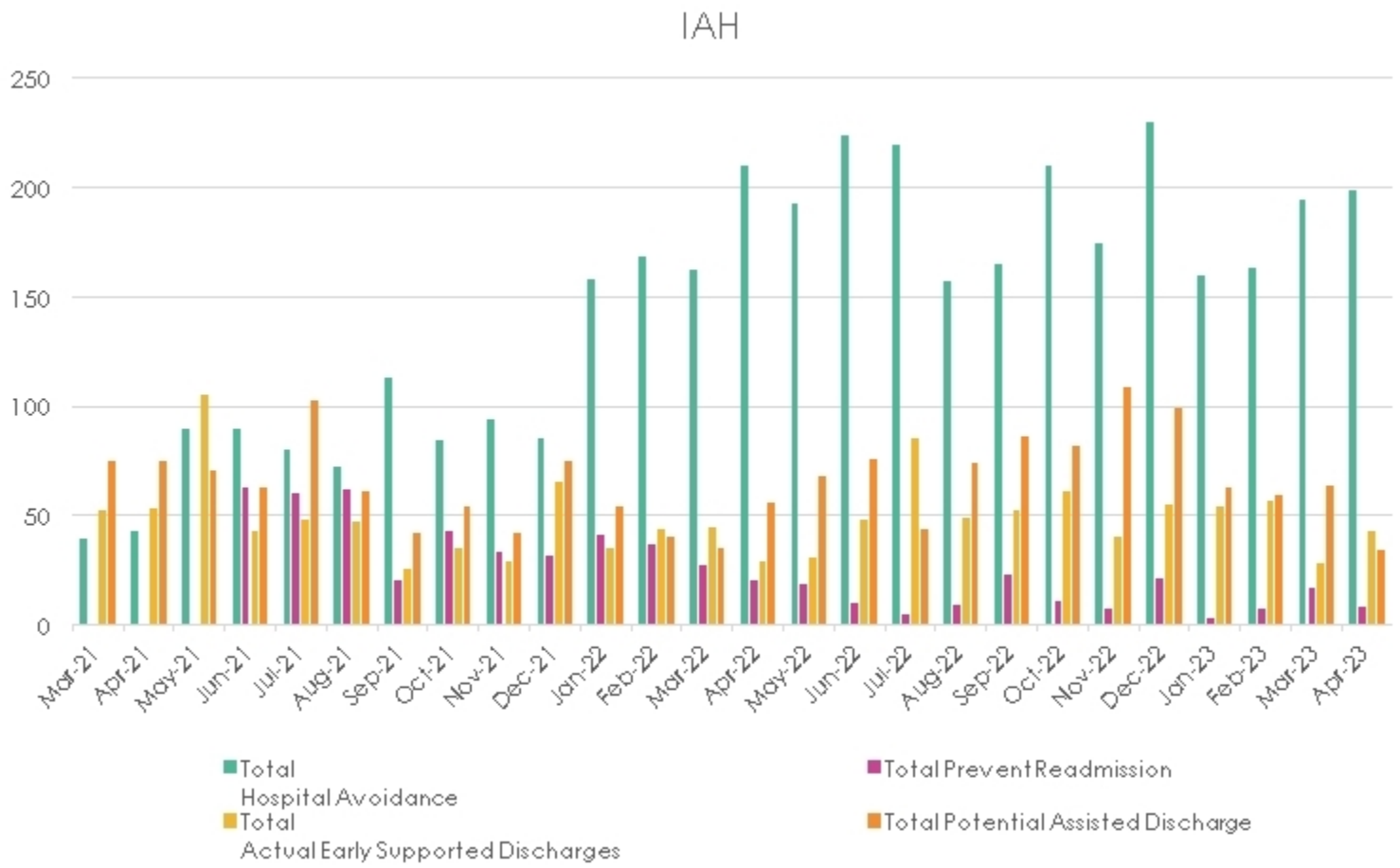
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients.

Patients continue to be placed on an interim basis into care home beds while continuing to seek a package of care to enable them to be cared for in their own home. Further work is being completed to reduce the number of patients in beds through expediting their discharge to home.

Work is continuing on bolstering up the admission avoidance activity and interventions of the hospital to try and reduce dependency and reduce the demand for packages of care.

Last updated : May 023

Tier 3/4:
Integrated Assessment Hub:

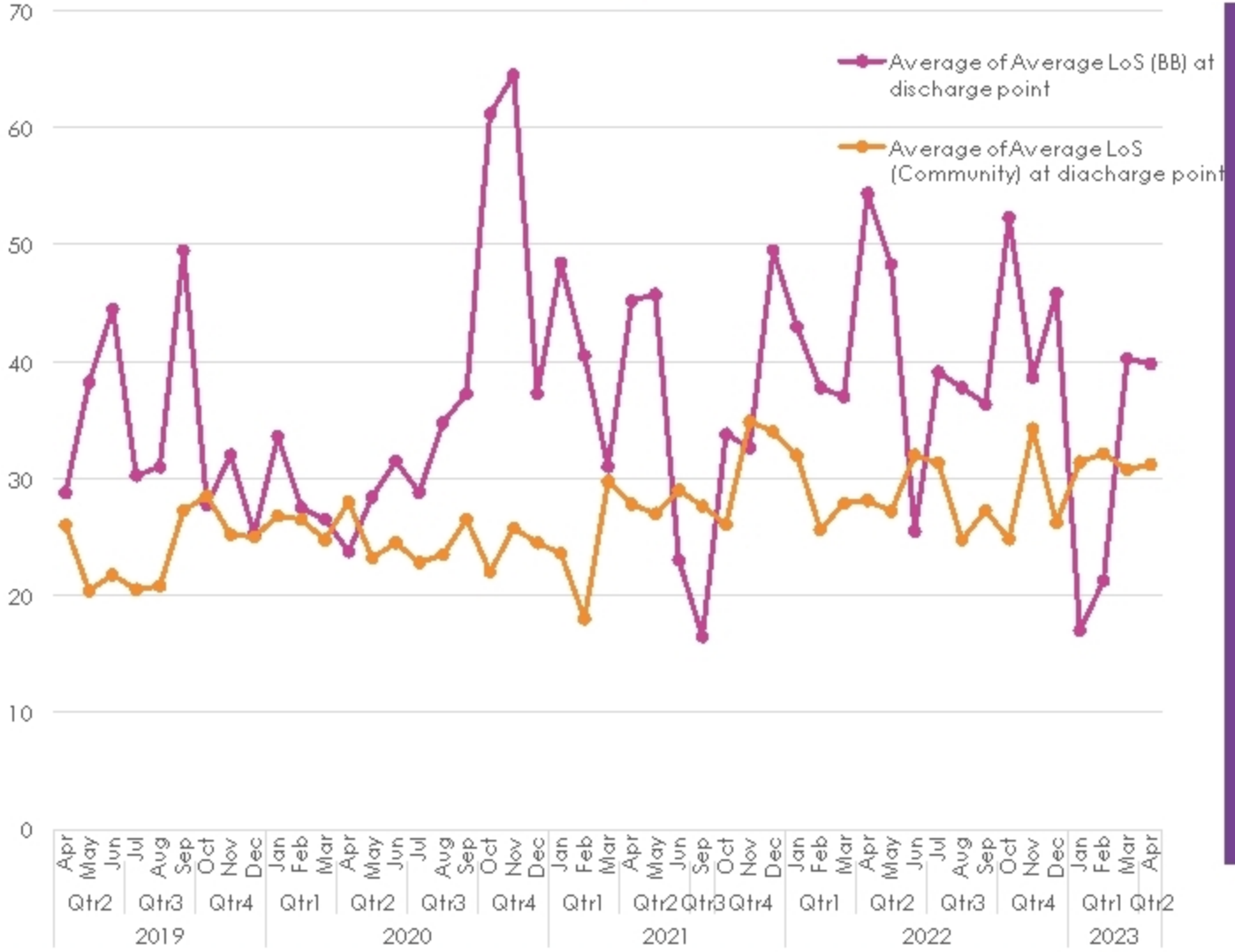


Integrated Assessment Hub

- **Hospital Avoidance:** This IAH pathway enables people directly contacting the Frail Elderly Service or Ambulatory Care at the Manor with post-discharge complications to be seen by Rapid Response, Enhanced Care Home Support Team or CIT team instead and receive a community-based assessment & clinical review, thereby avoiding conveyance to hospital.
- An enhanced service has been implemented through the Winter period where the pathway will be extended to patients attending ED. This will enable patients to be streamed, clinically assessed and dispositioned into Community pathways that are appropriate to manage their conditions and provide the support that they need. The success of this can be seen in the hospital avoidance activity data.

Last Updated : May 2023

Tier 3: Domiciliary and Bed-Based Pathways



- Therapy demands and the change in national model is having a significant impact on community ICS therapists, unplanned crisis demands and hospital discharges remain key priorities in patient safety.
- Due to Covid, individuals have been more unwell and therefore have needed rehab/Reablement for a longer period of time- Long Covid MDT exceptional success.
- There is a recruitment plan underway for gaps in the social care workforce which is impacting on LOS

Last updated : May 2023

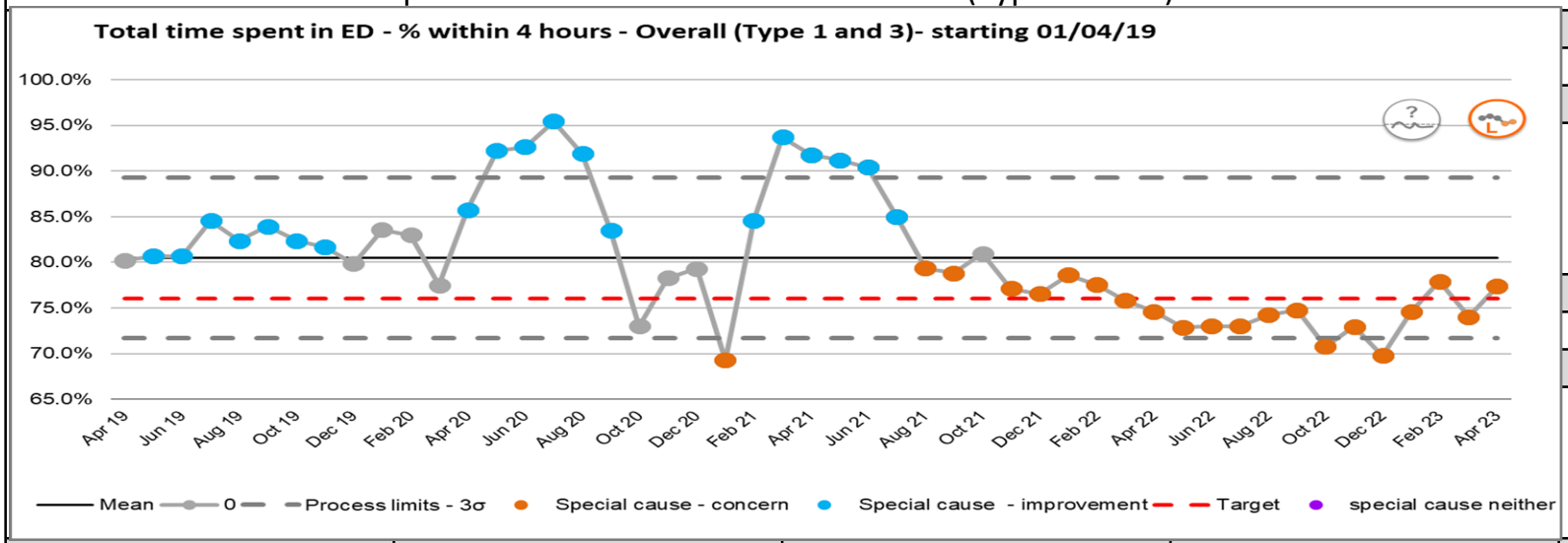
Walsall Healthcare NHS
NHS Trust

IQPR
P&FC

		Reporting Period	Actual	Trajectory	2023/24 Target	SPC Assurance	SPC Variation
PERFORMANCE & FINANCE COMMITTEE							
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Apr-23	55.68%	92.00%	92.00%	F	L
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	Apr-23	1453	1450		F	H
No.	18 weeks Referral to Treatment - No. of patients waiting over 65 weeks - Incomplete	Apr-23	354	0	0	F	
No.	18 weeks Referral to Treatment - No. of patients waiting over 78 weeks - Incomplete	Apr-23	2	0	0	F	L
%	Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED	Apr-23	95.97%		95.00%	?	
%	Cancer - 2 week GP referral to 1st outpatient appointment	Mar-23	81.11%		93.00%	?	
%	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	Mar-23	62.50%		93.00%	F	
%	Cancer - 62 day referral to treatment from screening	Mar-23	100.00%		90.00%	?	
%	Cancer - 62 day referral to treatment of all cancers	Mar-23	65.59%		85.00%	?	L
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test	Apr-23	20.62%		1.00%	?	H
%	Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)	Apr-23	77.36%	76.00%	76.00%	F	L
%	Percentage of patients spending more than 12 hours in ED	Apr-23	3.93%	2.00%	2.00%	?	H
%	Locality Teams - % of Hours Demand Unmet	Apr-23	2.77%		20.00%	F	L

		Reporting Period	Actual	Trajectory	2023/24 Target	SPC Assurance	SPC Variation
Ave	MSFD - Average number of Medically Fit for Discharge Patients in WMH	Apr-23	38		50		
%	Urgent Crisis Response (UCR) - 2 Hour Response Rate	Apr-23	81.25%		70.00%		
%	Rapid Response - % Admission Avoidance	Apr-23	83.27%		87.00%		
£	Total Income (£000's)	Apr-23	30209	See Financial Performance for further detail			
£	Total Expenditure (£000's)	Apr-23	34124	See Financial Performance for further detail			
£	Total Temporary Staffing Spend (£000's)	Apr-23	3448	See Financial Performance for further detail			
£	Capital Expenditure Spend (£000's)	Apr-23	337	See Financial Performance for further detail			

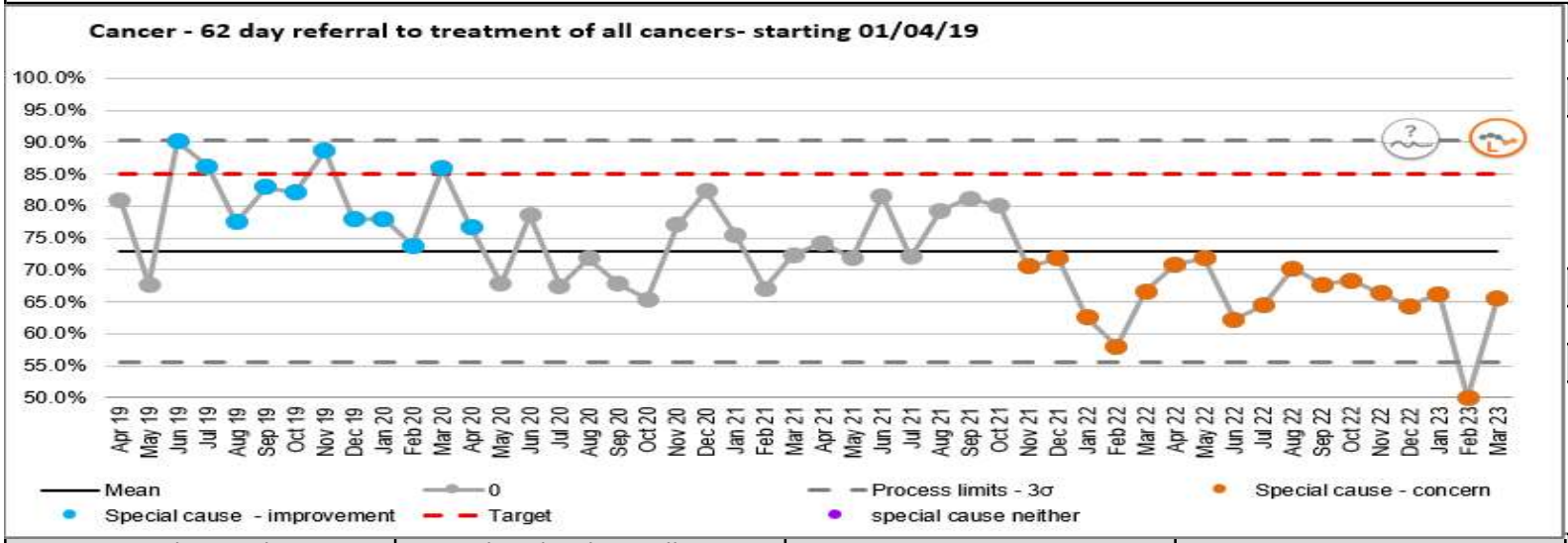
Metric Name: Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)



Month
Apr-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
95.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of A+E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A+E department. Trust's latest National ranking is 23rd out of 109 Trusts, regional ranking was 4th out of 19 reporting trusts.	The national target changed to 76% from April 2023, the Trust exceeded this target with a performance of 77.36%. Although performance is above the revised target, it will still show statistical special cause concern until performance improvements are sustained.	- High cubicle occupancy caused by exit block for patients needing medical admission. - Ability to improve Non Admitted pathway. - Ability to effectively manage the increase in Mental Health presenting patients to ED.	- Substantively opening Ward 14 following receipt of financial allocation from NHSE - Two further PDSA trials planned for 8th May that will aim to improve efficiencies of the non admitted pathway - Dedicated space for the Mental Health Pathway has been allocated (June 2023)	- Relocation of Ambulatory Emergency Care into the old ED footprint to facilitate stable GP medical referrals being assessed in AEC rather than ED

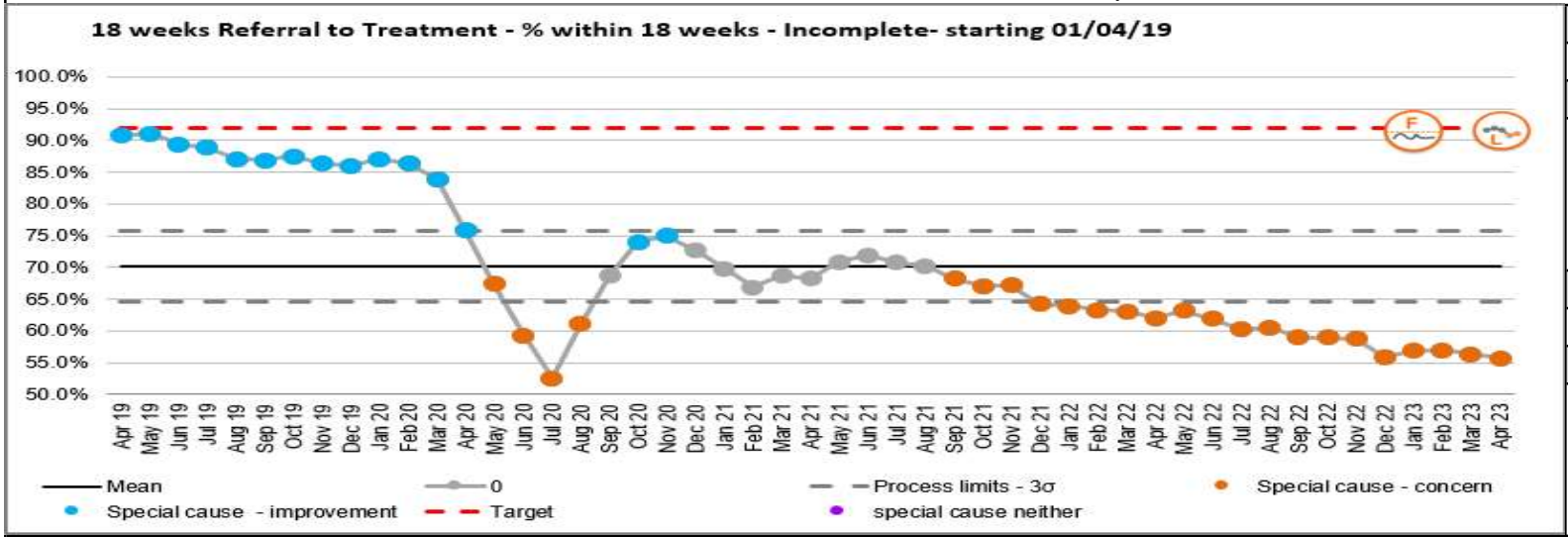
Metric Name: Cancer - 62 day referral to treatment of all cancers



Month
Mar-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
85.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Although significant improvement in March at 65.59%, there remains statistical special cause concern with 17 data points below average. Latest bench marking reports the Trust 54th out of 121 reporting Trusts.	- The core risks to delivery are currently timely endoscopy access (specifically for colonoscopy) and urgent histopathology results, as delivered by the Black Country Pathology Service. -Most challenged tumour sites remain to be urology, colorectal & breast.	- Tele-dermatology went live in April, the positive impact likely to be seen over the coming months - Endoscopy Insourcing to recommence May. - Urology integration with RWT	Emphasis to delivery of this measure is to reduce the volume of patients greater than 62 days. Good progress is being made to reduce the numbers exceeding 62 days, with the Trust meeting it's trajectory for reduction of over 62 day patients for the end of March 2023

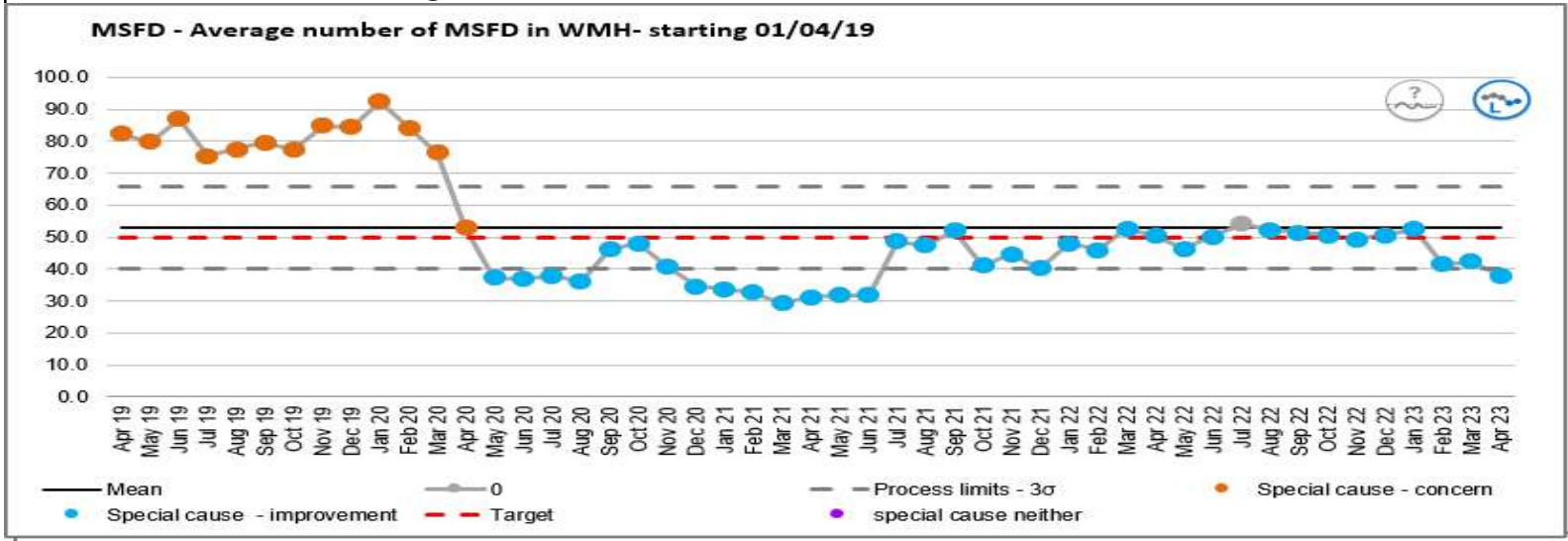
Metric Name: 18 weeks Referral to Treatment - % within 18 weeks - Incomplete



Month
Apr-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
92.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Performance remains statistical special cause concern in April but is in line with trajectory at 55.68%. National ranking position is now 79th (out of 121 reporting Trusts) for March 2023 performance. The Trust's 52-week waiting time performance is 8th best in the Midlands out of 20 Trusts.	April saw 500 elective procedures within Operating Theatres, despite loss of capacity as a result of the junior doctors strike action (76 patients cancelled) and the 2 Easter Bank Holidays.	Validation and partial bookings have commenced to reduce DNAs. The Trust reported two patients waiting in excess of 78 weeks during April. Both patients were offered dates during April, but preferred due to their personal circumstances to wait and have their surgery during May	Outpatient Improvement Programme supported by Four Eyes Insight with the explicit aim of reducing DNA rates, increasing clinic utilisation and reducing non-admitted waiting times. Lists are not stood down without the approval of the Divisional Director of Operations.

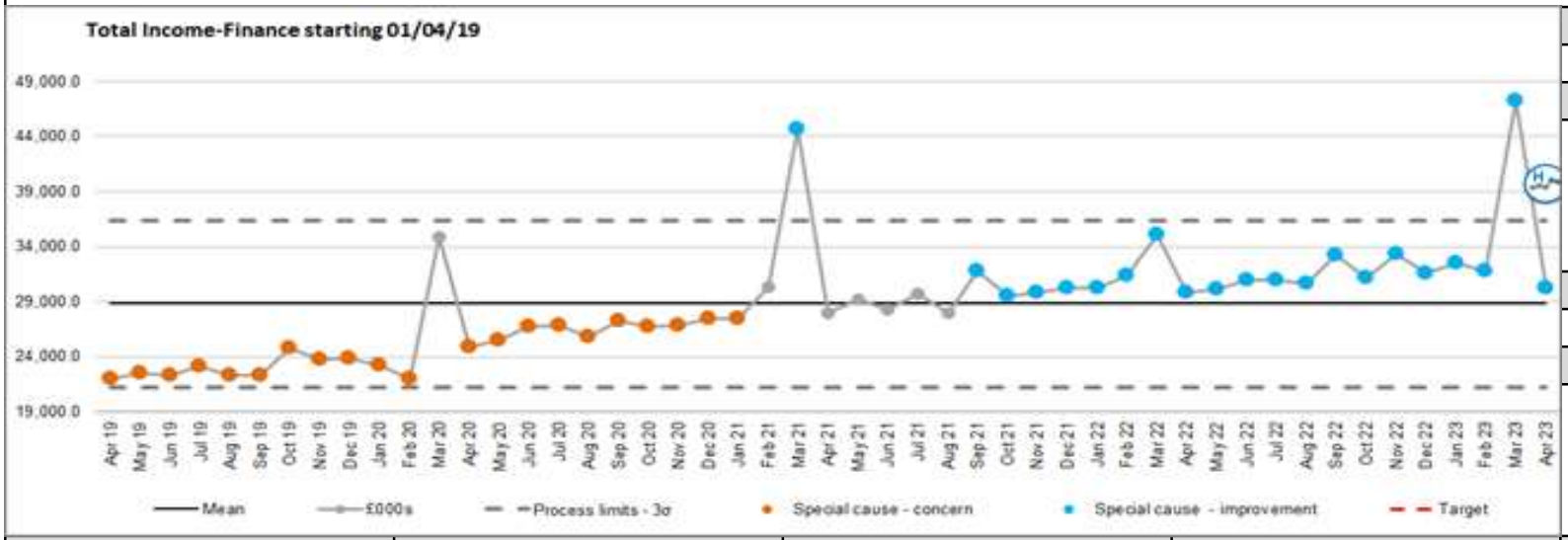
Metric Name: MSFD - Average number of MSFD in WMH



Month
Apr-23
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
50
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
The number of medically stable for discharge patients (average). These are patients who do not need hospital bed for their acute management (ICS pathways 1-4)	The Service delivered a strong performance in April with the number of MSFD patients lowering to 38.	Demand in terms of the Intermediate Care Service remains high. The Length of Stay in April was at an average of 2.6 days demonstrating good flow through the pathways.	Work continues to make efficiencies in the discharge and ICS pathways to ensure minimal delays for patients. Further work is being completed on enabling service to ensure resilience.	Actions have been taken by the Community Division in reference to the increase in demand. This will provide an increase in capacity in the Hospital Team and resilience within the service.

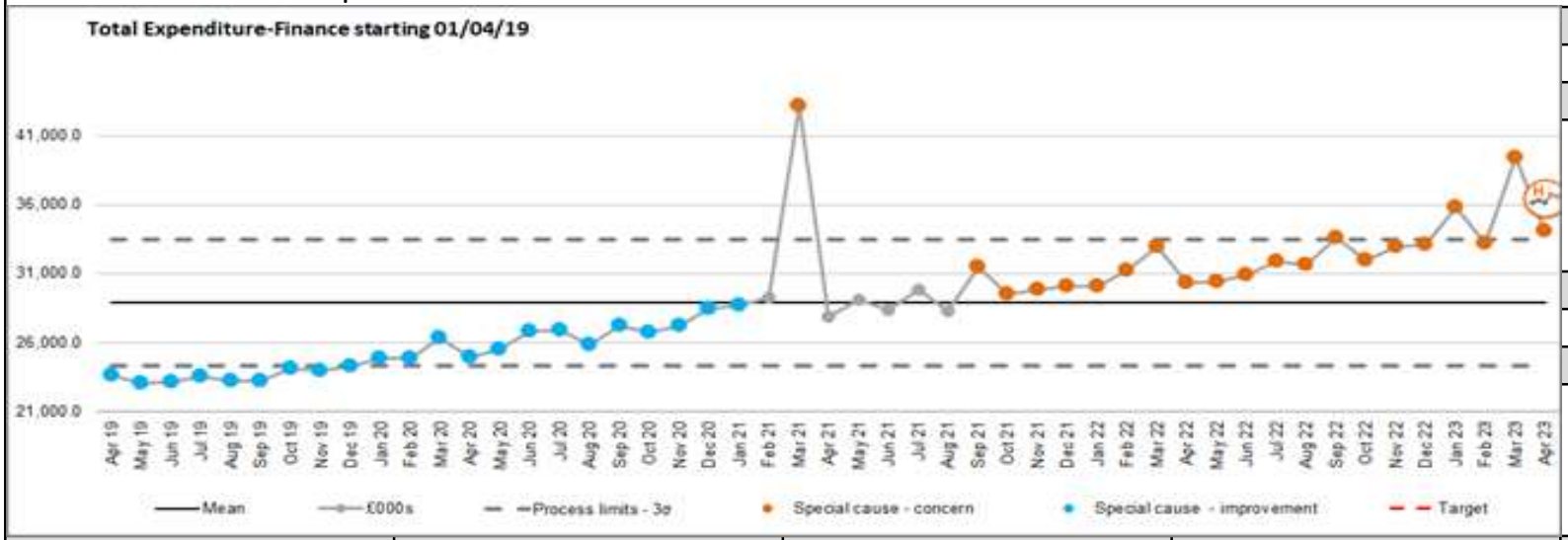
Metric Name: Total Income



Month
Apr-23
Special Cause of Improving Nature or Lower Pressure
Target
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Total income for the Trust	Statistically increase over time, maintaining above upper limit.	It is likely income will decline as the pandemic impact reduces and allocation to ICB's have Covid funding removed	The Trust needs to seek appropriate sources of income and cost efficiency to live within the funding envelope	Variable funding sources including risk share and elective recovery funding to be managed to secure as much income as possible to support the Trust planned delivery of breakeven for the financial year.

Metric Name: Total Expenditure

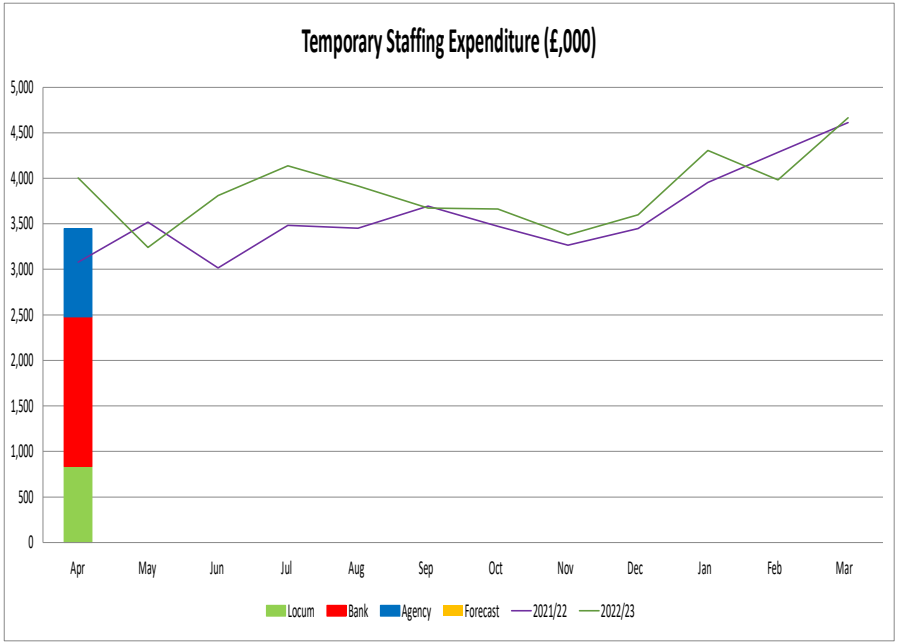


Month
Apr-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Total expenditure for the Trust	Statistically increase over time	Expenditure will need to decrease from historically high levels post pandemic	Cost efficiency must be targeted, £26m in 23/24	Delivery of the 2023/2 efficiency target of £26m. The Trust to move back into more 'normal' business, delivery of £17m Efficiency target from operations and £9m from non recurrent resources, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure

Financial Performance to April 2023 (Month 1)

	Mth 1 Plan £000s	Mth 1 Actual £000s	Mth 1 Variance £000s
Subtotal Income	29,966	30,209	243
Subtotal Pay Expenditure	(20,948)	(21,917)	(969)
Subtotal Non Pay Expenditure	(9,792)	(10,160)	(368)
Subtotal Finance Costs	(1,069)	(1,069)	0
Total Surplus / (Deficit)	(1,843)	(2,937)	(1,094)
Donated Asset Adjustment	(976)	(978)	(2)
Adjusted Surplus / (Deficit)	(2,819)	(3,915)	(1,096)
Reconciliation to Submitted Profile	690		(690)
Submitted Plan Profile	(2,129)	(3,915)	(1,786)



Financial Performance

- The Trust has submitted a deficit plan of £14.05m for 2023/24
- The Trust has reprofiled the submitted deficit plan
- The financial settlement offered to the Trust for 2023/24 has a considerable decrease in revenue. Trust plans show a higher % reduction in income than other acute providers in the system.
- The income movements following Covid-19 rescinding and changes to IPC guidelines has resulted in reduced income allocations for the 2023/24 financial year. It will be important the Trust moves quickly into financial recovery and more 'normal' operational performance
- The Trust is in discussion with BC ICB on a range of services that have traditionally being funded outside block but have not been in 2023/24 or 2022/23. The Trust may wish to terminate these services on the basis 50% of the funding has been offered.
- The Trust has delivered a deficit of £3.915m at Month 1, this is £1.096m above the planned deficit of £2.819m.
- Income was £0.243m higher than plan, Staffing costs were £0.969m above plan and non-pay costs were £0.368m above plan.
- The Trust is £0.178m below the ERF plan for April 2023

Capital

- Trust Board approved a level of capital expenditure of £25m for the 2023/24 financial year. This includes £2.5m of PDC funding for digital aspirant schemes and £12.6m grant funding for decarbonisation projects.
- The capital plan in 2023/24 is not fully funded and projects need to be prioritised to live within the available envelope.
- Capital expenditure in month 1 was £0.337m against a plan of £1.4m.

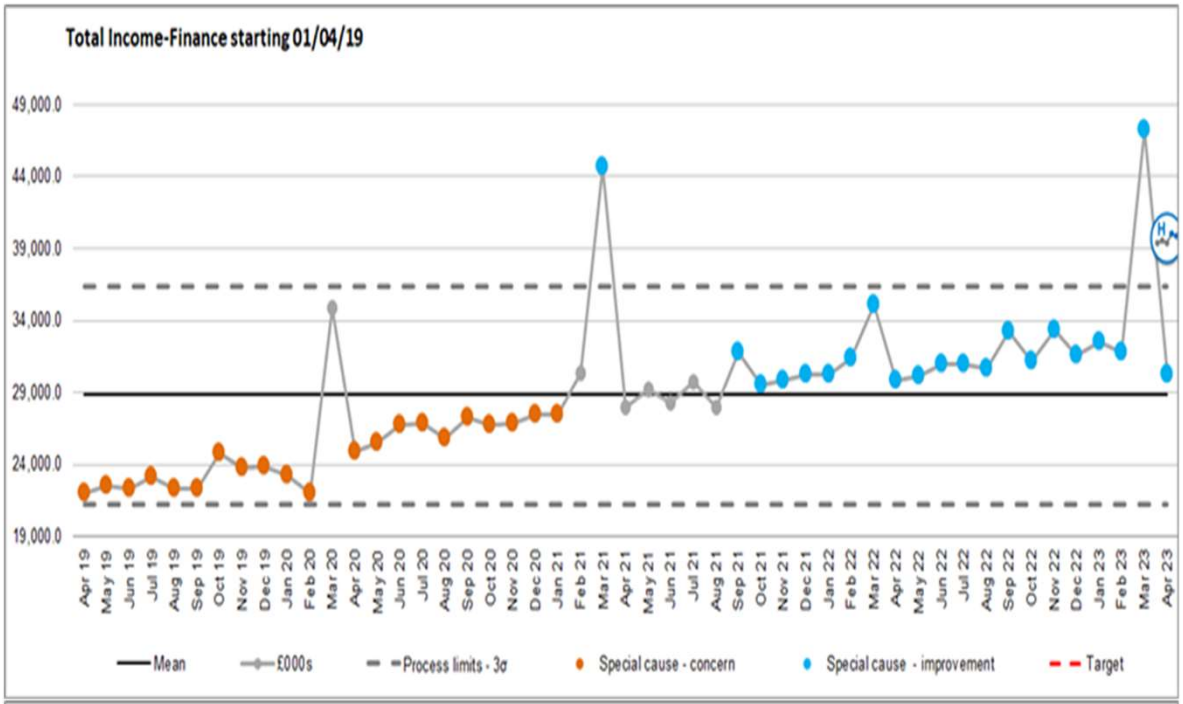
Cash

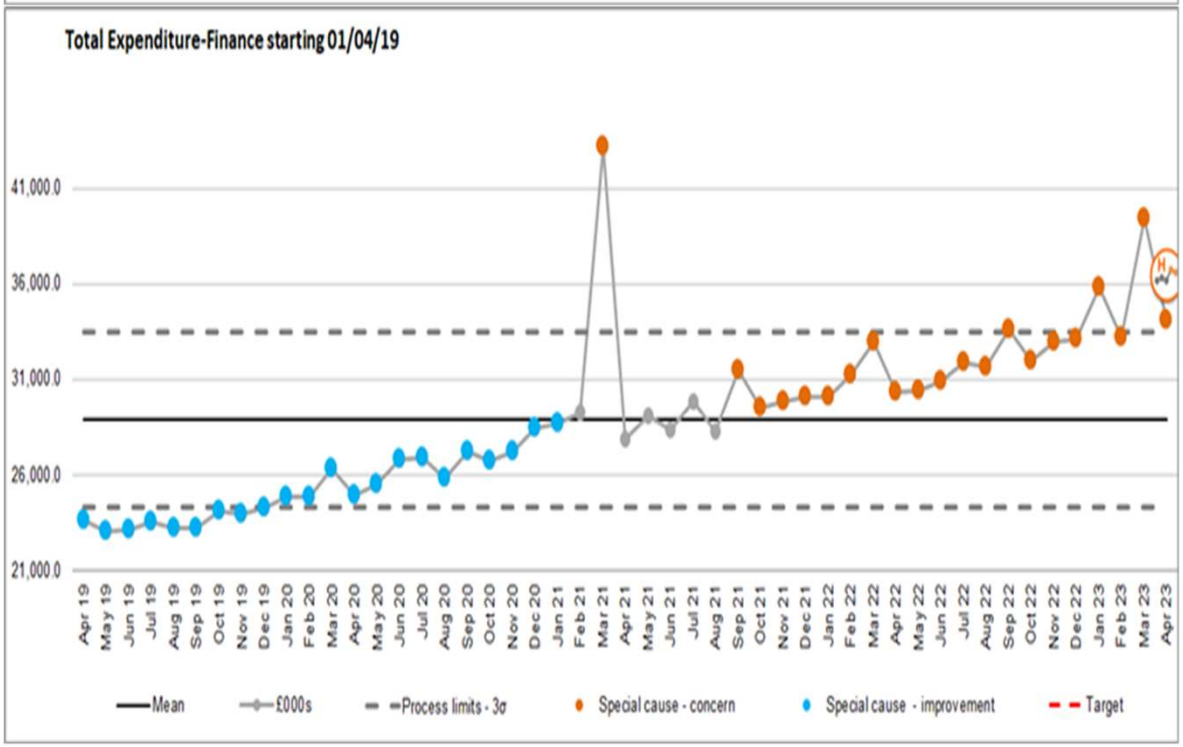
- The Trust is currently holds a healthy cash position but this is planned to be utilised throughout 2023/24

Efficiency attainment

- Efficiency and Cost Improvement Programme plans are currently £12.1m short of the £17.2m target
- At Month 1 there has been delivery of £0.1m against a plan of £0.3m, however if the plan was phased in equal twelfths the Trust would need to secure £1.4m YTD and have therefore an adverse variance of £1.3m

Income and expenditure run rate charts





Income additional information

- Income spiked in March 2023 due to the 23/24 pay award non-consolidated retrospective payment funding
- Income has reduced in 2023/24 due to covid allocation reductions, WHT losing more income proportionally compared to other providers in the system
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).
- From October 20 there will no longer be retrospective top up funding received, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.
- The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears.

Expenditure additional information

- March 2020 costs increased to reflect the Maternity theatre impairment £1m & Covid-19 expenditure
- Costs increased in support of COVID-19, with June and July seeing these costs increase further for elective restart and provision for EPR, Clinical Excellence Awards impacts on cost base, noting a reduction in expenditure in August due to the non recurrent nature of these. Spend increased again in September due to back dated Medical Pay Award, increased elective activity and non recurrent consultancy spend and increased further in Q4 20/21 driven by the additional pressures of a second wave of COVID activity.
- March 21 spend includes non recurrent items such as Annual leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income.
- In September 2021 the back dated pay award was paid to staff, increasing in month spend by £2.5m

IQPR
QPES

		Reporting Period	Actual	Trajectory	2023/24 Target	SPC Assurance	SPC Variation
QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE							
No.	Clostridium Difficile - No. of cases	Apr-23	4		0	?	H
No.	MRSA - No. of Cases	Apr-23	1	0	0	?	
%	VTE Risk Assessment	Apr-23	88.47%		95.00%	?	L
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Adults	Apr-23	82.42%		90.00%	F	H
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Paeds	Apr-23	46.43%		90.00%	F	
No.	Falls - No. of falls resulting in severe injury or death	Apr-23	5	0	0	?	H
Rate	Falls - Rate per 1000 Beddays	Apr-23	3.18				L
No.	National Never Events	Apr-23	0	0	0	?	
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	Apr-23	9				
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Apr-23	1				
Rate	Midwife to Birth Ratio	Apr-23	22.7	28	28	?	
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	Apr-23	15				
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	Apr-23	19				

Metric Name: Clostridium Difficile - No. of Cases

2022/2023	Actual	Traj.
Apr	0	2
May	1	2
Jun	4	2
Jul	1	2
Aug	2	2
Sep	6	2
Oct	7	2
Nov	4	2
Dec	5	3
Jan	7	3
Feb	3	2
Mar	10	3

CUMULATIVE	Actual	Traj.
Apr	0	2
May	1	4
Jun	5	6
Jul	6	8
Aug	8	10
Sep	14	12
Oct	21	14
Nov	25	16
Dec	30	19
Jan	37	22
Feb	40	24
Mar	50	27

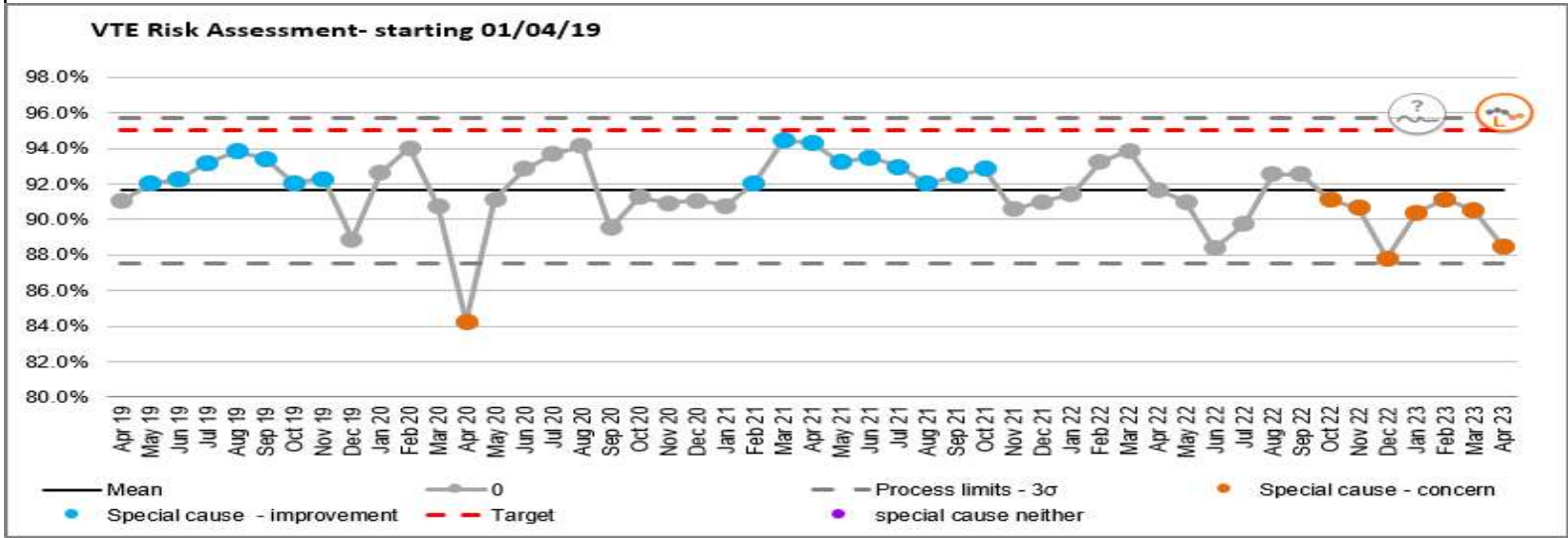
2023/2024	Actual	Traj.
Apr	4	2
May		2
Jun		2
Jul		2
Aug		2
Sep		2
Oct		2
Nov		2
Dec		3
Jan		3
Feb		2
Mar		3

CUMULATIVE	Actual	Traj.
Apr	4	2
May		4
Jun		6
Jul		8
Aug		10
Sep		12
Oct		14
Nov		16
Dec		19
Jan		22
Feb		24
Mar		27

Month
Apr-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
27
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Minimise rates of Clostridium difficile The target for 23/24 has not yet been published, therefore previous years target & trajectory has been applied in the interim.	There were 4 cases reported in April taking the year to date to 4.	A total of 4 C.Diff toxin cases were reported during April 2023, of these cases were deemed avoidable.	New nurse associate has joined the IPC team with a focus on C.Difficle, sample collection and antibiotic management. A trust wide training event has taken place and another event is planned this month.	N/A

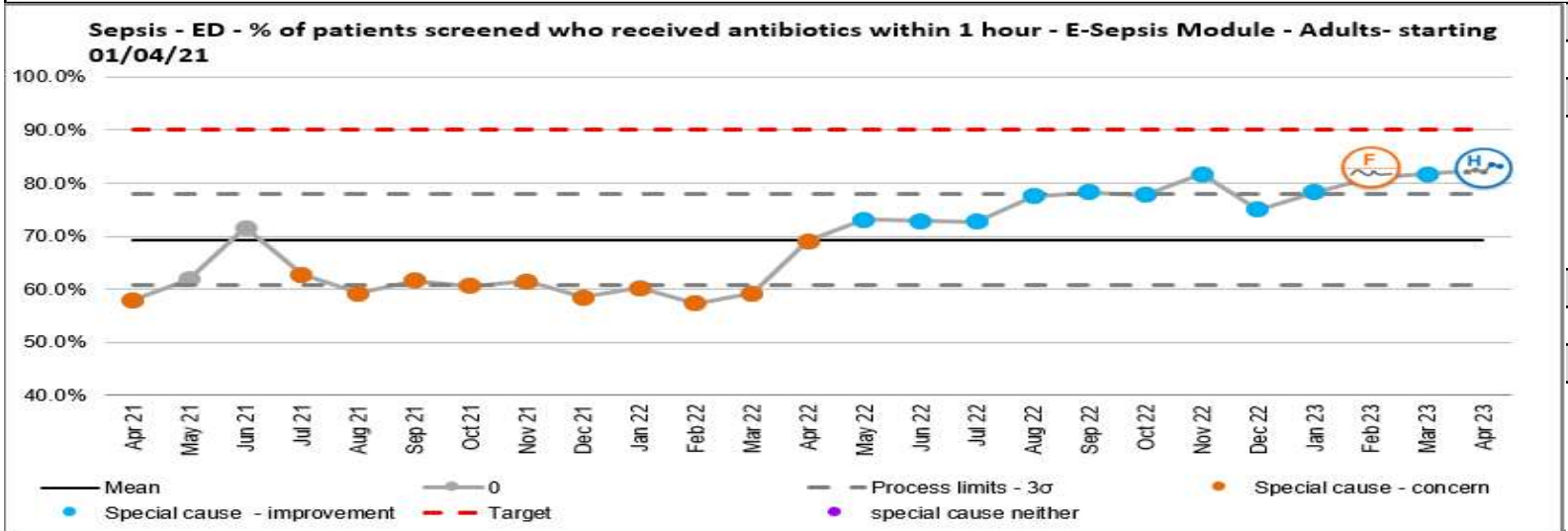
Metric Name: VTE Risk Assessment



Month
Apr-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
95.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
VTE risk assessment: all admitted patients aged 16 or over undergoing risk assessment for VTE (agreed cohorts applied)	Performance remains below the target of 95%, within normal variation. April reported 88.47% and remains below the average 92%.	An issue with the single pregnancy recorded has been identifed which has affected the VTE data. Monthly reports continue to be sent to Divisions, in addition to the daily reporting to consultants.	Audits have shown a number of process and IT issues which are now being worked through in QI projects.	Hospital acquired thrombosis (HATS) are reported on Safeguard and discussed at Divisional Quality Boards. HATS are also reported to the Thrombosis Group and each Division continues to report on the outcome of investigations.

Metric Name: Sepsis - % of patients screened who received antibiotics within 1 Hour - ED (E-Sepsis Module) - Adults



Month
Apr-23
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
90.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis (Adults)	The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department in April 2023 was 82.42% . The data shows improving statistical variation and has been above the mean for the last 12 months.	Focus on staff training continues and the sepsis team continue to review all open assessments on vital pac.	The PBI report has been refreshed to focus on the Antibiotics within the hour. Training on vitals to be refreshed. Sepsis performance is now reviewed via the newly formed deteriorating patient group and reported via patient safety group.	The sepsis team reviews all open sepsis assessments on vital pac ensuring they are closed down when appropriate. They are also responding to sepsis alerted patients. Results are comparable with high perfoming trusts.

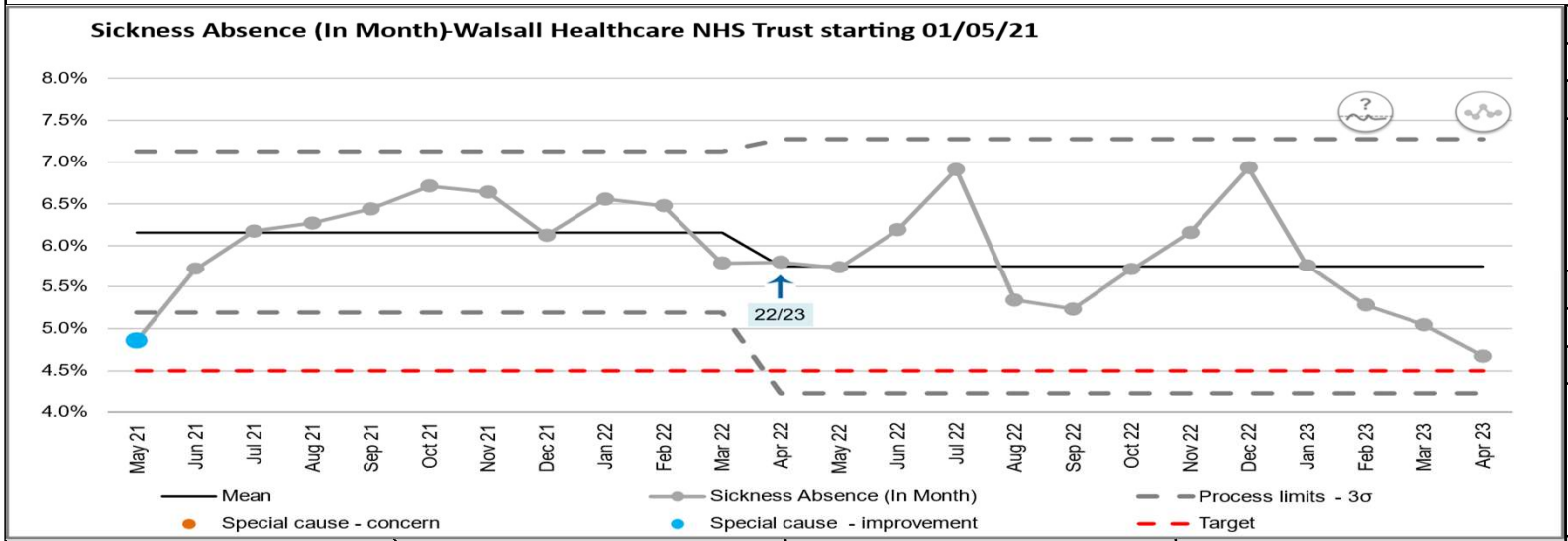
Walsall Healthcare NHS
NHS Trust

IQPR

POD

		Reporting Period	Actual	Trajectory	2023/24 Target	SPC Assurance	SPC Variation
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE							
%	Sickness Absence	Apr-23	4.67%		4.50%	?	
%	PDRs	Apr-23	81.27%		90.00%	F	H
%	Mandatory Training Compliance	Apr-23	87.58%		90.00%	F	
%	% of RN staffing Vacancies	Mar-23	-2.05%				L
%	Turnover (Normalised)	Apr-23	11.33%		10.00%	?	H
%	Retention Rates (24 Months)	Apr-23	79.39%		85.00%	F	L
%	Bank & Locum expenditure as % of Paybill	Mar-23	11.52%				
%	Agency expenditure as % of Paybill	Mar-23	5.25%				

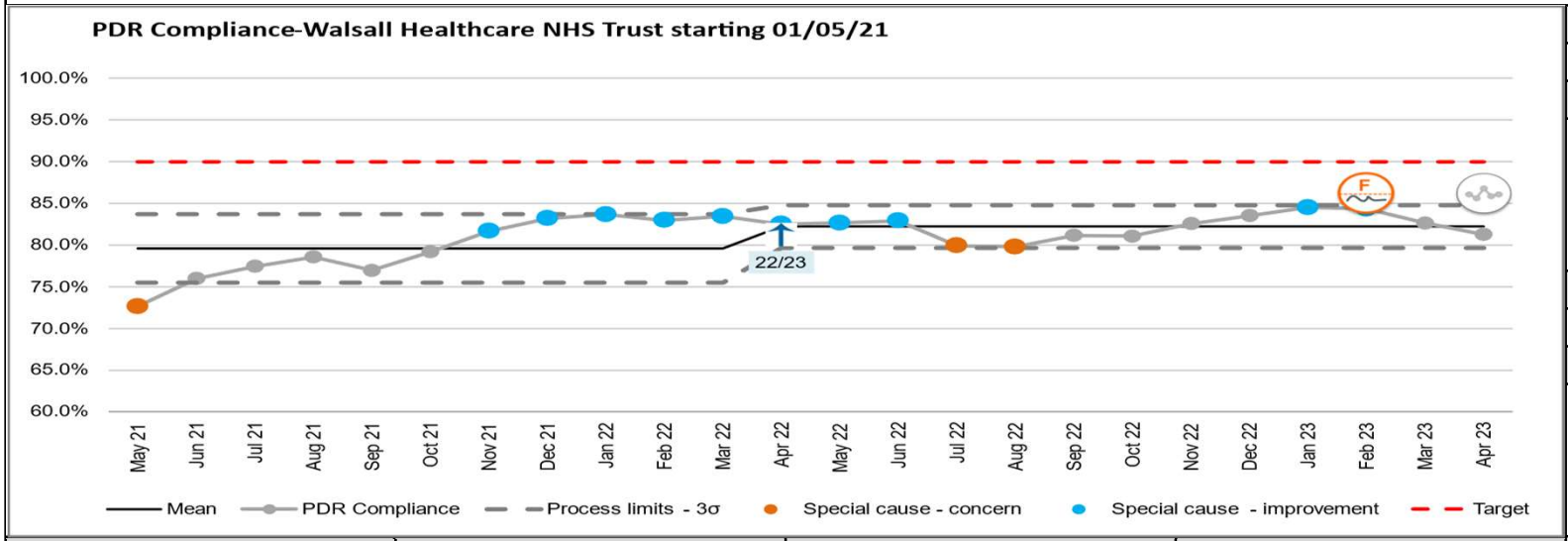
Metric Name: Sickness Absence



Month
Apr-23
Variance Type
Common Cause - No Significant Change
Target
4.50%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.	Sickness absence spiked to the upper limits of the trend range, reflecting an escalation in days lost to traditional winter illness (Cold/Influenza). This has shown to start declining but is not yet showing a sustained positive trend However is now close to the target.	Reductions in long-term musculoskeletal illness, due to recovery plan interventions, are being offset by rising stress/anxiety-related absence.	Realising the procedural improvements and colleague lifestyle benefits identified within the recently drafted Health & Well-Being strategy will represent a significant catalyst towards restoration of pre-pandemic absence levels.	Monitoring of sickness absence includes Executive oversight at the monthly Divisional review meetings. Fast track referrals by the Occupational Health Team to Physiotherapy Services will ensure that injured colleagues receive early recovery interventions.

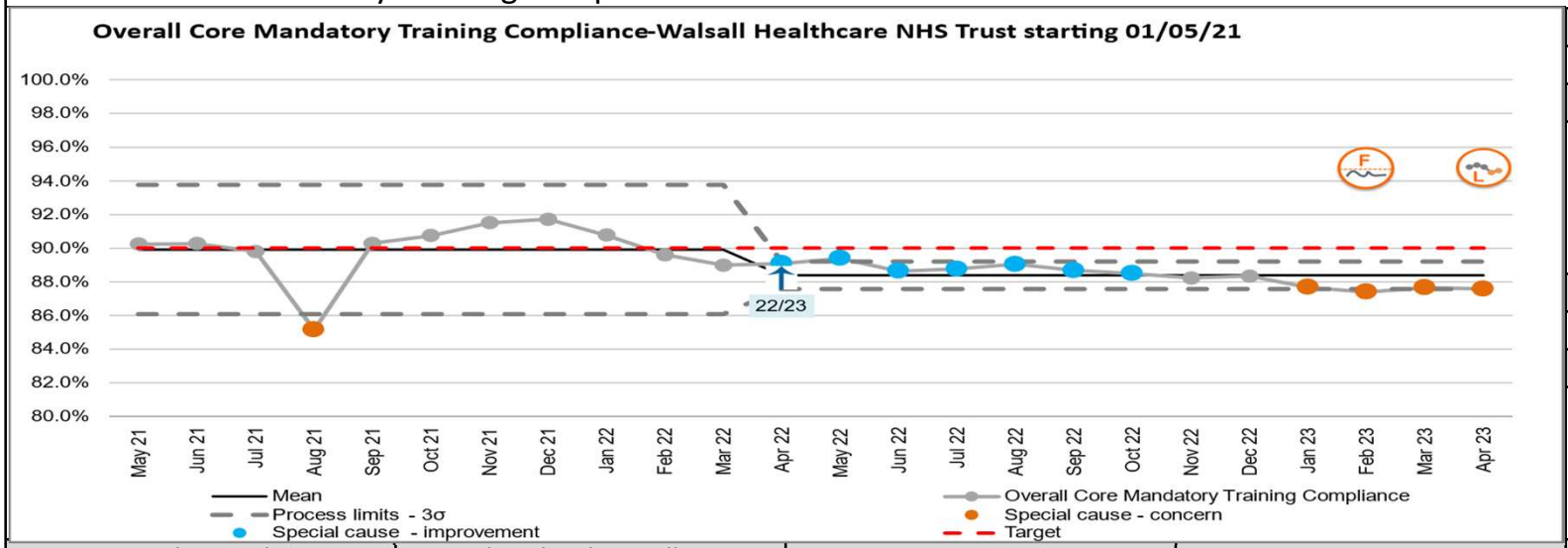
Metric Name: PDRs



Month
Apr-23
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
90.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Appraisal compliance is calculated using exclusion lists.	Annual appraisal compliance continues to decline and is currently 80.95%.	Compliance remains highest amongst Medical and Dental colleagues (92.9%), although evidence of increased appraisal sessions across all staff groups is present. Appraisals within the Administrative and Clerical staff group are lowest at 73.13%	Line managers have been emailed directly, in addition to Heads of Service, requesting the reasons for non-compliance. These confirm and challenge style emails contain relevant information on how to access the appraisal forms, and signposting to training if required.	Monitoring of PDR compliance is reviewed at the monthly executive led Divisional review meetings.

Metric Name: Mandatory Training Compliance



Month
Apr-23
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
90.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Training compliance is calculated using exclusion lists.	Training compliance remains high at 88%, with most individual competencies now at or above the 90% target.	Safeguarding Adults Level 3 (84.5%) and Adult Basic Life Support (62%) remain outliners. Infection Prevention and Patient Handling compliance has continued to fall.	Collaboration with RWT colleagues continues to align requirements and delivery models for mandatory training.	The project team continues to consult with stakeholders and services to ensure implementation of the Totara LMS is carried out at a pace which does not compromise regulatory or governance commitments.

Item 14.8

Walsall Healthcare NHS Trust

Meeting of Trust Board Meeting	
Meeting Date:	Wednesday 7th June 2023
Title of Report:	Audit Committee Annual Review of Activities Report
Action Requested:	Members of the Committee are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒
For the attention of the Board	
Assure	The aims of the committee are to provide an objective review of governance within the Trust, to include financial systems, financial information, risk management and compliance with laws and guidance. This ensures regulations governing the NHS and statutory obligations in regard to annual filings have been and continue to be met.
Advise	At each committee meeting, updates on any new risks or assurance concerns from the Chairs of the Quality, Patient and Safety Committee (QPES), the Performance and Finance Committee (P&FC), People and Organisational Committee (PODC) and the Trust Management Committee (TMC) are received. Representatives from the Internal and External Audit commissioned services are in attendance at committee, reviewing and reporting on systems and processes in operation within the Trust, members receiving recommendations to strengthen systems, as appropriate.
Alert	The Audit Committee has alerted the Trust Board when Internal Audit reports have shown high or medium risk recommendations requiring management attention.
Author and Responsible Director Contact Details:	Mary Martin Chair, Audit Committee Mary.martin1@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care d) Deliver the priorities within the National Elective Care Strategy e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities

Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care
Resource Implications:	There are no resource implications
Equality and Diversity Impact	There are no legal, equality & diversity implications associated with this paper.
Risks: BAF/ TRR	The report provides assurance to the Board on matters of governance, oversight and risk. Assuring Board members risks quantified within the BAF and Risk Registers have been recorded accurately alongside mitigations to support achievement of plans.

Walsall Healthcare NHS Trust

Audit Committee Annual Review of Activities Report

1. PURPOSE OF REPORT

To provide the Trust Board with an overview of the Audit Committee's annual review of it's activities for 2022/23.

2. BACKGROUND

The aims of the committee are to provide the Trust Board with an independent and objective review of its financial systems, financial information, risk management, and compliance with laws, guidance, and regulations governing the NHS.

3. DETAILS

Each meeting received an update on any new risks or assurance concerns from the chairs of the Quality Patient Experience and Safety Committee (QPES), the Finance and Performance, Finance and Investment Committee (PFIG), People and Organisational Committee (PODC) and the Trust Management Committee (TMC).

The Committee received and discussed reports on the:

- o Annual Report for Trust Charitable Funds 2022-23
- o Trust Annual Report and accounts 2022-23
- o Board Assurance Framework, Strategic Risk Register and related governance processes
- o Financial Sustainability
- o Core financial systems: Payroll and Creditors
- o Data Quality - Sepsis
- o Effective Rostering
- o Covid Recovery
- o Theatre Utilisation
- o Data Security Protection Toolkit
- o Cyber Security

Most of the audits and reviews were completed to plan. Where not completed they were planned for completion early in 2023-24.

These matters featured in the Committee's reports to the Trust Board, including a high level summary of the Internal Audit reports received at each meeting. The Trust Board have been kept informed of when audit reports showed high or medium risk recommendations requiring management attention, and has been assured that mitigating actions are being taken in accordance with the agreed timeframes.

The Committee also receives regular reports from the Local Counter Fraud Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud, having a zero-tolerance policy on fraud, bribery and corruption. The Trust has a counter fraud plan and strategy in place designed to make all staff aware of what they should do if they suspect fraud.

The Committee monitors this strategy and oversees when fraud is suspected and fully investigated. The Committee seeks assurance that appropriate action has been taken, which can result in criminal, disciplinary and civil sanctions being applied. There were no significant frauds detected during the year, although some cases reported to the counter fraud team remain on-going.

The Chair of the Quality, Patient Experience and Safety Committee (QPES) is a member of the Audit Committee, which helps to maintain the flow of information between the two committees, particularly on clinical audit matters. Two of the Committee members have recent and relevant financial experience.
Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

4. RECOMMENDATIONS

To receive the report for information and assurance.

Walsall Healthcare NHS Trust

Trust Board Meeting	
Meeting Date:	Wednesday 7th June 2023
Title of Report:	Financial Performance Update Month 12
Action Requested:	Members of the Committee are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒
For the attention of the Board	
Assure	Members can take assurance over the Trust financial oversight from the following: • The Trust has delivered a pre-audit surplus of £0.049m at the year end, this is in line with the revised forecast outturn reported previously. • The Trust has a balanced capital plan with spend of £42.248m at the year-end, £18k within the capital resource limit (subject to final NHSE approval). This has included the delivery of the new A& E department, enhancement to the hospital estate (ward refurbishment), significant investment in imaging, a new endoscopy stack and significant investment in IT. • The Trust is holding significant cash balances at close of the period which gives greater stability regarding trading on a going concern basis moving forwards • The Trust has completed the NHSE Financial Sustainability review (reported to Audit Committee) and Internal Audit validated high or maximum scores in over 93% of areas. Benchmarking received from the RSM (Internal Audit), shows that WHT performed well above average across their client base. • The Trust achieved the highest possible Internal Audit rating in the Creditors internal audit. • The Trust has achieved financial balance in the previous 3 years and has also had 'clean' external audits. • The Trust continues to develop closer working relationships with Royal Wolverhampton Trust including the appointment of a Group CFO across both trusts. This will enable increased scrutiny and adoption of best practice
Advise	The Trust has the following key elements for 2022/23 and 2023/24 reported for members attention: • The overall ICB Full Year position is £0.357m surplus against a break even forecast position. • The 2022/23 financial year has been challenging, with reductions in income baselines and capital funds. To continue with the much needed investment within our services it was important to ensure value for money is secured from within the operation of the Trust. • The income movements following Covid-19 rescinding and changes to IPC guidelines has resulted in reduced income allocations for the 2023/24 financial year. It will be important the Trust moves back into more 'normal' operational performance and

	key aspects to financial sustainability will be o Delivery of efficiencies in year o Reduction in use of temporary workforce (removal of agency) o Securing income allocated to the system for the Trust o Reduction where appropriate of covid designated expenditure • Planning Guidance for annual planning was published just before Christmas. The Trust made the draft submission on 23 February 2023 and a final submission 30 March 2023 (endorsed by Trust Board). Work is ongoing to develop a financial plan in line with national and ICB guidance. A separate update on 2023/24 will be presented to the Committee
Alert	The report draws the attention of committee to: • The final year end position is subject to external audit scrutiny, the findings presented to the Trust's Audit Committee (in a report titled the ISA 260) where amendments to the accounts produced can be requested. The final accounts will be endorsed by the Trust Board will include the recommendations of Audit Committee (though adoption of the accounts can be delegated to Audit Committee by Trust Board). • The overall ICB Full Year position is £0.357m surplus against a break even forecast position. • The financial settlement offered to the Trust for 2023/24 has a considerable decrease in revenue. The ICB has agreed to allocate further resources held back in the original offer but in the original offer the Trust is seeing a considerable reduction in income from the ICB compared to 2022/23. Analysis is still taking place, but the Trust has been offered a higher % reduction in income than other acute providers • Walsall has been given an ERF target of 104.9% (subject to negotiation) of 2019/20 activity (pre-pandemic) priced at 23/24 prices. Any performance below this level will see the Trust income settlement reduced but performance above this level will see additional income earned paid@ 100% PbR. • The Trust is in discussion with BC ICB on a range of services that have traditionally being funded outside block but have not been in 2022/23. The Trust may wish to terminate these services in 23/24 on that basis. • Trust Board approved a draft capital programme for 23/24 at the meeting on 29 March 2023. The report recommends: • That members note the delivery of a breakeven revenue position for 2022/23. • That members continue to seek assurances over delivery of the efficiency programme and agency cessation trajectories in 23/24 as these improvements will be essential for financial stability • That the Trust enters 2023/24 with a significant underlying revenue deficit which will worsen with a significant reduction in income. • While the Trust has a balanced capital plan for 23/24, the Trust's

	ambitions for 23/24 would require further capital resources.
Author and Responsible Director Contact Details:	Dan Mortiboys, Operational Director of Finance d.mortiboys@nhs.net Kevin Stringer- Group CFO Kevin.stringer@nhs.net
Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	We will deliver financial sustainability by focussing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	
Improve the Healthcare of our Communities	
Effective Collaboration	
Resource Implications:	The report summarises revenue and capital positions of the Trust for the current and next financial years
Report Data Caveats	This is a standard report using the previous month's date. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	Nothing specifically associated with his report.
Risks: BAF/ TRR	Corporate Risks 2081 and 2082
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	
References	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	**Financial Performance Update Month 12**

1. PURPOSE OF REPORT

The purpose of the report is to inform members of the Trust Management Committee of the financial performance of the Trust for the 2022/23 and attainment of the financial plan (revenue, capital, and cash).

BACKGROUND

In accordance with national planning guidance, the Trust submitted a Board endorsed financial outturn of a £7.6m deficit in April 2022, system deficit for the Integrated Care System (ICS) being c£48m.

National colleagues reviewed the submissions and allocated further system resources (at a national level c£1.4b) though these funds are only receivable for systems submitting balanced plan outturns.

The regulator required a further national round of planning following release of additional funds. The Trust re-submitting the financial plan for the 2022/23 financial year from the £7.6m deficit to break-even, as endorsed through the Extraordinary Performance and Finance Committee on the 17th of June 2022 (as detailed within the below table):

£m	WHT	Allocation Basis	Comment
Plan Deficit @ 28 April	**(7.6)**		
Additional Funding	2.3	Current Deficit Plan	Additional funding received with no attached requirements = £14.6m. Current deficit plan was based on excess inflationary pressures at a point in time
ERF Upside	1.3	2019/20 Baseline	
Balance sheet flex	1.6	Fair Shares	Adjusted Income
Residual Gap	**(2.5)**		
Further Realignment	2.5	Residual Gap	Realignment to reach break-even for each organisation
Break-even	**-**		

2. FINANCIAL PERFORMANCE MONTH 12

2.1 Black Country Integrated Care System

The ICB Year End reported position is £0.317m surplus and variance against a break-even plan. This is an improvement from M11, where the ICS reported a £17.7m deficit, £16.2m adverse to plan. The position achieved because the ICB released income to providers (without worsening its own position) and asked providers to re-analyse, and where appropriate, utilise the flexibility in their balance sheets.

The financial positions for ICS member organisations is:

Item	Revenue Position			Prior Month Comparative		Prior Month Comparative	
	Plan Year End £'000	Actual Year End £'000	Variance Year End £'000	M11 Actual £'000	Difference £'000	M11 Variance £'000	Difference £'000
BCH	0	9	9	(1,946)	1,955	(1,946)	0
DIHC	0	45	45	13	32	13	0
SWBH	0	99	99	(4,049)	4,148	(3,573)	(476)
DGFT	0	24	24	(1,340)	1,364	(559)	(781)
RWT	0	91	91	(2,172)	2,263	(1,458)	(714)
WHT	0	49	49	(7,533)	7,582	(7,036)	(497)
WMAS	0	0	0	(668)	668	(1,649)	981
ICS	**0**	**317**	**317**	**(17,695)**	**18,012**	**(16,208)**	**(1,487)**

It should be noted the 2022/23 financial plan was achieved through the considerable use of one-off funding and this challenges the sustainability of the model of care across the ICS with an indication of a significant normalised system deficit.

2.2 Walsall Healthcare Trust Financial Performance 2022/23 Month 12

2.2.1 Revenue

Year End Position

The Trust has achieved a £0.049m surplus in 2022/23. This is the fourth year consecutively the Trust has achieved its statutory breakeven duty.

National pay negotiations saw an offer to NHS Agenda for Change staff in March 2023 which included a one off payment relating to service in 2022/23 financial year. NHSE have instructed Trusts to include the anticipated income and expenditure for this one off payment in 22/23 financial year. For Walsall this is a value of c£8.5m and vastly distorts the year end picture. In addition it was announced that Walsall's CFO would be redundant from the Trust and these one off costs have been included in 22/23. The full impact of junior doctors industrial action is still being finalised.

Annual Planning 2023/24

Key submission dates for the final submission for the Trust to NHSE was 30 March 2023. Trust Board and PF Committee had meeting on 29 March 2023 to consider the plan to submit.

The ICB has reissued financial envelopes to Trusts. The Trust is being offered a considerable reduction in income from 2022/23. Negotiations across the ICB continue, and escalation with NHSE/I is in process. A separate update will be presented to the Committee on the current financial plan for 2023/24, for the Trust and across the wider ICB.

3. INCREMENTAL COSTS ASOCIATED WITH RESPONSE TO COVID 19

NHSI/E have asked for these costs to be reported (having previously been reported monthly in 2020/21). The Full Year return showed Covid 19 expenditure of c£1.013m.

Allowable cost type 22/23	Full Year
Existing workforce additional shifts to meet increased demand	158,359
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	48,951
Increase ITU capacity (incl. Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	128,859
PPE associated costs	97,583
Segregation of patient pathways	579,448
Grand Total	**1,013,199**

4. Balance Sheet

4.1 Cash

Description	Balance 31st March 2022 £m's	Balance 31st March 2023 £m's	Movement (adverse) /positive £m's
Cash held and in Bank	55.6	38.7	(16.9)

The Trust cash position remains strong. The Trust is forecasting a significant deficit in 2023/24 and will therefore supply more detailed cash reporting in 23/24.

4.2. Capital

2022/23

Trust Board approved a level of capital expenditure of £41.450m for the 2022/23 financial year. However, following subsequent review (the material change being the removal of the Skin Hospital) the total capital programme for 2022/23 was redefined as £38.188m. At the start of the financial year the programme was not fully funded but the Board wished to progress the theatres project.

During the financial year the Trust has been awarded further capital for specific investments (theatres) and also an increase in capital from the ICB. The handover of the new Urgent and Emergency Care Centre (UECC) from the contractor has caused delay to a number of other capital schemes in year. The Trust has re-profiled capital as appropriate.

The total capital funding available to the Trust was £42.266m at the year end. Full Year Capital expenditure is £42.248m, and under delivery of £18k (subject to NHSE approval), a significant achievement given the issues with supply chain, slippage in key programmes and the late award of capital from NHSE in February 2023. Details of the Year End position are included in **Appendix 4**.

5. Summary, Key Risks & Mitigations

Black Country and West Birmingham Integrated Care System:
The ICB Year End reported position is £0.317m surplus against a break even plan.

Trust:

Revenue
- The Trust has reported a Full Year surplus of £0.049m against a revised break even forecast (subject to audit)
- The Trust has been asked to include income and expenditure for a one off payment to Agenda for Change staff

Capital and Balance Sheet
- The Trust cash position remains able to support the need of the Trust within the financial year.
- The capital plan in 2022/23 is within CRL and has maximised use of resources.
- The current 23/24 capital plan is balanced but does not match all the Trust's ambitions.

Governance and next actions:

- External Audit will review the 22/23 statement of accounts and report to Audit Committee. The Trust will incorporate External Audit finding on that basis.
- The financial standing of the Trust is regularly reported to Executive, TMC, P&F and Trust Board
- Nursing Director has targeted zero nurse agency from 1 April 2023
- Chief Medical Officer is looking to remove medical agency costs
- Recurrent CIP plans need to be developed to ensure the financial sustainability of the Trust
- Current forecast position highlights a significant risk to breakeven duty in 2023/24.
- Current capital ambitions exceed funding in 2023/24.

APPENDICES

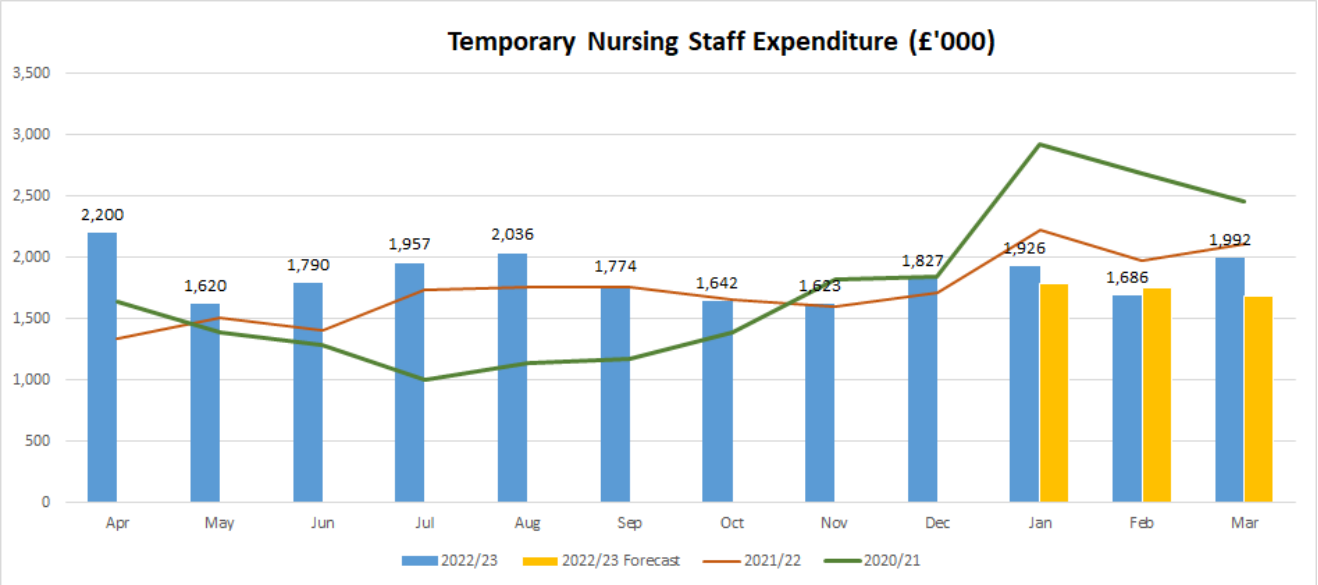
1. Financial Performance 2022/23
2. Temporary Staffing 2022/23
3. Trust charting of income and expenditure run rates (SPC charts)
4. Capital Programme
5. Better Payment Practice Code Performance

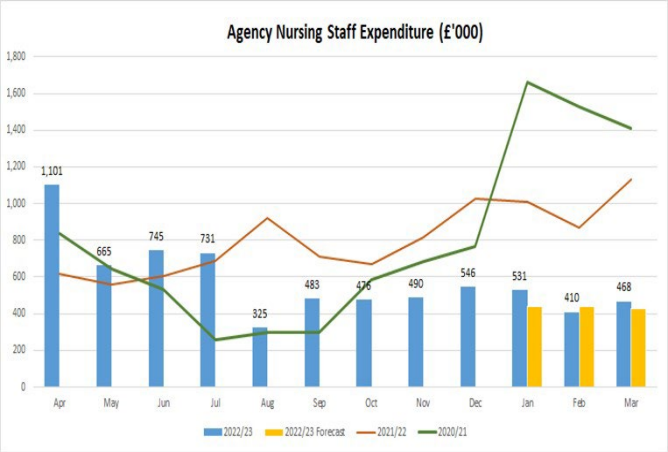
Appendix 1 -Trust wide Financial Performance 2022/23 as at Month 12

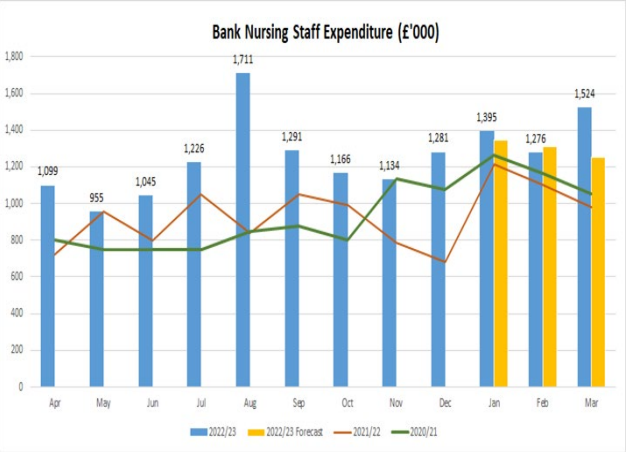
Year to Date Plan v Actual

	Full Year Plan £000s	Full Year Actual £000s	Full Year Variance £000s
Income			
Healthcare Income (Inc. Vaccs)	357,287	371,036	13,749
Other Income (Education&Training)	7,745	10,282	2,537
Other Income (Other)	7,605	11,886	4,281
Subtotal Income	**372,637**	**393,204**	**20,567**
Pay Expenditure			
Substantive Salaries	(238,506)	(210,389)	28,117
Temporary Nursing	(2,798)	(21,947)	(19,149)
Temporary Medical	(2,028)	(16,501)	(14,473)
Temporary Other	(1,267)	(7,524)	(6,257)
Vaccination Programme	(594)	(753)	(159)
Subtotal Pay Expenditure	**(245,193)**	**(257,113)**	**(11,920)**
Non Pay Expenditure			
Drugs	(20,132)	(22,949)	(2,817)
Clinical Supplies and Services	(17,053)	(21,620)	(4,567)
Non-Clinical Supplies and Services	(25,874)	(28,951)	(3,077)
Other Non Pay	(36,281)	(39,107)	(2,826)
Vaccination Programme	(22)	(176)	(154)
Depreciation	(15,025)	(12,348)	2,677
Subtotal Non Pay Expenditure	**(114,389)**	**(125,151)**	**(10,763)**
Interest Payable	(11,415)	(11,182)	233
Subtotal Finance Costs	**(11,415)**	**(11,182)**	**233**
Total Surplus / (Deficit)	**1,641**	**(242)**	**(1,883)**
Donated Asset Adjustment	191	291	100
Adjusted Surplus / (Deficit)	**1,832**	**49**	**(1,782)**

Appendix 2 – Temporary Staffing Report







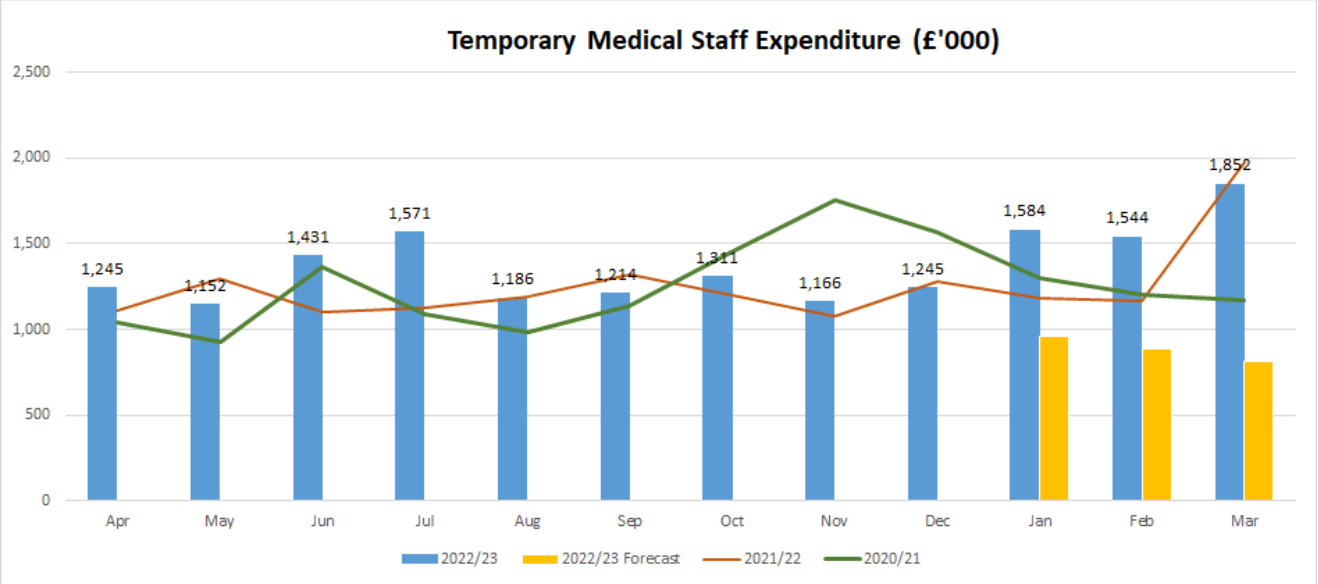
Overall Summary

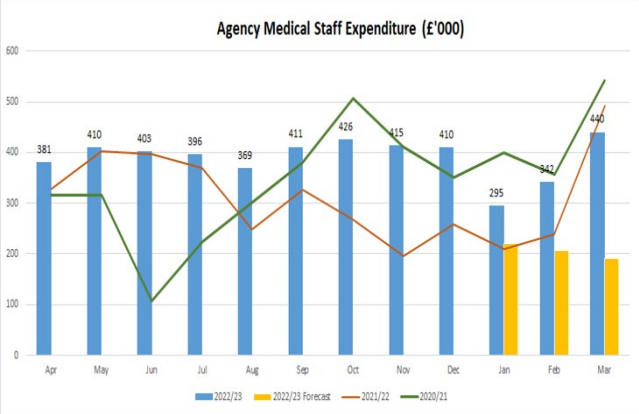
Temporary Nurse staffing spend has increased from £1.688m in February to £1.992m in March, this represents a reduction of £0.121m in spend seen in the same period of the prior year.

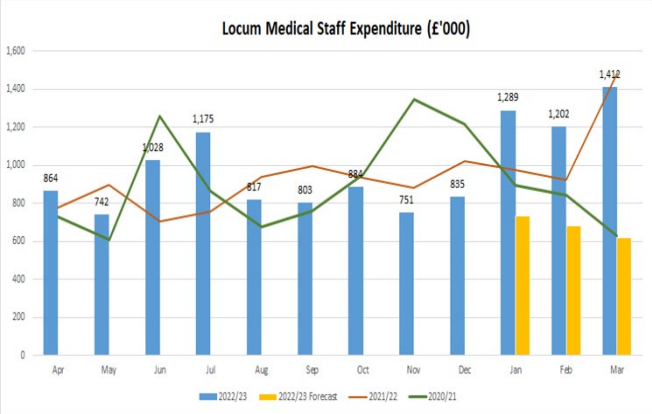
Agency spend increased to £0.468m from £0.410m in Feb. The main increases were seen in Paediatrics & Emergency Care and Medicine LTC, with a reduction seen in General Surgery.

Bank spend increased to 1.524m from £1.276m in Feb. The main increases were seen in Paediatrics & Emergency Care and Medicine LTC, with a reduction seen in General Surgery.

Temporary Medical Staffing







Overall Summary

Temporary Medical Staffing has increased from February to March by £308k due to increased usage of locums

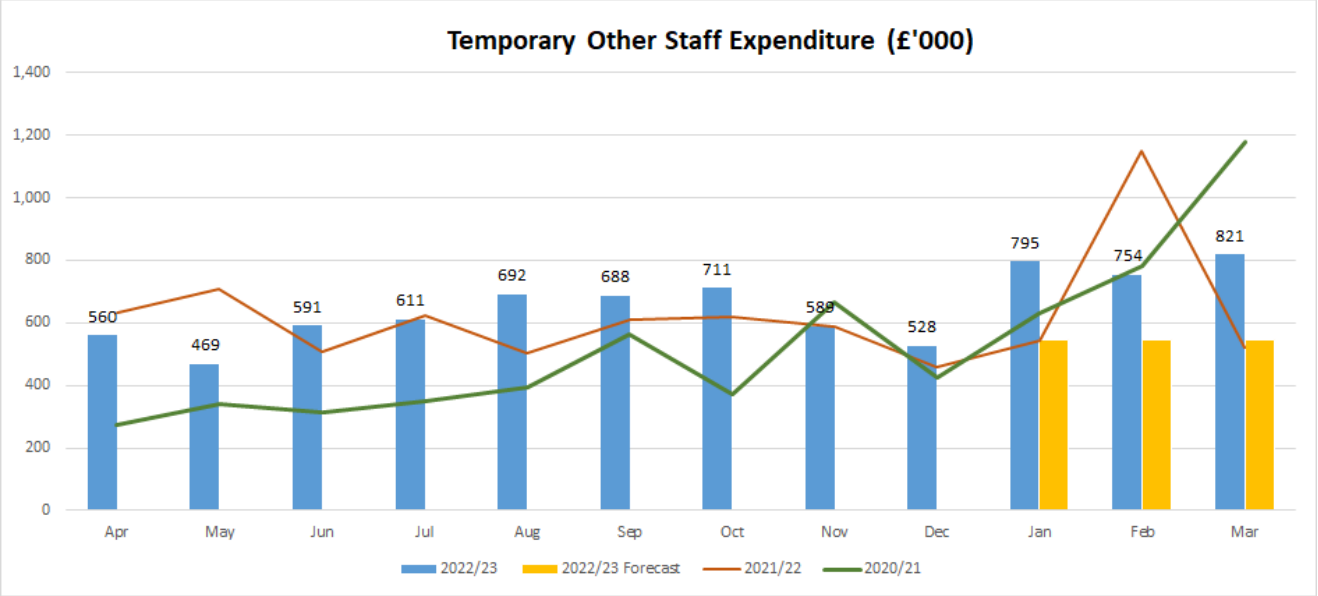
Key areas of increase are:

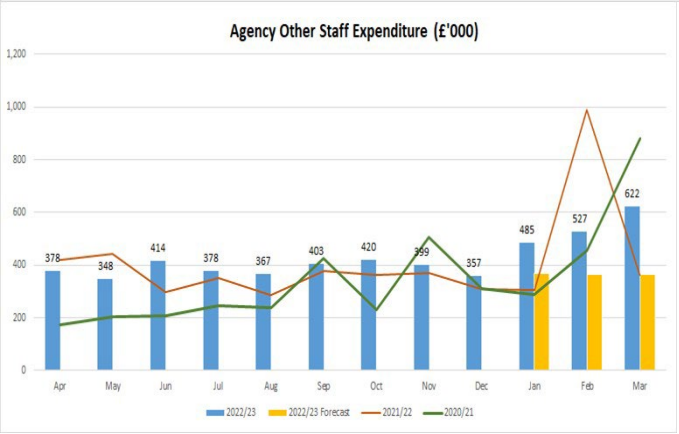
- Theatres & Critical Care
- Acute Care
- Elderly Care

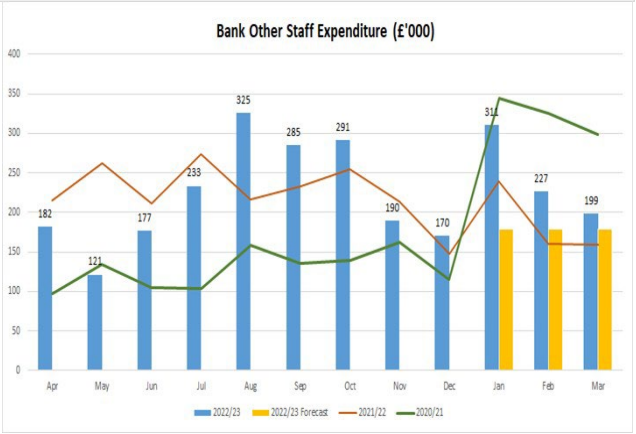
Key booking reason movements (based on TempRE booking system) between February and March are:

- Additional Capacity
- Industrial Action
- Winter

Temporary - Other Staffing



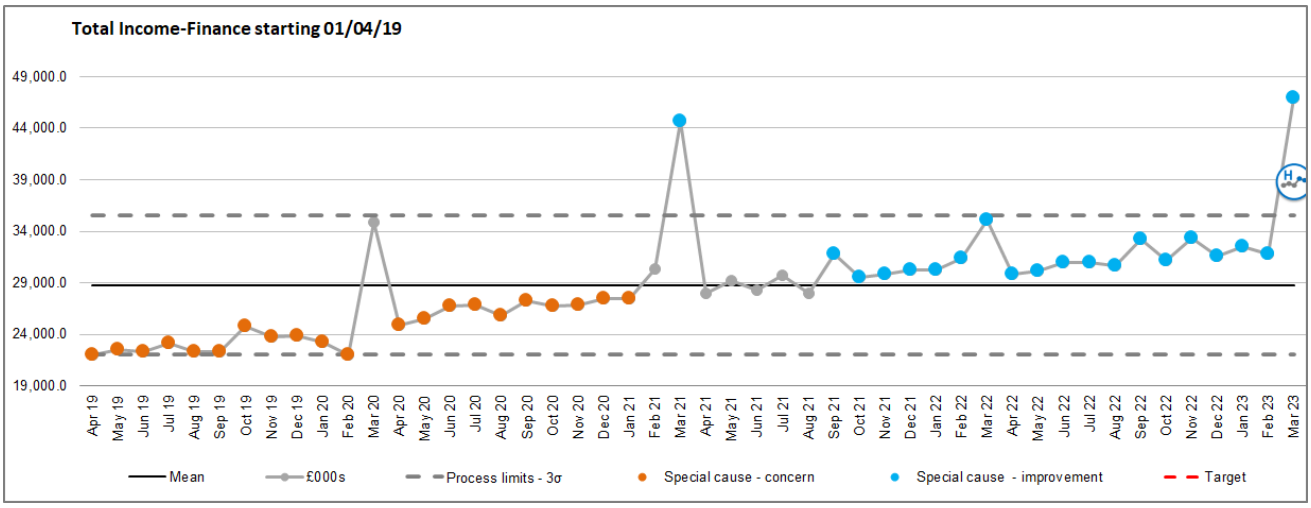




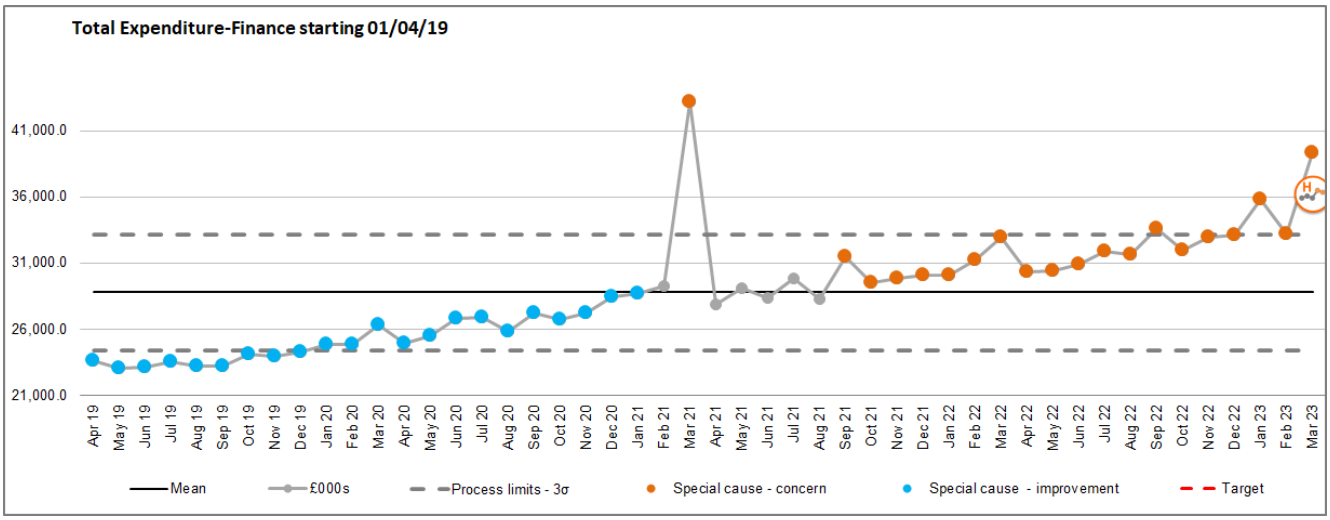
Temporary staffing spend in non-nursing and medical staff groups has historically been low but increased significantly due to the admin and clerical staff supporting the vaccination programme towards the end of 2022/23. The significant spike in spend in February is related to backdated admin agency related to the Vaccination programme and has been reclaimed as reimbursement.

Appendix 3 – Trust Income & Expenditure Charting of Run Rates

The graphs represent the income and expenditure trending information for the past 3 financial years:



In January 2020 - March 2020 the Trust received CCG funding support to enable achievement of control total and was able to claim the whole of Q4 FRF and PSF at £6.3m in March 2020 as well as central Covid-19 support. In February 2021 the Trust received an additional £2.3m NHSEI Income to offset 'lost income' assumed with the financial plan. In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment. The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears. The income increase in March 2022 relates to additional one-off income of £2.3m received through the ICS Risk Share.



In March 2020 increased costs were incurred in relation to the Maternity theatre impairment £1m & Covid expenditure £2.6m. Throughout 20/21 costs increased in support of COVID-19, with further increases for elective restart and provision for EPR, CEAs, annual leave and pay award impacts on cost base. March 21 spend includes non recurrent items such as Annual leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income. In September 2021 the back dated pay award was paid to staff, increasing in month spend by £2.5m. March 2022 saw a small increase in spend related to non recurrentl items such as the Annual Leave accrual.

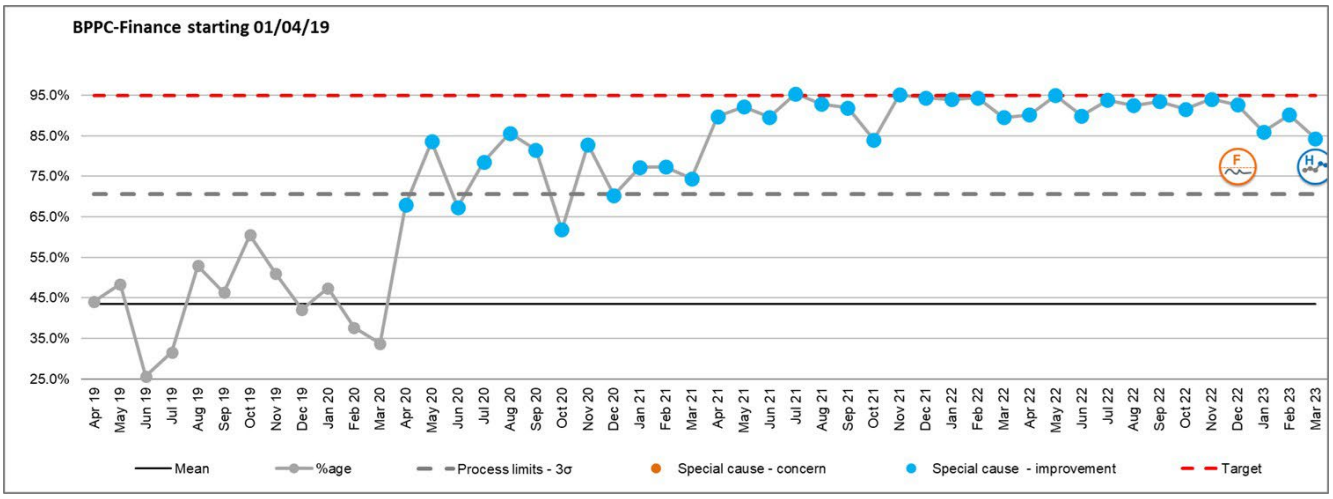
Walsall Healthcare NHS Trust

APPENDIX 4 – Capital Expenditure Full Year as @ Mar'23

Walsall Healthcare NHS Trust - Capital Programme 2022/23		
Scheme	**Annual Budget £000's**	**Full Year Spend £000's**
Estates:		
PFI Lifecycle	1,408	1,408
Emergency Department	23,847	20,438
Estates Lifecycle	1,100	2,676
Theatre Refurb	4,023	186
Wards Refurbishment	4,000	3,558
Chapel	400	13
Other Estates	1,439	2,054
Maternity	1,000	1,652
Estates Total	**37,217**	**31,984**
Medical Equipment:		
Medical Equipment Replacement	1,260	2,583
Mako Robot		1,443
Endoscopy Stack		2,080
Medical Equipment Total**	**1,260**	**6,106**
Information Management & Technology:		
IM&T Replacement	1,591	2,128
Information Management & Technology Total	**1,591**	**2,128**
Additional Funding In Year:		
Additional IMT Funding	1,658	1,588
Additional Medical Equipment Funding	480	442
Additional Falls capital monies	60	
Additional Funding Total	**2,198**	**2,030**
Grand Total	**42,266**	**42,248**

Walsall Healthcare NHS Trust

Appendix 5 - Better Payment Practice Code



The Trust is targeted with paying 95% of invoices under the Better Payment Practice Code within 30 days of receipt. The Trust in March 23 processed 91.1% YTD of its invoices within 30 days (91.9% in February), this remains in line with last year's performance previous year's 91.7% and an improvement over 2021/22, 73% in 2020/21 and 45% in 2019/20. In March, the Trust has paid 84.3**%** of all invoices within 30 days (below the Trusts target of 95%). Performance for Non-NHS invoices is 86% (down from a month average of 92.3%). Performance remains below the national target (YTD), this primarily relates to Agency invoices where only 74.1% YTD (87.1% in month, an improvement from February 67.1%) was passed due to staffing shortfalls within the approving department.

Walsall Healthcare NHS Trust

Trust Board Meeting	
Meeting Date:	Wednesday 7th June 2023
Title of Report:	Financial Performance Update Month 1
Action Requested:	Members of the Committee are asked to: Approve ☐ Discuss ☒ Inform ☐ Assure ☐
For the attention of the Board	
Assure	Members can take assurance over the Trust financial oversight from the following: • The Trust and System have submitted deficit plans of £14m and £74m respectively. • Capital expenditure plans need to be prioritised in order to live within the capital envelope of £25m • The Trust is holding significant cash balances at close of the period which provides stability regarding trading on a going concern basis moving forwards • The Trust has completed the NHSE Financial Sustainability review (reported to Audit Committee) and Internal Audit validated high or maximum scores in over 93% of areas. Benchmarking received from the RSM (Internal Audit), shows that WHT performed well above average across their client base. • The Trust achieved the highest possible Internal Audit rating in the Creditors internal audit. • The Trust has achieved financial balance in the last 3 years preceding 2022/23 and has also had 'clean' external audits. • The Trust continues to develop closer working relationships with Royal Wolverhampton Trust including the appointment of a Group CFO across both trusts. This will enable increased scrutiny and adoption of best practice.
Advise	The Trust has the following key elements for 2023/24 reported for members attention: • The overall ICB Month 1 position is £20.2m deficit against a planned deficit of £12.7m, (£7.5m variance). • The 2023/24 financial plan is challenging and contains significant risk. • The 2023/24 financial plan has seen reduced income baselines and capital funds. This has resulted in a requirement for significantly reduced expenditure run rates. • WHT have re-profiled the submitted deficit plan to account for planned mitigations taking effect • The income movements following Covid-19 rescinding and changes to IPC guidelines has resulted in reduced income allocations for the 2023/24 financial year. It will be important the Trust moves quickly into financial recovery, more 'normal'

	operational performance and key aspects to financial sustainability will be: • Delivery of efficiencies in year • Reduction in use of temporary workforce (removal of agency and temporary costs supporting unfunded areas and performance) • Securing income allocated to the system for the Trust • Reduction where appropriate of covid designated expenditure • Delivery of the regulatory imposed productivity gains in order to deliver the ERF target Capital expenditure plans need to be prioritised in order to live within the capital envelope
Alert	The report draws the attention of committee to: • The Trust has submitted a deficit plan of £14.05m • The Trust has delivered a deficit of £3.915m at Month 1, this is £1.096m above the planned deficit of £2.819m. • The income movements following Covid-19 rescinding and changes to IPC guidelines has resulted in reduced income allocations for the 2023/24 financial year. It will be important the Trust moves quickly into financial recovery, more 'normal' operational performance and key aspects to financial sustainability will be: • Delivery of efficiencies in year • Reduction in use of temporary workforce (removal of agency and temporary costs supporting unfunded areas and performance) • Securing income allocated to the system for the Trust • Reduction where appropriate of covid designated expenditure • Delivery of the regulatory imposed productivity gains in order to deliver the ERF target • Capital expenditure plans need to be prioritised in order to live within the capital envelope of £25m • Efficiency and Cost Improvement Programme plans are currently £12.1m short of the £17.2m target • Temporary staffing costs remain high and require planned reductions to take place to achieve the agreed financial forecast. • The Trust is £0.178m below the ERF plan for April 2023 • The financial settlement offered to the Trust for 2023/24 has a considerable decrease in revenue. Trust plans show a higher % reduction in income than other acute providers in the system. • The Trust is in discussion with BC ICB on a range of services that have traditionally being funded outside block but have not been in 2023/24 or 2022/23. The Trust may wish to terminate these services on the basis 50% of the funding has been offered.

	The report recommends: • That members note the 2023/24 plan and the risks contained within. • That members continue to seek assurances over delivery of the efficiency programme, agency cessation and overall temporary cost trajectories across 2023/24 That the Trust enters 2023/24 with a significant underlying revenue deficit.
Author **Responsible Director** **Contact Details:**	Robin Andrews – Interim Operational Director of Finance robin.andrews4@nhs.net Kevin Stringer – Group CFO Email kevin.stringer@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	
Improve the Healthcare of our Communities	
Effective Collaboration	
Resource Implications:	The report summarises revenue and capital positions of the Trust for the current and next financial years
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	Nothing specifically associated with this report
Risks: BAF/ TRR	Corporate Risks 2081 and 2082
Risk: Appetite	
Public or Private:	Private
Other formal bodies involved:	NHSE
References	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	**Financial Performance Update Month 1**

1. PURPOSE OF REPORT

The purpose of the report is to inform members of the Performance and Finance Committee of the financial performance of the Trust for the 2023/24 and attainment of the financial plan (revenue, capital, and cash).

1.1 BACKGROUND

In accordance with national planning guidance, the Trust submitted a Board endorsed financial outturn of a £31.3m deficit in March 2022, system deficit for the Integrated Care System (ICS) being c£145.8m.

National colleagues reviewed the submissions and fed back to the system that plans were not affordable, the ICS was a national outlier for planned financial performance and that there was a requirement to improve significantly.

The regulator required a further round of planning following the March 2023 submission. The Trust re-submitting the financial plan for the 2023/24 financial year from the £31.3m deficit to a £14.0m deficit, as endorsed through the Extraordinary Board on 3rd May 2023. The ICS submitted a revised deficit of £68.9m.

	ICB	BCH	DIHC	SWBH	DGFT	RWT	WHT	WMAS	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Draft Plan Submission 23rd Feb	**0.00**	**0.00**	**0.00**	**(71.00)**	**(69.00)**	**(83.00)**	**(51.00)**	**(63.00)**	**(337.00)**
Income	0.00	0.00	0.00	7.10	5.70	9.90	4.40	43.10	70.20
Expenditure	0.00	1.10	0.65	8.20	12.50	15.30	10.20	15.60	63.55
Technical	20.00	2.80	0.15	25.80	0.00	(0.70)	5.10	4.30	57.45
Plan submission 30th March	**20.00**	**3.90**	**0.80**	**(29.90)**	**(50.80)**	**(58.50)**	**(31.30)**	**0.00**	**(145.80)**
Income	(10.80)	0.00	0.00	9.00	7.10	9.90	5.10	0.00	20.30
Expenditure	0.00	0.00	0.00	2.20	2.50	3.50	1.80	0.00	10.00
Technical	25.00	0.00	0.30	6.10	0.00	3.00	7.20	0.00	41.60
25th April position	**34.20**	**3.90**	**1.10**	**(12.60)**	**(41.20)**	**(42.10)**	**(17.20)**	**0.00**	**(73.90)**
Distribution of ICB surplus	(34.20)	0.00	0.00	0.00	19.80	13.30	1.10	0.00	0.00
Residual ICS challenge	0.00	0.00	0.00	(6.15)	2.05	2.05	2.05	0.00	0.00
27th April position	**0.00**	**3.90**	**1.10**	**(18.75)**	**(19.35)**	**(26.75)**	**(14.05)**	**0.00**	**(73.90)**

N.B.
The ICB declared a £5m planned surplus at submission bringing the revised system deficit plan to £68.9m.

1.2 Plan Profile

The Trust submitted a deficit profile on 4th May based on delivery of efficiencies growing throughout the year and higher spend during the winter months resulting in a profile with higher deficits in the early and later months of the year with smaller deficits during summer.

Upon review it has been identified that a £12.5m staffing challenge has been profiled broadly evenly, further analysis indicates the Trust requires a re-profiled delivery of this element of the financial plan to reflect the plans in production.

This reprofile is centred around pushing the majority of the challenge £12.5m challenge sitting in M1-4 into M5-12. The logic behind this is that grip and control measures and mitigations are yet to take a grip or be implemented or currently being planned. The main items not impacting M1-4 are:

- Vacancy control panel
- Agency spend control processes/panel
- Temp medical spend planned mitigations in development
- Temp Nursing review against delegated budgets
- Vacancy freeze
- Others still to be identified

Therefore the Trust is requesting the plan reprofile below which pushes 85% of the £4m challenge in M1-4 into M5-12 of the year. This produces the below revised deficit profile for the Trust which pushes the M1 planned deficit from £2.1m to £2.8m.

Re-profile 85% of M1-4 challenge	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Submitted deficit profile	(2,129)	(1,550)	(1,499)	(2,298)	(502)	158	(1,153)	(232)	(562)	(1,718)	(793)	(1,740)	**(14,018)**
Revised deficit profile	(2,819)	(2,523)	(2,342)	(3,267)	(1,333)	(344)	(1,402)	(461)	587	(282)	485	(316)	**(14,018)**

2. FINANCIAL PERFORMANCE MONTH 1

2.1 Black Country Integrated Care System

- Although there is no national reporting at Month 1, Trusts have submitted a summary of their month 1 performance data to the ICS.
- This data indicates that the ICS is off plan in the month one. This is a £20m deficit representing an adverse variance of £7.5m (2.9% of the M1 ICS allocation). All organisations except Dudley Group and West Midlands Ambulance Service are in deficit.
- The key adverse variances reported by organisations are against Income (£8.3m) and Pay (£4.3m) budgets.

The financial positions for ICS member organisations is:

Item	Revenue Position			
	Plan Mth 1 £'000	Actual Mth 1 £'000	Variance Mth 1 £'000	Variance Mth 1 % *
BCH	325	(331)	(656)	(2.5)%
DIHC	72	33	(39)	(1.8)%
SWBH	(2,566)	(5,328)	(2,762)	(4.9)%
DGFT	(2,593)	(2,559)	34	0.1%
RWT	(5,997)	(8,287)	(2,290)	(3.2)%
WHT **	(2,129)	(3,915)	(1,786)	(6.0)%
WMAS	189	238	49	0.1%
ICS	**(12,699)**	**(20,149)**	**(7,450)**	**(2.9)%**

* Percentage of Planned Turnover

** Plan to be reprofiled. Variance to reprofiled plan is £1.1m

N.B.
Members of the committee are asked to note the re-profiled % variance of planned turnover is 3.4%.

2.2 Walsall Healthcare Trust Financial Performance 2023/24 Month 1

2.2.1 Revenue

In Month Position

The April 2023 in month actual position was a £3.915m deficit, £1.096m above plan (£2.819m) – See Appendix 1

Income was £0.243m higher than plan due to additional Education & Training income (offset by costs), one-off community FCP income and passthrough drugs over performance. This was offset by £0.178m ERF underperformance against the Trust planned delivery for April.

Staffing costs were above plan in month (£0.969m).This was driven by substantive staff costs underspend due to vacancies in Surgery, WCCSS, & MLTC offset by overspends in Temporary Nursing (vacancy & sickness cover A&E, AMU, PAU, Theatres, ICU & Community) and Temporary Medical (Vacancy cover in Acute, Emergency Care, Obs, Imaging, Paediatrics & Surgery). Temporary costs for the “other” staff group also overspent in Imaging, Cancer, Pharmacy, I.T., Audiology and MLTC. Additional staffing costs associated with the impact of the Jnr Dr strike are £0.407m.

This is being investigated within Divisions and additional actions will be necessary to bring back to budget.

Non-pay costs were over plan (£0.368m). Driven by Drugs, Provisions & Catering, Energy, Business Rates and Pathology Services. Again further work to understand the drivers and determine possible mitigation is underway.

Drivers of the position

The submitted plan included risks associated with known inflation above the planned levels agreed by the system. There are also other adverse variances to plan which are outside of the control of WHT. The table below details uncontrollable costs in Month1:

Driver	£000's
Excess Inflationary Pressures	
Drugs (incl volume)	141
Energy	97
Business Rates	23
Excess Inflationary Pressures - sub total	**261**
Drivers outside WHT Control	
Jnr Dr Strike - Acting Down	306
Jnr Dr Strike - Temp Costs	101
Drivers outside WHT Control - sub total	**407**
Other Drivers	
CIP (excess of 6%)	329
Other	99
Other Drivers - sub total	**428**
Total variance to plan	**1,096**

In summary, the Trust position contains pressures highlighted as inflationary risks of £0.261m, pressures driven by the Jnr Dr strike of £0.407m and £0.428m of pressures linked to under delivery of the efficiency plan and temporary staffing.

2.2.2 Efficiencies

The Cost Improvement Programme (efficiency) identified £5.1m of savings for 2023/24 against a divisional target of £17.2m (a shortfall of £12.1m in schemes needed to deliver the required levels of saving) with 29.7% of the £5.1m of schemes rated as high risk. Significant work is needed to identify further schemes / mitigations to close the remaining CIP gap.

At Month 1 there has been delivery of £0.1m against a plan of £0.3m. However, if the plan was phased in equal twelfths the Trust would need to secure £1.4m YTD and have therefore an adverse variance of £1.3m (CIP plans and unidentified schemes are back phased).

Additional stretch CIP of £7.2m (Balance Sheet Release) and £2.05m is targeted against non-operational budgets adds further risk to the CIP programme (also phased in the latter end of the financial year)

Further detail on the efficiency programme is included within a separate report on the PF agenda by the Chief Operating Officer who oversees CIP efficiency delivery. It is imperative that the CIP plan is delivered in order to achieve the planned budget deficit.

3. Balance Sheet

3.1 Working Capital

As the Trust financial position deteriorates it is important to understand and assess the movement in working balances, to ensure cash is available to service:

- Payments to our staff
- Payments to our suppliers of goods and services

- Payment for capital works and repayment of loan liabilities (PFI)

Trade and Other Receivables Analysis	April 2023 Actual		(DRAFT) March 2023 Actual	Variance
	£'000		£'000	£'000
Debtors NHS (Accounts Receivable and Accrued)	13,785		10,930	2,855
Debtors non-NHS	6,705		7,544	(839)
Debtors - Prepayments	14,297		11,626	2,671
Bad Debt Provision	(1,789)		(1,808)	19
Total Trade and Other Receivables	**32,998**		**28,292**	**4,706**

In line with previous discussions at PF, the table below highlights the position with Black Country ICB who make up the majority of the NHS debt.

Breakdown of ICB Debtors @30th April 23	Value	Commentary
Trade Debt	£'m	
Legacy Debt from Walsall CCG	0.34	This debt is old and has been provided for
Disputed Items	4.67	Income for these items has been received via the BC ICB year end agreement, so no further I&E impact. Discussions for these services with the ICB for next year continue
Items raised in April 23 (under 30 days)	7.15	Invoices raised as part of YE settlement (mainly relating to Risk Share and IFRS16 Allocations)
Payments Received	-2.11	Relating to invoices raised in April 23
Items over 30 days awaiting approval @30 April (not disputed)	1.19	This primarily relates to the provision of ICT services to the ICB. Further work is taking place.
NHS Debt	**11.24**	

CREDITORS

Trade and Other Payables Analysis	April 2023 Actual		(DRAFT) March 2023 Actual	Variance
	£'000		£'000	£'000
Trade Creditors	4,148		6,232	(2,084)
Capital Creditors	2,714		7,355	(4,641)
NHS Creditors	15,260		4,008	11,252
Creditor Accruals	17,539		23,376	(5,837)
Deferred Income	3,460		711	2,749
Other Creditors	16,237		16,408	(171)
Tax, NI	5,606		4,920	686
Total Trade and Other Payables	**64,964**		**63,010**	**1,954**

Trade Creditors and Capital Creditors have reduced in April 23 reflecting payments made following year end. NHS Creditors are increased due to Q1 charges now being invoiced and is also reflected in the increase of pre-payments. The Trust continues to minimise NHS creditors to simplify Agreement of Balances. However, 65.1% of NHS creditors (90.9% in volume) have been paid within 30 days in April 23 and in 2022/23 this was 76.2% (83.1% volume).
Key variances to year end on Deferred Income since 22/23-year end mainly relates to the receipt of Q1 HEE income and cancer funding.

Description	Balance 31st March 2023 £m's	Balance 30th April 2023 £m's	Movement (adverse) / positive £m's
Cash held and in Bank	38.4	32.5	(5.9)

The Trust has maintained a positive cash balance, the reduction centring upon the movement in working balances and cash outflow to service trade and capital creditors. The cash position remains positive, though at planned deficit levels (noting also balance sheet flexibility release will not provide cash to service increased costs above I&E outturn) the Trust needs to carefully manage and project cashflows to maintain payment terms for suppliers (in addition to staff).

There will be a need to accurately forecast cashflows at Trust and system level as there is a possibility that cash will need to move around the system if providers have insufficient working capital to operate.

4. Capital

2023/24

Trust Board approved a level of capital expenditure of £25m for the 2023/24 financial year. This includes £2.5m of PDC funding for digital aspirant schemes and £12.6m grant funding for decarbonisation projects.

Details of the April 2023 position are included in **Appendix 4**.

5. Summary, Key Risks & Mitigations

Black Country and West Birmingham Integrated Care System:
The overall ICB Month 1 position is £20.2m deficit against a planned deficit of £12.7m, (£7.5m variance).

Trust:

Revenue
The April 2023 Month 1 position was a £3.915m deficit, £1.096m above the £2.819m planned deficit. The drivers were Income higher in the month (£0.343m) offset by Staffing costs above plan (£0.969m) and non-pay costs above plan (0.368m).

Capital and Balance Sheet
- The capital plan in 2023/24 is not fully funded and projects need to be prioritised to live within the available envelope.

- Debtors are being progressed and further escalation will be needed if progress is not made.
- The Trust is currently holds a healthy cash position but this is planned to be utilised throughout 2023/24.

Risks

If the Trust were to move away from our submitted deficit position the following consequences would apply:

- Risks to movement from level 3 to level 4 mandatory intervention for the Trust
- Impact on 'Use of Resources' and thus CQC rating (to include 'well led')

Financial risks notified to the board upon adoption of the financial plan are:

- Failure to deliver the efficiency target
- Failure to recover in month overspends
- Failure to deliver the stretch £7.2m B/S flexibility
- Failure to deliver the stretch £2m fair share system challenge
- Inflationary pressures forecast but taken as a risk into the plan
- Failure to meet NHSE/I ERF target
- Income disputes with the BCICB and BSOLICB
- Failure to adequately reduce temporary staffing levels
- Winter pressures above planned resources

Governance and next actions:

- The risks to achievement of revenue and capital outturn highlighted to Executive, TMC, P&F and Trust Board
- Director of Nursing & Medical Director developing plans to reduce Temporary Workforce costs.
- Recurrent CIP plans need to be developed further and focused on.
- Current position highlights a significant risk to plan delivery in 2023/24.
- Currently identified capital needs exceed funding in 2023/24 plan but will be addressed through prioritisation via the capital control group.
- Pressures and investments for 2023/24 are still to be prioritised by Executive.

APPENDICES

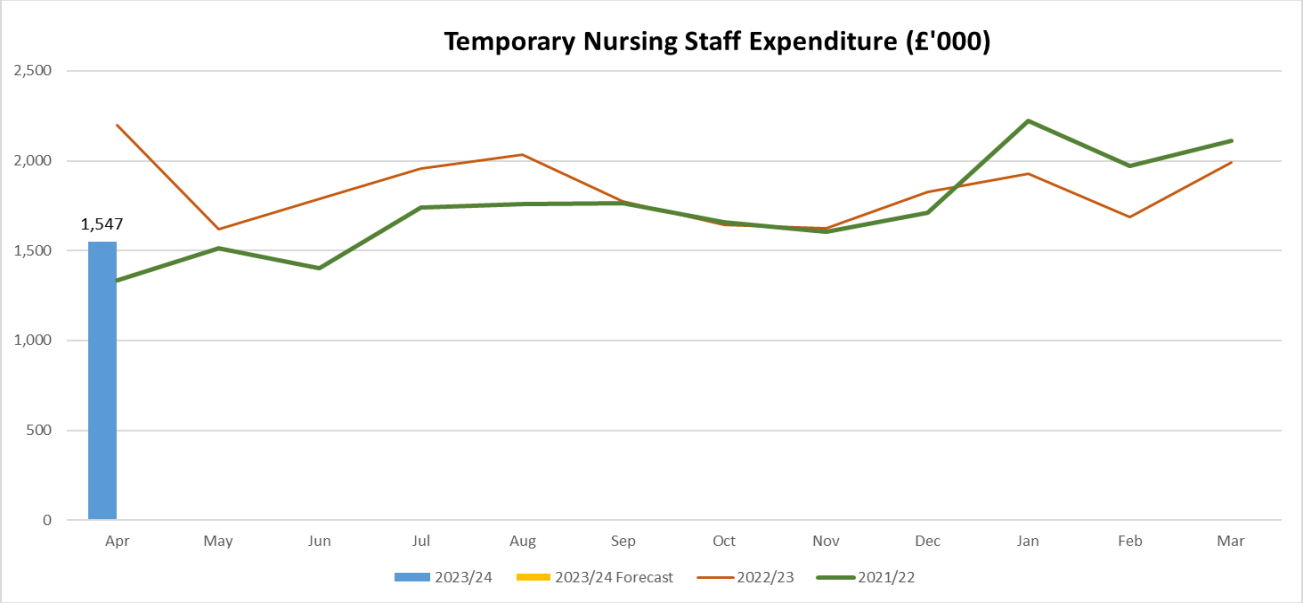
1. Financial Performance 2023/24
2. Temporary Staffing 2023/24
3. Trust charting of income and expenditure run rates (SPC charts)
4. Capital Programme
5. Performance against Efficiency Targets
6. Better Payment Practice Code Performance

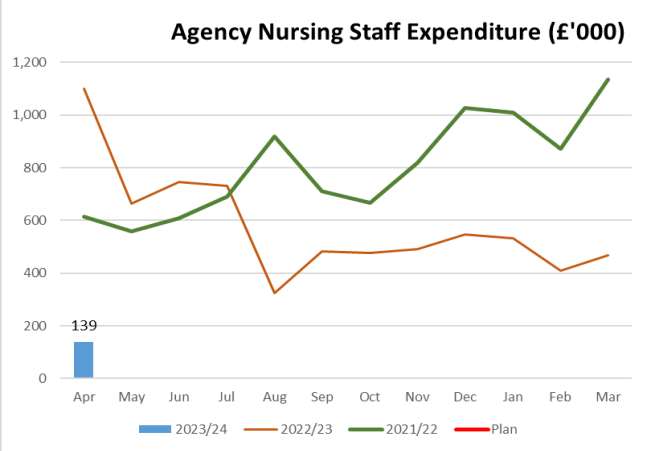
Appendix 1 -Trust wide Financial Performance 2023/24 as at Month 1

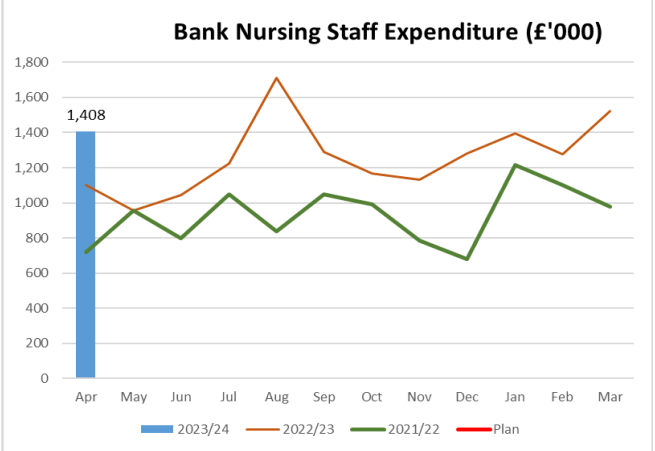
Year to Date Plan v Actual

	Mth 1 Plan £000s	Mth 1 Actual £000s	Mth 1 Variance £000s
Income			
Healthcare Income	27,708	27,646	**(63)**
Other Income (Education&Training)	632	792	**160**
Other Income (Other)	1,625	1,771	**146**
Subtotal Income	**29,966**	**30,209**	**243**
Pay Expenditure			
Substantive Salaries	(20,554)	(18,469)	**2,085**
Temporary Nursing	(261)	(1,551)	**(1,291)**
Temporary Medical	(101)	(1,190)	**(1,090)**
Temporary Other	(33)	(706)	**(674)**
Subtotal Pay Expenditure	**(20,948)**	**(21,917)**	**(969)**
Non Pay Expenditure			
Drugs	(1,523)	(1,672)	**(149)**
Clinical Supplies and Services	(1,513)	(1,328)	**185**
Non-Clinical Supplies and Services	(2,426)	(2,841)	**(415)**
Other Non Pay	(3,170)	(3,159)	**11**
Depreciation	(1,159)	(1,159)	**(0)**
Subtotal Non Pay Expenditure	**(9,792)**	**(10,160)**	**(368)**
Interest Payable	(1,069)	(1,069)	**0**
Subtotal Finance Costs	**(1,069)**	**(1,069)**	**0**
Total Surplus / (Deficit)	**(1,843)**	**(2,937)**	**(1,094)**
Donated Asset Adjustment	(976)	(978)	**(2)**
Adjusted Surplus / (Deficit)	**(2,819)**	**(3,915)**	**(1,096)**
Plan Re-profile	690		**(690)**
Submitted Plan Profile	**(2,129)**	**(3,915)**	**(1,786)**

Appendix 2 – Temporary Staffing Report







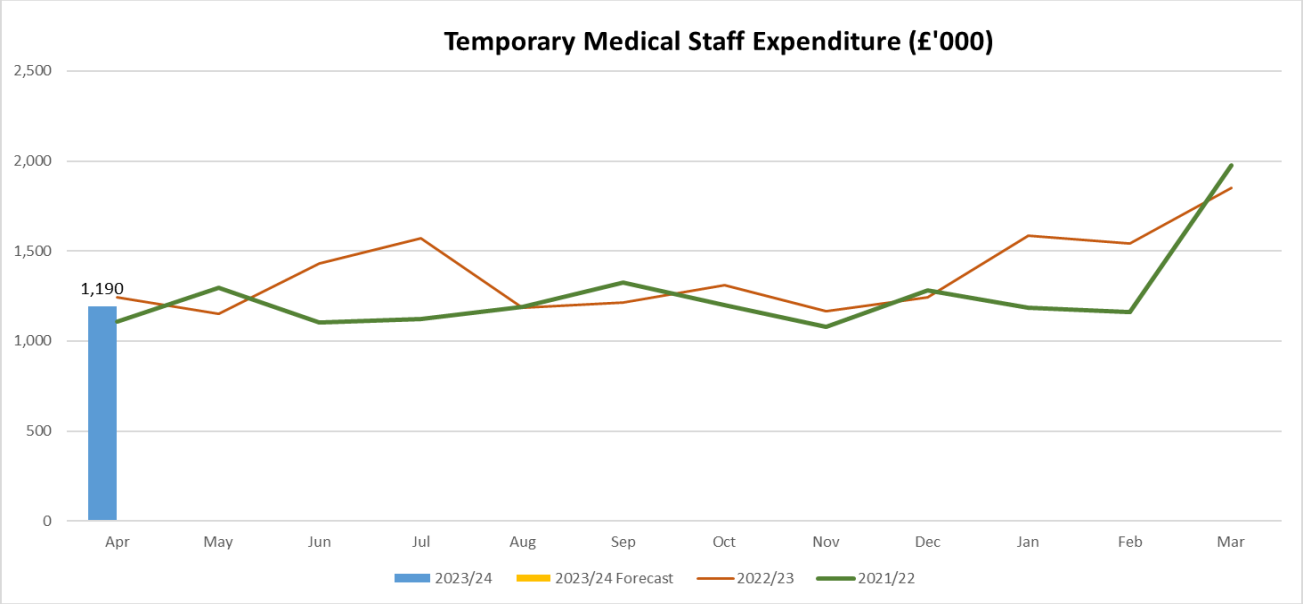
Overall Summary

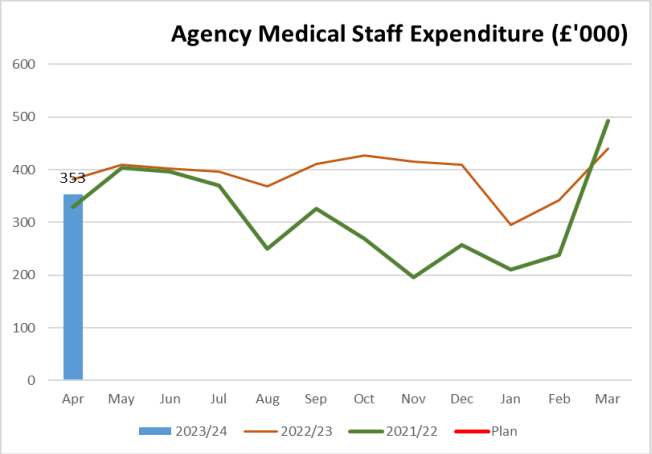
Nursing temporary staffing overall has reduced from March 23 to April 23 by c£0.5m, with the majority of the reduction from agency.

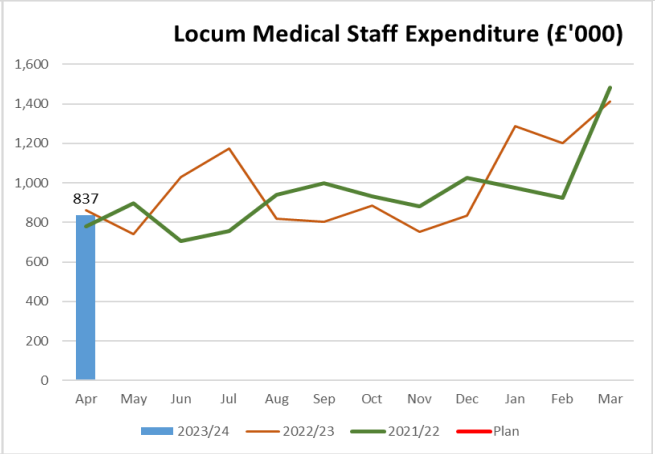
The reduction from agency is due to less vacancy bookings mostly coming from ward 5/6 and A&E. Sickness usage has also come down, mostly coming from theatres, A&E and ward 5/6.

The reduction in bank is due higher levels in March 2023 as a result of the transition into the new ED.

Temporary Medical Staffing







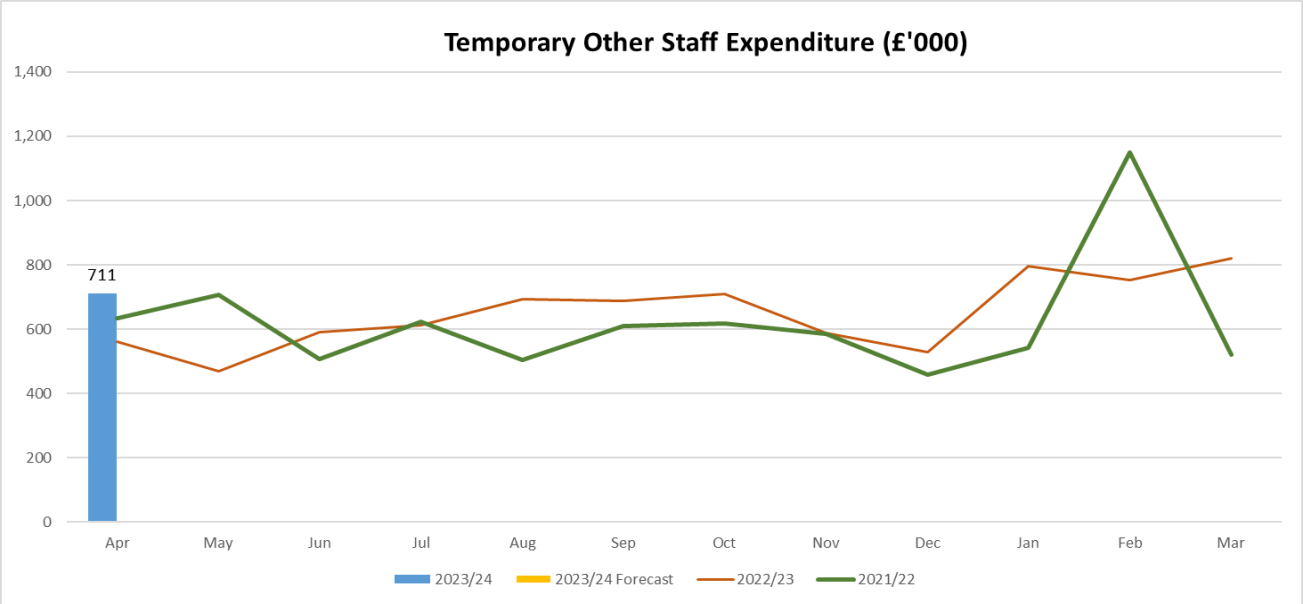
Overall Summary

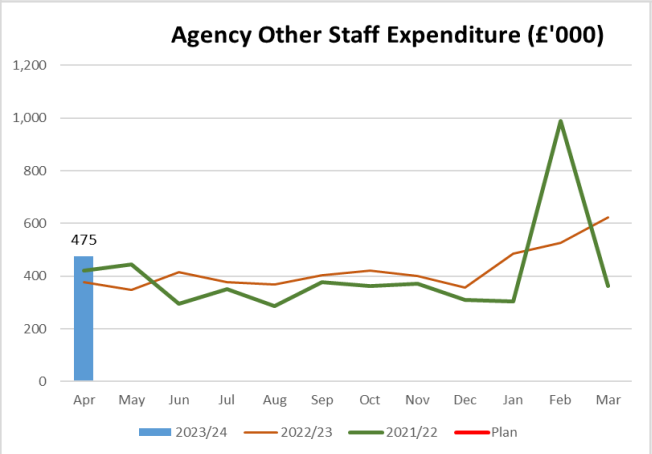
Temporary Medical Staffing has reduced from March to April by £662k due to decreased use of Agency and Locums.

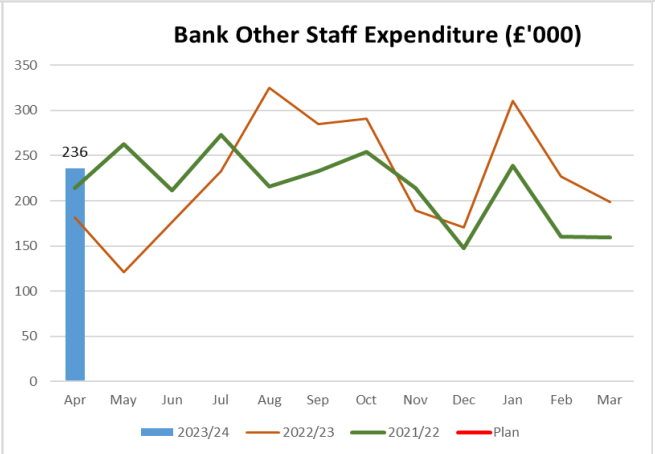
Main specialties incurring spend in April are:

- Emergency Care £268k
- Medicine LTC £234k
- Elderly Care £108k

Temporary - Other Staffing





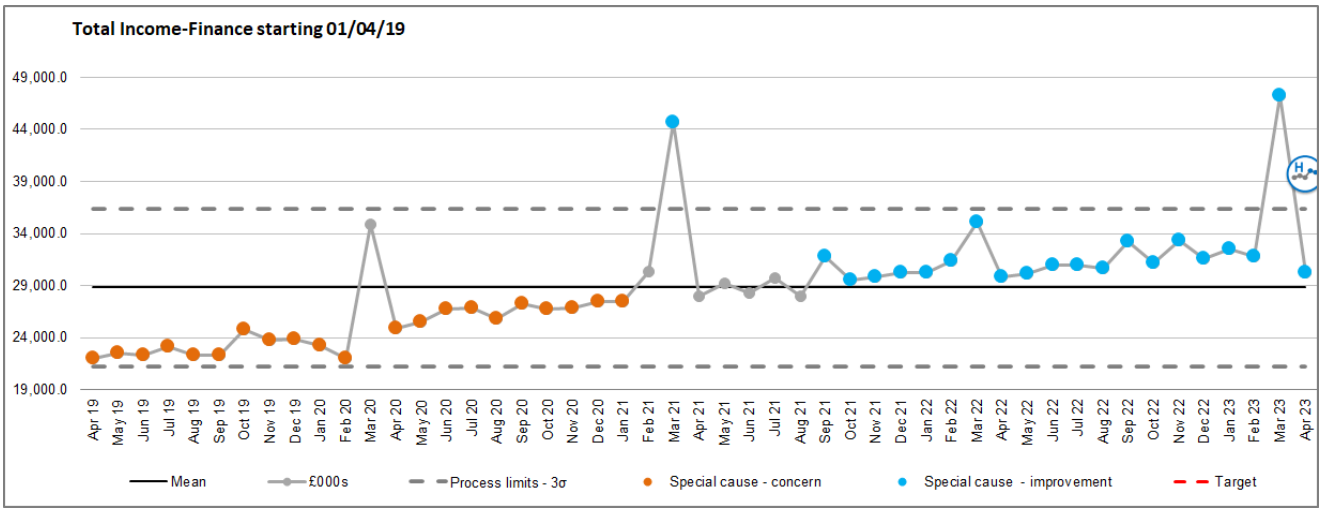


Overall Summary

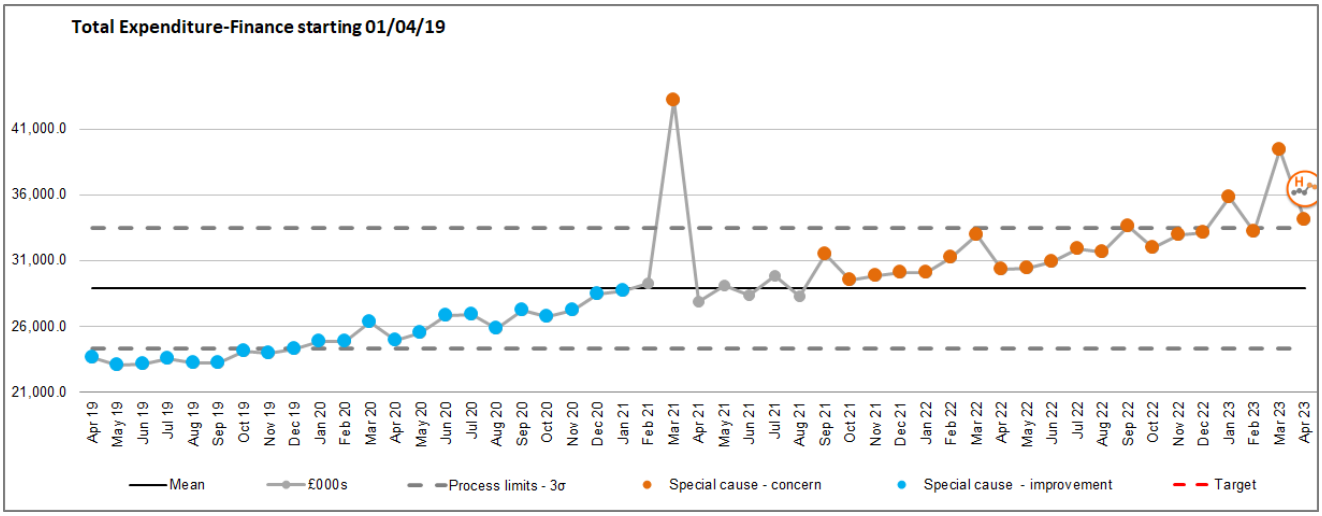
Temporary spend levels in “other” have come down from March 2023 but are still significantly above planned levels and are driven by ED admin, Estates and diagnostic services.

Appendix 3 – Trust Income & Expenditure Charting of Run Rates

The graphs represent the income and expenditure trending information for the past 3 financial years:



In January 2020 - March 2020 the Trust received CCG funding support to enable achievement of control total and was able to claim the whole of Q4 FRF and PSF at £6.3m in March 2020 as well as central Covid-19 support. In February 2021 the Trust received an additional £2.3m NHSEI Income to offset 'lost income' assumed with the financial plan. In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment. The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears. The income increase in March 2022 relates to additional one-off income of £2.3m received through the ICS Risk Share.



In March 2020 increased costs were incurred in relation to the Maternity theatre impairment £1m & Covid expenditure £2.6m. Throughout 20/21 costs increased in support of COVID-19, with further increases for elective restart and provision for EPR, CEAs, annual leave and pay award impacts on cost base. March 21 spend includes non recurrent items such as Annual leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income. In September 2021 the back dated pay award was paid to staff, increasing in month spend by £2.5m.

March 2022 saw a small increase in spend related to non recurrentl items such as the Annual Leave accrual.

Walsall Healthcare NHS Trust

Appendix 4 – Capital Expenditure as @ April'23

Alternate Version below:-

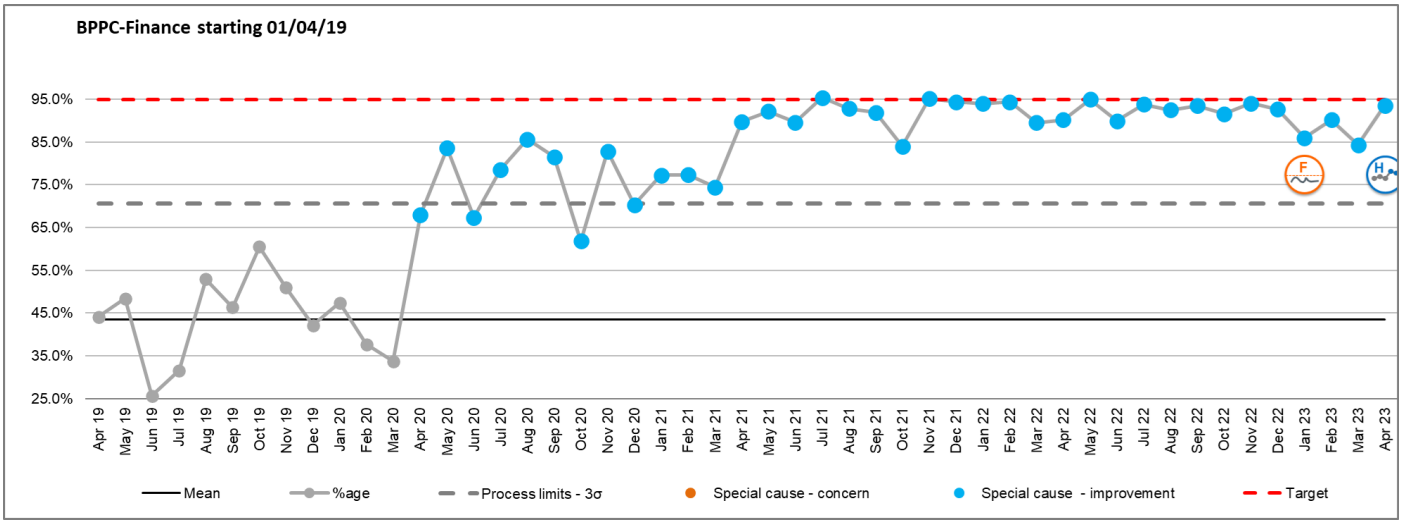
Walsall Healthcare NHS Trust - Capital Programme 2022/23		
Scheme	**Month 1 Budget £000's**	**Month 1 Spend £000's**
Estates:		
PFI Lifecycle	124	126
Estates	1,280	13
Estates Total	**1,404**	**139**
Medical Equipment:		
Medical Equipment Replacement		183
Medical Equipment Total**		**183**
Information Management & Technology:		
IM&T Replacement		15
Information Management & Technology Total		**15**
Grand Total	**1,404**	**337**

Appendix 5 – Performance against Efficiency Targets

Division	Target	YTD Target	YTD Plan	YTD Actual	Variance
Community	2,621,000	218,417	70,428	0	(70,428)
DoS	3,474,000	289,500	54,947	17,277	(37,670)
Estates	1,250,000	104,167	20,178	3,031	(17,147)
MLTC	3,908,000	325,667	0	0	0
WCCSS	3,882,000	323,500	44,125	833	(43,292)
Corp (IMT)	444,000	37,000	37,883	37,922	39
Corp (HR)	242,000	20,167	12,479	12,479	0
Corp (Fin)	360,000	30,000	22,000	21,053	(947)
Corp (Nurs)	314,000	26,167	0	0	0
Corp (Comms)	21,000	1,750	0	0	0
Corp (COO)	188,000	15,667	0	0	0
Corp (MD)	253,000	21,083	0	0	0
Corp (Gov)	173,000	14,417	0	0	0
Corp (Improv)	70,000	5,833	5,918	5,918	0
Trust Wide (Proc)	0	0	25,000	0	(25,000)
Grand Total	**17,200,000**	**1,433,335**	**292,958**	**98,513**	**(194,445)**

Walsall Healthcare
NHS Trust

Appendix 6 - Better Payment Practice Code



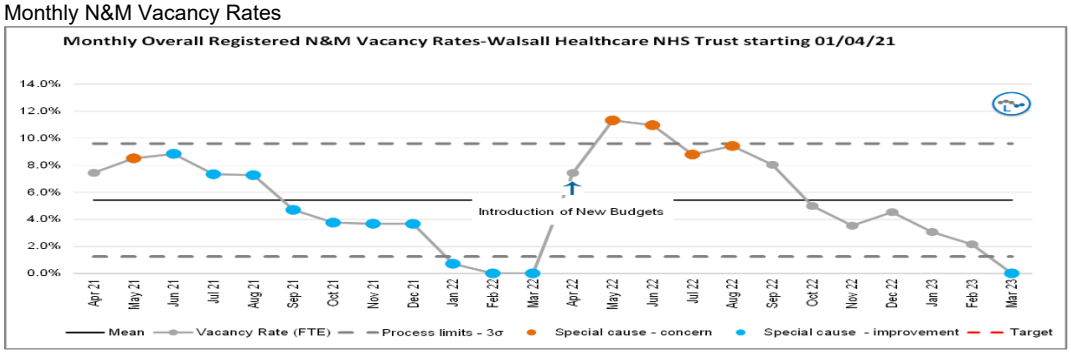
The Trust is targeted with paying 95% of invoices under the Better Payment Practice Code within 30 days of receipt. The Trust in April 23 processed 93.6% of its invoices within 30 days, this remains an improvement previous year's 91.1% in 2022/23, 91.7% in 2021/22, 73% in 2020/21 and 45% in 2019/20. In April 23, the Trust has paid 93.6**%** of all invoices within 30 days (below the Trusts target of 95%). Performance for Non-NHS invoices is 94.6% (up from 2022/23's 92.3%). Performance remains below the national target (in month and YTD), this primarily relates to Agency invoices where only less than 72% of invoices are passed within 30 days due to staffing shortfalls within the approving department.

1.0 Workforce

1.1 Nursing and Midwifery staffing

- In March 2023 the total number of Registered Nurse/Midwife vacancies decreased from 3% to just over 1%.

Monthly N&M Vacancy Rates

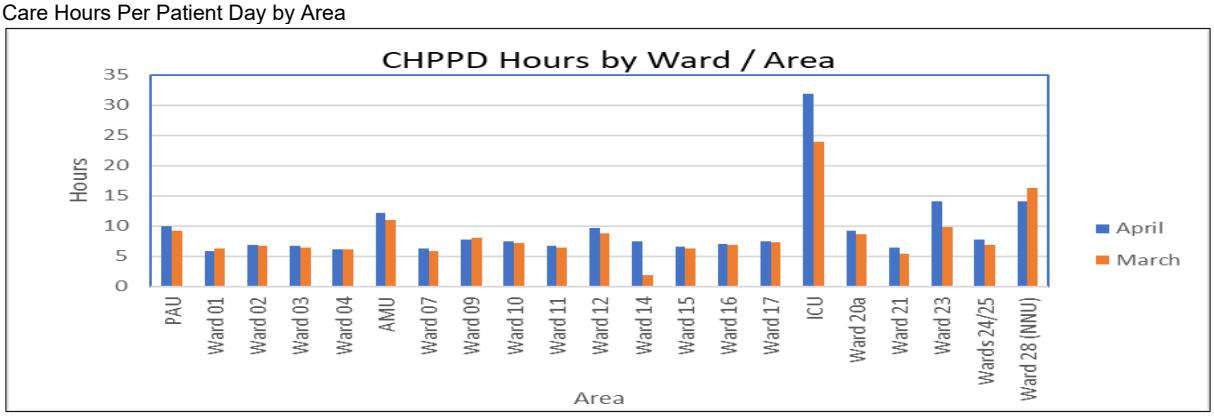


- Throughout 2022/23 a total of 302 Clinical Fellowship Nurses (CFNs) have been recruited into the Trust. 17 arrived in April 2023 and a further 20 are expected in May 2023.

1.2 Care Hours per Patient Day (CHPPD)

- CHPPD Trust average for April 2023 was 8.0, an increase from March 2023 (7.5) in comparison to the national average of 8.1. Model Hospital data has not been updated since January 2023.

Care Hours Per Patient Day by Area



1.3 Rosters and Attendance

- The combined sickness for March 2023 was reported at 3.26%, 1.06% Short-term and 2.20% Long term sickness (latest available data).
- Scheduled rostering confirm and challenge meetings are in place to ensure best rostering practice and compliance with KPIs.

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1.4 Retention – Registered and non-registered staff

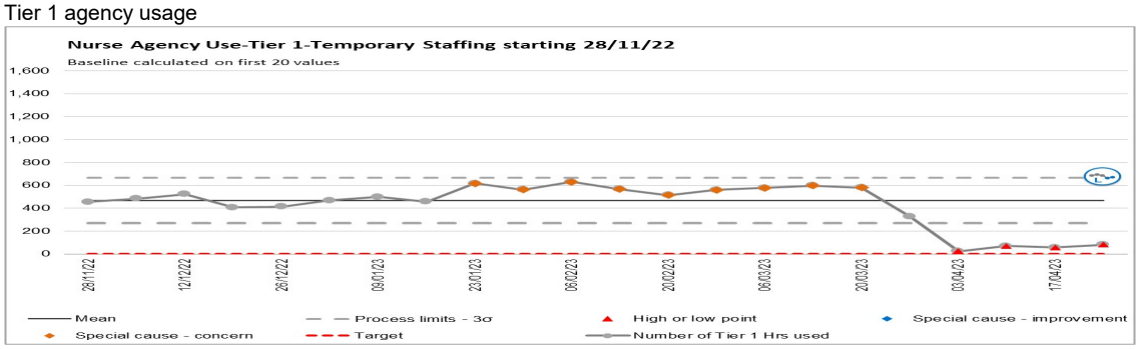
- In March 2023 the RN internal transfer scheme was launched.
- Legacy Mentors have been recruited to support a 12-month pilot.

1.5 Agency Cessation

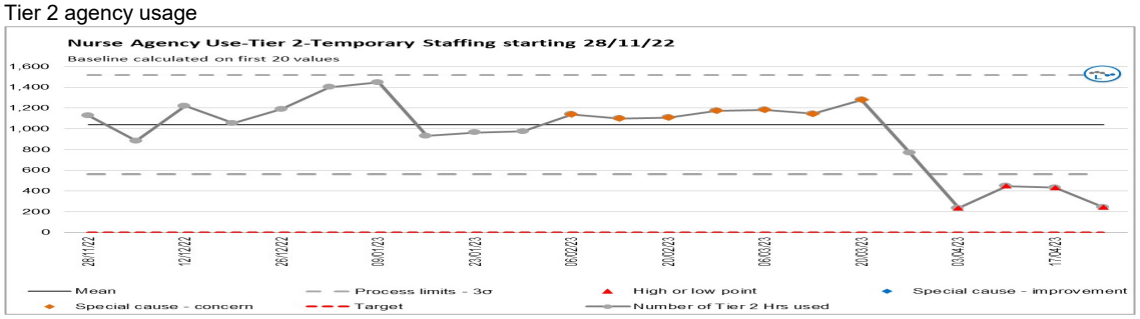
On the 1st April agency use ceased in all but exceptional circumstances and areas where recruitment to vacancies is still underway

- Agency Authorisation now requires risk assessments to have been completed and reviewed by senior divisional leadership before being presented to Director of Nursing or on call Directors for authorisation.

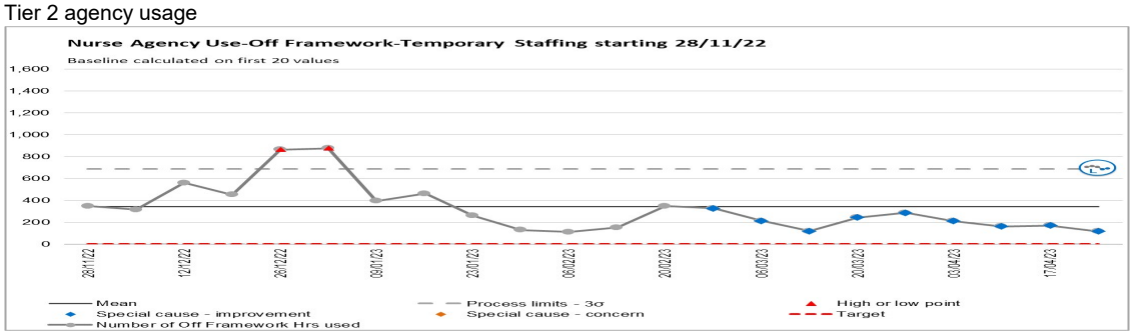
Tier 1 agency usage



Tier 2 agency usage



Tier 2 agency usage



1.6 Red Flags

- A total of 129 Red Flags were raised on the safecare system in April 2023 (222 in March 2023).
- Red flags are reviewed / mitigated by the matrons and discussed at the twice daily staffing meeting 75% of open Red Flags are reported during the day and 25% at night.
- 18 red flags remained open in March 2023 and 8 in April 2023.

2.0 Education

Key updates for nursing and midwifery education and staff development include:

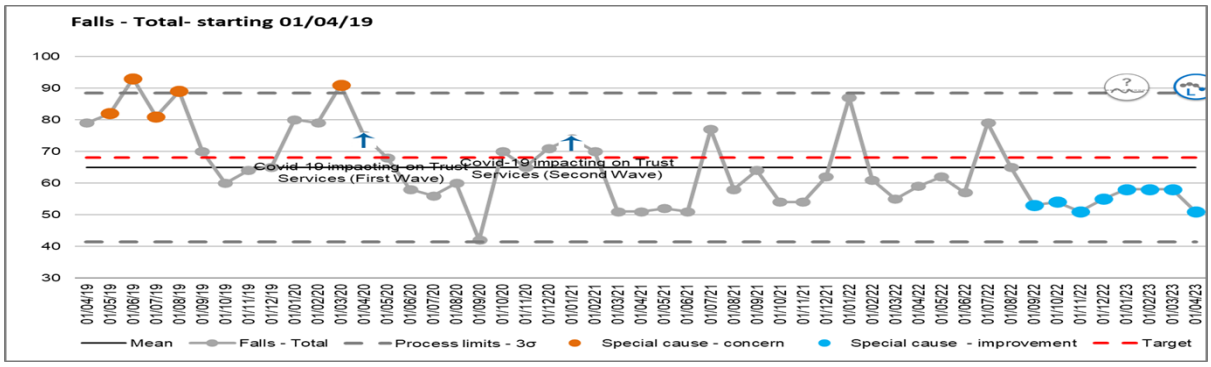
- An action plan is in place in response to the National Education and Training Survey (NETS). Progress is reported to NMAAF and the Education and Training Steering group. The Trust is awaiting confirmation of dates for a Health Education England (HEE) visit.
- The Trust has received confirmation of CPD funding for Nursing/Midwifery and AHPs for 2023/2024 and this is being allocated via the Training Needs Analysis process.
- A new Learner Management System has been launched in May 2023
- Standards for student Supervision and Assessment S(SSA) training compliance is 66%
- Monthly HCSW induction continues with 30 new HCSWs being inducted each month
- 39 soon to qualify Nurses are taking up posts at WHT upon graduation in September (36 Adult and 3 Children's nurses).

3.0 Excellence in care

3.1 Falls

- The number of Trust falls recorded for April 2023 is 51 (59 in March 2023).
- The Royal College of Physicians' mean average performance of 6.1 falls per 1000 occupied bed days has been achieved continuously for the past 32 months (Chart 2).
    - Falls per 1000 bed days was 3.18 (3.38 in March 2023).
- There have been 4 falls resulting in serious harm. 3 caused fractured neck of femurs (2 deemed serious incidents (SIs) and 1 deemed unavoidable), 1 fall caused a head injury which led to death, also reported as an SI.
- The reported SIs are currently being investigated

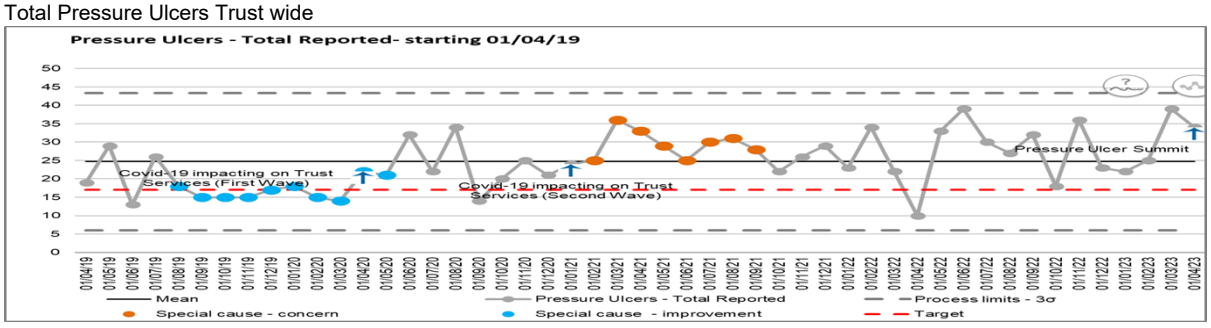
Total Falls



3.2 Pressure ulcers and moisture associated skin damage (MASD)

- There was a slight decrease in reported incidents in April 2023
- The hybrid mattress installation has been completed.
- There has been a sustained reduction in the number of reported MASD incidents.
- A new Trust risk assessment is to be piloted.

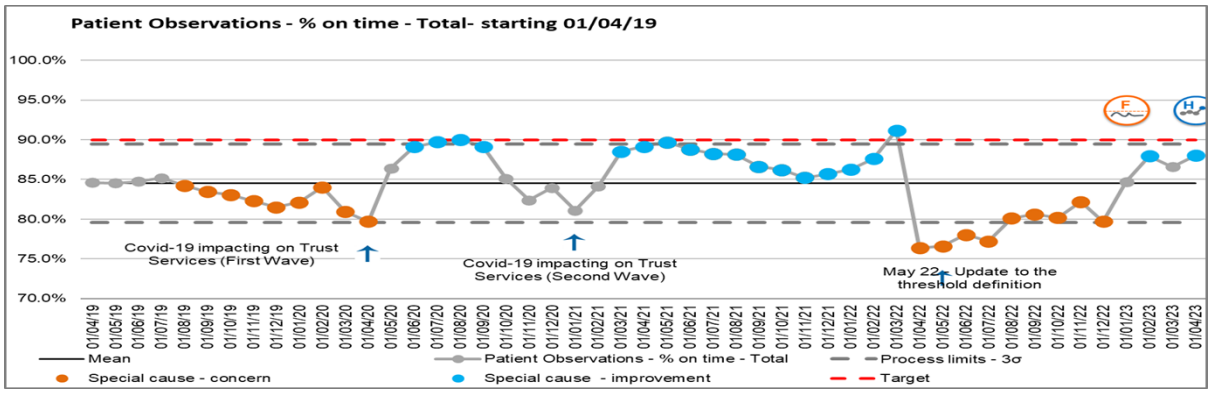
Total Pressure Ulcers Trust wide



3.3 Observations on time

- The timeliness of observations for April 2023 was 88.02%, including ED and 89.70%, excluding ED. March 2023 results were 86.57%, including ED and 89.69%, excluding ED.

Patient Observations on Time



- 15 out of 26 clinical areas achieved the 90% target. Focus is required on FES, wards 4, 29 and AMU who all scored < 85%. The quality team are supporting these clinical areas to improve their compliance.

3.4 Quality and Safety Enabling Strategy 2023 - 2026

- The quality and safety enabling strategy was launched in April 2023.
- This joint strategy is our commitment to quality and safety and ensuring we work with staff and patients as our joint partners to improve patient outcomes and their experience.
- Our key priority areas have been identified from local, regional, and national sources, including engagement with staff, patients, and the community we serve.

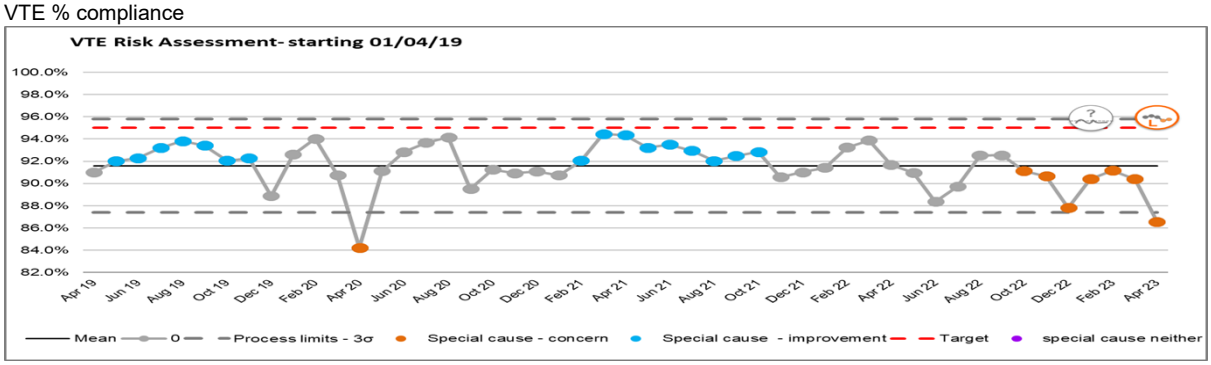
3.5 Wider quality activities

- The Clinical Accreditation Scheme was launched at the beginning of April 2023. A Clinical Accreditation Board and Shared Professional Decision-Making council for Clinical Accreditation have been established.

3.6 Venous Thromboembolism (VTE) Compliance

- VTE compliance for April 2023 was 86.55% (90.40% in March 2023). It has been identified that the single pregnancy record has caused a problem with the Badgernet VTE data which has impacted on performance figures. This has now been rectified.

VTE % compliance



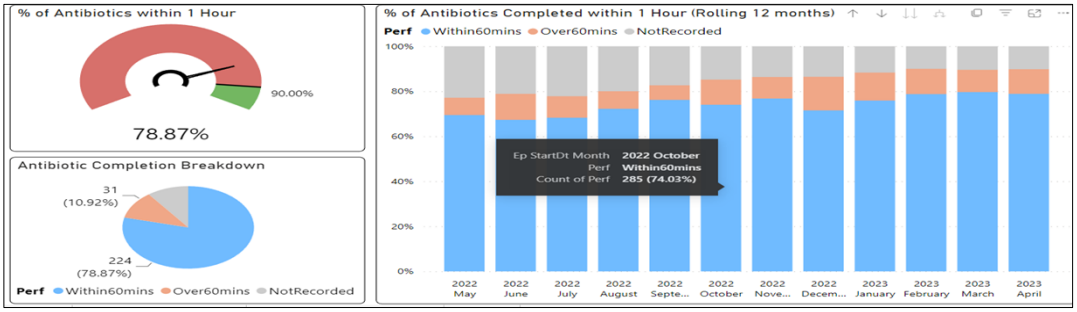
3.7 Deteriorating Patient

- Issues with Scale 2 within NEWS2 has been de-escalated as a corporate risk following review at the Risk Management Executive in April 2023.
- The critical care outreach team identify all patients placed onto Scale 2 for appropriateness of use.

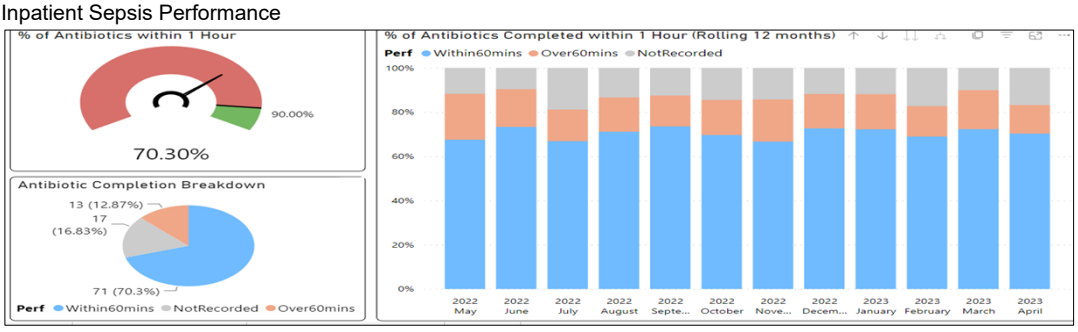
3.8 Sepsis

- Within the Emergency Department (ED), 78.87% of patients received antibiotics within the first hour in April 2023 (79.65% in March 2023).
- For inpatients, 70.30% of patients received antibiotics within the first hour in April 2023 (72.27% in March 2023).
- Sepsis performance and actions to improve are overseen by the Deteriorating Patient Group.

ED Sepsis Performance



Inpatient Sepsis Performance



3.9 Nursing Quality Audits –

- Divisional confirm, challenge and support meetings where audit results are discussed, and action plans produced to improve results and celebrate successes are established across the Trust.
- Ward level data can be found in the dashboards in appendix 1 and 2

Trust overall – Audit Compliance

	CARE OF THE DYING	CATHETER AUDIT	CONTINENCE	DETERIORATING PATIENT & SEPSIS	DOCUMENTATION	ENVIRONMENT	FALLS & DECONDITIONING	IPC	MEDICINES MANAGEMENT	NUTRICIAN & HYDRATION	ORAL CARE	PAIN MANAGEMENT	PATIENT EXPERIENCE	PHARMACY AUDIT (WARD & AREAS - pharmacy	TISSUE VIABILITY
2022 Average	93.1%	67.3%	80.6%	74.6%	92.4%	89.8%	85.0%	95.7%	90.7%	85.8%	87.3%	92.3%	90.8%	91.5%	78.6%
JANUARY	95.7%	67.5%	83.2%	77.8%	91.7%	93.7%	78.8%	95.0%	91.7%	91.2%	89.4%	95.7%	88.0%	83.5%	79.5%
FEBRUARY	95.9%	82.3%	93.4%	97.5%	92.3%	92.5%	87.6%	95.3%	92.0%	89.2%	96.1%	98.1%	95.8%	82.4%	96.0%
MARCH	93.1%	87.0%	82.4%	98.9%	86.4%	92.9%	85.7%	94.2%	92.8%	92.0%	88.8%	97.2%	95.8%	100.0%	90.6%
APRIL	100.0%	91.0%	84.0%	98.9%	88.6%	93.1%	89.1%	95.6%	90.3%	90.9%	92.2%	94.3%	95.2%	84.2%	87.4%

3.10 Medicines Management

- Weekly medication management audits cover medication storage, prescribing and administration practice, and CD management.

- An improvement plan is in place to address areas where improvement is required, and this is monitored through the Medicines Management Group.
- A new drug chart has been developed and piloted and this is currently being rolled out across the trust, starting with emergency portals.

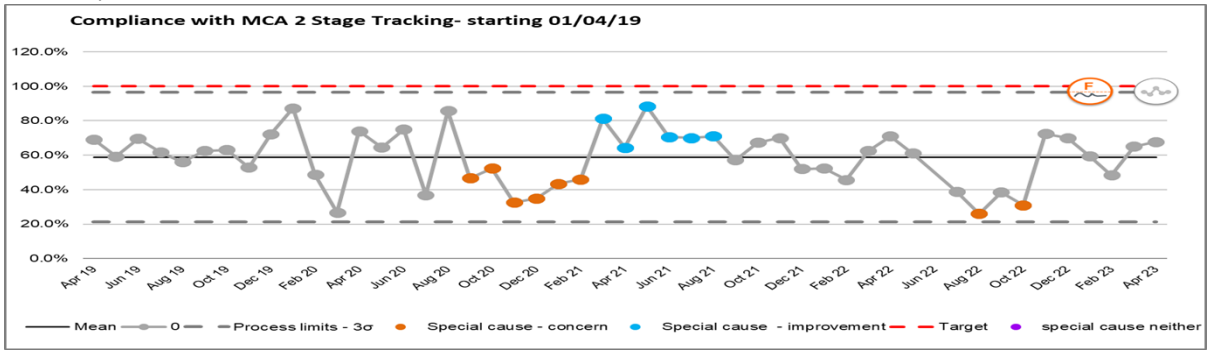
Weekly medicines management results – Trust-wide

	Overall score	Medicine room	Does patient have a wrist band insitu with appropriate allergy status	Patient prescription charts have details of patient name, date of birth and hospital number or NHS number?	Is allergy status documented on the prescription chart?	Is the nature of the allergy documented on the prescription chart?	If there has been an omission of a medication, has a code been used?	Is there evidence that action has been taken to address the omission, unless there is a valid clinical reason for the omission?	Is the patient's weight documented on the prescription chart?	Are all the medication names on the prescription chart written in block capitals?	Are all the medications prescribed on the prescription chart signed?	Are all the medications prescribed on the prescription chart signed with name printed in block capitals / or stamp used?	Are all the medications within their expiry date? (5 random medications checked)	Controlled drugs
02/01/2023	90.11	93.56	95.84	98.01	99.19	71.30	91.62	84.33	63.75	76.60	98.85	70.26	100.00	93.91
09/01/2023	87.71	89.45	95.93	98.89	97.40	68.11	91.98	88.62	73.07	62.01	99.26	72.27	98.77	86.34
16/01/2023	91.76	92.99	97.16	99.00	98.20	67.20	97.26	95.34	81.09	78.36	98.00	75.01	100.00	96.89
23/01/2023	92.58	92.82	96.67	99.23	98.46	84.36	94.58	94.58	81.90	83.38	98.68	82.70	99.26	91.00
30/01/2023	93.19	96.52	98.21	100.00	99.64	80.24	87.89	80.94	81.72	78.87	97.03	77.05	98.57	97.76
06/02/2023	93.54	95.21	95.85	99.45	99.43	77.24	94.27	88.62	85.16	80.34	99.36	84.55	100.00	95.00
13/02/2023	92.36	92.30	98.89	99.26	99.22	76.55	94.65	87.14	82.42	83.29	98.33	80.62	100.00	97.67
20/02/2023	90.17	93.46	91.50	99.62	99.62	77.26	89.90	80.47	77.76	73.16	98.85	72.42	98.46	90.97
27/02/2023	92.25	93.24	96.15	99.19	99.57	84.05	98.34	95.07	82.63	80.96	99.60	78.21	100.00	96.67
06/03/2023	94.45	95.31	98.04	99.13	98.21	73.99	95.19	91.56	82.19	85.09	99.13	87.70	100.00	100.00
13/03/2023	92.38	93.24	96.67	100.00	99.63	67.62	95.41	91.07	83.56	79.37	100.00	85.56	100.00	95.67
20/03/2023	91.64	90.54	97.62	99.05	100.00	88.37	95.89	89.60	86.45	80.64	99.40	76.34	100.00	93.34
27/03/2023	93.12	96.67	92.27	99.24	96.55	76.50	93.27	82.08	77.38	81.49	99.55	79.67	100.00	95.08
03/04/2023	93.08	93.97	98.10	99.52	99.05	79.58	98.42	89.86	84.55	84.60	99.52	79.05	100.00	92.59
10/04/2023	92.67	93.03	95.90	98.56	99.23	73.61	91.67	87.49	84.39	83.46	99.62	78.97	100.00	97.57
17/04/2023	89.84	90.44	96.81	98.40	99.20	78.81	97.68	87.81	84.15	79.73	98.70	75.57	98.40	85.15
24/04/2023	93.59	94.44	97.78	99.63	100.00	78.18	95.83	84.41	85.93	81.97	99.63	80.98	100.00	96.15

3.11 Mental Capacity Assessment (MCA)

MCA compliance for April 2023 was 67.74% (65.00% in March 2023).

MCA compliance



3.12 Adult and Children Safeguarding and Associated Training

- See safeguarding report.

3.13 Infection Prevention and Control

NHSE have released the national thresholds within the NHS Standard Contract 2023/24.

Future figures will be reported as Hospital-onset healthcare-associated (HOHA), Community-onset healthcare-associated (COHA) and Community-onset community-associated (COCA). HOHA and COHA are counted toward the Trust threshold.

Organism	Threshold 2023/24
Clostridiodes difficile	26
MRSA Bacteraemia	0
MSSA Bacteraemia	11
E. coli Bacteraemia	47
Klebsiella species	23

Pseudomonas aeruginosa	6

Clostridiodes difficile (C. diff):

- A total of 4 C.*diff* toxin cases were reported during April 2023.
- The Trust threshold for 2022/23 was 27 cases and the Trust reported a total of 50 cases for the year.

C.Diff cases

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max Cases per Month	2	2	2	2	2	2	2	2	3	3	2	3
Actual cases per month	4											
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	27
Acute Cumulative actual	4											

3.14 Digital and Innovation

- Work continues with the Group Technology Director in his new role overseeing and directing both RWT and WHT IT/Digital services to support convergence in terms of support to nursing and AHP staff for both systems, devices, and future application of technology (around the implementation of a modular System C EPR in both organisations).
- The Draft NHS Documentation Standards is being reviewed in preparation for its formal expected launch in July 2023. When available for formal review will complete a gap analysis against current documentation standards with and in concert with Shared Decision-Making Council.
- EPR implementation - awaiting outcome of budget setting and funding of implementation business cases to confirm speed and process of further works to implement System C EPR modules.

3.15 Patient experience

- Little voices initiative took place in April 2023, a separate paper is reporting into board.

End of Report

NHS Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust Executive Level Nursing Quality Dashboard
Data Period = March 2023

Where there is no figure, please insert 'N/A' into the cell

Ward/Clinical Location	Dvn	STRUCTURE				PROCESS			PATIENT VOICE		PATIENT SAFETY						
		Workforce - Nursing Whole Time Equivalents											Medicines Management	Deterioration		Infection	
		Vacancies Untrained	Vacancies Trained	Combined Sickness	CHPPD	Mandatory Training % - trend from last month	Maternity Leave	Annual Leave	FFT % Recommendation	Complaints	Pressure Ulcers (Safeguard Reported)	Falls (Safeguard Reported)	Administration Errors (Safeguard Reported)	Late Obs % (Data Captured from Vitals)	Cardiac Arrests	C-Diff	MRSA Acquisitions
Surgery																	
WARD 9 SURGERY OVER FLOW	S	-2.92	-4.92	15.85%	8.0	94.44%	0.00%	30.04%	80%	0	0	2	0	96.21%	0	0	0
WARD 10 SURGERY ORTHOPAEDICS	S	-1.16	-0.42	7.96%	7.2	81.62%	2.70%	18.52%	75%	1	1	2	0	91.28%	0	0	0
WARD 11 SURGERY	S	-0.56	-0.17	3.66%	6.4	82.38%	2.62%	14.78%	86%	0	1	1	1	91.19%	0	0	0
WARD 12 SURGERY	S	-8.54	-11.25	0.38%	8.8	82.33%	12.51%	15.09%	74%	0	0	4	2	95.98%	0	0	0
20A PLANNED SURGERY	S	0.67	1.53	8.26%	8.7	86.50%	4.58%	30.52%	88%	1	0	2	0	96.00%	0	0	0
ARRIVALS LOUNGE	S	-0.84	1.20	0.89%	N/A	91.98%	0.40%	9.54%	82%	0	0	0	0	N/A	0	0	0
ENDOSCOPY	S	-0.79	2.11	12.27%	N/A	71.92%	0.00%	12.95%	95%	0	0	0	0	N/A	0	0	0
THEATRES	S	-5.12	10.02	7.44%	N/A	87.68%	0.75%	11.39%	N/A	0	0	0	0	N/A	1	0	0
CRITICAL CARE	S	-2.83	5.50	7.44%	23.9	85.98%	4.73%	14.16%	100%	0	0	0	0	N/A	0	0	0
SACU/Ward 22	S	-9.51	-9.62	12.76%	N/A	96.47%	8.65%	12.81%	81%	1	0	0	0	93.22%	0	1	0
FRACTURE CLINIC	S	1.95	0.00	3.14%	N/A	86.67%	5.47%	5.53%	N/A	0	0	0	0	N/A	0	0	0
PRE ASSESSMENT, EASY BOOK	S	0.58	0.65	13.46%	N/A	75.00%	0.00%	13.98%	N/A	0	0	0	0	N/A	0	0	0
OPD	S	4.35	1.77	5.88%	N/A	87.63%	0.00%	12.74%	N/A	0	0	0	0	N/A	0	0	0
Total		-1.90	-0.28	7.65%	10.5	85.43%	3.26%	15.54%	84.56%	3	2	11	3	93.98%	1	1	0
Medicine																	
WARD 14	M	-12.25	-11.45	7.09%	1.9	79.60%	0.00%	18.49%	71%	1	1	1	0	83.62%	0	0	0
WARD 15	M	-3.33	6.36	4.64%	6.3	85.90%	2.51%	15.75%	88%	0	1	4	0	87.87%	0	0	0
WARD 16 GASTROENTEROLOGY	M	-4.69	1.48	7.44%	6.8	85.90%	1.48%	15.49%	76%	0	1	1	0	88.71%	1	1	0
WARD 17 RESPIRITORY	M	-0.16	2.12	9.97%	7.3	87.17%	8.76%	12.42%	89%	2	0	3	0	96.24%	1	1	0
AMU	M	-1.68	-7.24	2.36%	11.0	80.49%	2.67%	14.37%	87%	2	1	4	3	82.54%	1	2	0
WARD 29 SHORT STAY MEDICINE	M	-0.46	6.35	0.38%	6.0	79.09%	6.13%	23.78%	67%	1	1	5	0	85.54%	0	0	0
WARD 1 ELDERLY	M	-3.25	2.47	4.85%	6.3	90.18%	9.32%	10.94%	96%	0	3	3	1	86.94%	1	2	0
WARD 2 ELDERLY	M	-5.59	3.51	2.64%	6.7	81.09%	0.74%	17.91%	97%	1	1	2	0	96.20%	0	0	0
WARD 3 ELDERLY	M	-1.41	2.44	9.82%	6.4	85.77%	4.16%	12.21%	62%	0	0	8	0	88.68%	1	1	0
WARD 4 ELDERLY	M	-4.40	-2.80	5.29%	6.2	78.03%	2.23%	19.49%	56%	3	1	7	1	82.81%	0	0	0
FRAILTY UNIT	M	0.98	-2.49	1.95%	N/A	83.50%	5.47%	16.76%	93%	0	0	2	0	80.18%	0	0	0
AMBULATORY CARE	M	-3.79	1.10	11.95%	N/A	90.17%	5.44%	9.19%	81%	0	0	0	0	90.82%	0	0	0
EMERGENCY DEPARTMENT	M	-2.34	24.18	7.73%	N/A	91.98%	17.83%	28.20%	86%	5	1	2	2	69.67%	0	0	0
DISCHARGE LOUNGE	M	-3.40	-2.60	1.76%	N/A	93.50%	0.00%	19.20%	85%	0	0	0	0	N/A	0	0	0
WARD 7 CARDIOLOGY AND CATH LAB	M	1.90	-3.64	8.87%	5.8	87.44%	4.73%	18.89%	86%	0	3	1	1	92.32%	0	0	0
CHEMOTHERAPY DAY UNIT	M	-0.42	-2.38	7.21%	N/A	89.84%	3.97%	9.92%	96%	0	0	0	0	N/A	0	0	0
Total		-2.77	1.09	5.87%	6.4	85.60%	4.72%	16.44%	82.25%	15	14	43	8	86.58%	5	7	0
Womens and Childrens																	
WARD 21 PAEDIATRICS	WC	-5.79	5.42	1.53%	5.4	84.82%	5.44%	25.24%	97%	0	0	0	0	91.71%	0	0	0
WARD 23 GYNAE	WC	-0.40	0.99	12.05%	9.8	94.89%	0.00%	12.63%	86%	1	0	0	0	90.76%	0	0	0
WARD 24,25 POST NATAL & TRIAGE	WC	6.54	8.15	1.01%	6.9	92.94%	4.42%	19.29%	89%	2	0	0	0	N/A	0	0	0
PAU AND DAY CASE UNIT	WC	0.01	0.00	13.79%	9.2	86.11%	0.00%	5.67%	100%	0	0	0	1	91.21%	0	0	0
DELIVERY SUITE	WC	2.07	-5.25	5.20%	N/A	92.38%	7.13%	19.73%	92%	1	0	0	0	N/A	0	0	0
NEONATAL UNIT	WC	-0.20	2.71	8.48%	16.3	93.32%	7.21%	19.27%	100%	0	0	0	0	N/A	0	0	0
SEXUAL HEALTH	WC	0.20	0.74	9.74%	N/A	96.38%	0.00%	10.41%	100%	0	0	0	0	N/A	0	0	0
Total		0.35	1.82	7.40%	9.5	91.55%	3.46%	16.03%	94.86%	4	0	0	1	91.23%	0	0	0
Community																	
GOSCOTE HOSPICE	C	-15.12	-15.65	5.85%	N/A	92.11%	2.79%	17.73%	N/A	0	0	2	1	N/A	0	0	0
HOLLYBANK HOUSE STROKE & REHAB	C	1.96	0.95	19.57%	N/A	99.19%	0.00%	12.35%	N/A	0	0	3	0	92.65%	0	0	0

NHS Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust Executive Level Nursing Quality Dashboard
Data Period = March 2023

Where there is no figure, please insert 'N/A' into the cell

Ward/Clinical Location	Dvn	STRUCTURE				PROCESS			PATIENT VOICE		PATIENT SAFETY						
		Workforce - Nursing Whole Time Equivalents											Medicines Management	Deterioration		Infection	
		Vacancies Untrained	Vacancies Trained	Combined Sickness	CHPPD	Mandatory Training % - trend from last month	Maternity Leave	Annual Leave	FFT % Recommendation	Complaints	Pressure Ulcers (Safeguard Reported)	Falls (Safeguard Reported)	Administration Errors (Safeguard Reported)	Late Obs % (Data Captured from Vitals)	Cardiac Arrests	C-Diff	MRSA Acquisitions
INTERMEDIATE CARE	C	0.30	0.00	12.20%	N/A	93.03%	0.00%	16.04%	N/A	0	0	0	0	N/A	0	0	0
DISTRICT NURSES	C	-8.56	7.94	21.03%	N/A	85.11%	13.53%	19.71%	N/A	0	19	0	4	N/A	0	0	0
Total		-5.36	-1.69	14.66%	N/A	92.36%	4.08%	16.46%	#DIV/0!	0	19	5	5	92.65%	0	0	0
Overall		-2.42	0.24	8.89%	8.8	88.74%	3.88%	16.12%	#DIV/0!	22	35	59	17	91.11%	6	8	0

KEY		Green	Amber	Red
Vacancies Untrained	wte = whole time equivalents	**<3**	**3 - 5**	**>5**
Vacancies Trained	wte = whole time equivalents	**<3**	**3 - 5**	**>5**
Combined Absence	Combined absence average per ward area	**<4.50%**	**4.50 - 5.00%**	**>5.00%**
CHPPD	Care Hours Per Patient per Day (as calculated via monthly Safer Staffing Return)	**>6**	**5-6**	**<5**
Mandatory Training	Percentage of all training mandatory requirements completed for each clinical location	**>90%**	**90% - 85%**	**<85%**
FFT - Recommendations	Friends and Family Test - from the patient response rates, how many would recommend care at WHT	**>90%**	**90% - 85%**	**<85%**
Complaints	Total number of complaint received for the clinical location/ward (Formal & Pals)	**0**	**Not applicable**	**≥1**
Pressure Ulcers	Number of pressure injuries as reported on Safeguard (sample date - circa 5th day of new month)	**0**	**Not applicable**	**≥1**
Falls	Number of falls as reported on Safeguard (sample date - circa 5th day of new month)	**0 - 1**	**2**	**≥3**
Med Administration Errors	Number of Administration errors reported on Safeguard (sample data - circa 10th of new month)	**0**	**Not applicable**	**>1**
Late Observations	% of observations completed from Care Flow Vitals	**>90%**	**Not applicable**	**<90%**
Cardiac Arrests	Total number of cardiac arrest calls to clinical location: not including other 2222 calls for non-cardiac arrest	**0**	**Not applicable**	**≥1**
C-diff	Number of clostridium difficile incidences per month (as reported by Infection Prevention)	**0**	**Not applicable**	**≥1**
MRSA	Number of MRSA acquisitions per month (as reported by Infection Prevention)	**0**	**Not applicable**	**≥1**

NHS Walsall Healthcare NHS Trust

Walsall Healthcare NHS

WARD/CLINICAL LOCATION	CARE OF THE DYING	CATHETER AUDIT	CONTINENCE	DETERIORATING PATIENT & SEPSIS	DOCUMENTATION	ENVIRONMENT	FALLS & DECONDITIONING
SURGERY							
CHEMOTHERAPY	N/A	N/A	N/A	N/A	100.0%	100.0%	N/A
FRACTURE CLINIC	N/A	N/A	N/A	N/A	87.5%	85.7%	N/A
ICU	NAP	91.5%	100.0%	NAP	73.3%	94.4%	100.0%
MEDICAL DAYCASE UNIT	N/A	N/A	N/A	N/A	100.0%	87.5%	N/A
OUTPATIENTS	N/A	N/A	N/A	N/A	100.0%	100.0%	N/A
SACU	NAP	NAP	100.0%	100.0%	N/D	100.0%	76.2%
WARD 9	NAP	75.0%	100.0%	NAP	76.7%	93.4%	68.7%
WARD 10	NAP	70.0%	62.5%	100.0%	91.7%	94.4%	95.4%
WARD 11	91.7%	63.6%	100.0%	100.0%	N/D	94.1%	93.0%
WARD 12	NAP	77.8%	100.0%	100.0%	80.0%	84.2%	88.6%
WARD 20A	NAP	95.8%	78.3%	NAP	57.1%	98.9%	93.2%
MLTC							
AMU	N/D	83.3%	80.0%	100.0%	62.5%	77.8%	86.1%
AEC	N/A	N/A	N/A	N/D	N/D	N/D	N/D
FES	N/A	N/A	N/A	N/D	N/D	N/D	N/D
CATH LAB	N/A	N/A	N/A	N/A	N/D	N/D	N/A
EMERGENCY DEPARTMEN	N/D	N/A	N/A	N/D	N/D	N/D	N/D
ENDOSCOPY	N/A	N/A	N/A	N/A	N/D	N/D	N/A
WARD 1	NAP	77.8%	100.0%	N/D	82.9%	87.4%	89.4%
WARD 2	NAP	90.9%	94.4%	N/D	100.0%	93.3%	96.7%
WARD 3	NAP	N/D	66.0%	N/D	71.4%	94.4%	65.0%
WARD 4	NAP	N/D	59.3%	N/D	80.0%	83.3%	88.3%
WARD 7	N/D	N/D	91.7%	N/D	N/D	N/D	93.8%
WARD 14	N/D	N/D	50.0%	N/D	N/D	N/D	75.9%
WARD 15	100.0%	92.3%	93.3%	N/D	97.5%	82.1%	88.4%
WARD 16	NAP	100.0%	100.0%	N/D	100.0%	90.0%	81.4%
WARD 17	N/D	N/D	65.0%	N/D	N/D	N/D	66.1%
WARD 29	NAP	85.7%	80.0%	100.0%	60.0%	84.2%	70.5%
WOMEN & CHILDRENS							
CCN TEAM	N/A	N/A	NAP	N/A	95.0%	100.0%	N/A
GOPD / PRE-ASSESSMENT	N/A	N/A	N/A	N/A	N/D	100.0%	N/A
NNU	NAP	N/A	N/A	100.0%	98.6%	97.8%	N/A
PAU	N/A	N/A	100.0%	88.2%	81.7%	82.4%	N/A
SEXUAL HEALTH	N/A	N/A	N/A	N/A	N/A	100.0%	N/A
WARD 21	NAP	NAP	100.0%	100.0%	92.5%	97.9%	100.0%
WARD 23	N/D	83.3%	100.0%	100.0%	100.0%	100.0%	95.8%
WARD 24 IF OPEN	N/D	N/D	N/D	N/D	N/D	100.0%	N/D
WARD 25	N/A	N/D	N/A	N/A	N/A	88.9%	N/A
WARD 27	N/A	N/D	N/A	N/A	N/A	94.1%	N/A
ANC	N/A	N/A	N/A	N/A	N/A	N/D	N/A
COMMUNITY							
EAST LOCALITY	N/D	100.0%	40.0%	N/A	N/A	N/A	N/A
GOSCOTE HOSPICE	98.6%	100.0%	88.9%	NAP	100.0%	100.0%	94.4%
HOLLYBANK STROKE TEA	NAP	92.3%	100.0%	100.0%	85.6%	N/D	79.1%
NORTH LOCALITY	82.4%	86.0%	87.5%	N/A	N/A	N/A	N/A
SOUTH LOCALITY	92.6%	100.0%	33.3%	N/A	N/A	N/A	N/A
WEST LOCALITY	N/D	N/D	55.8%	N/A	N/A	N/A	N/A

0.0% - 79.9%	50.0%
80.0% - 89.9%	85.0%

90.0% - 100.0%	95.0%
NOT APPLICABLE	N/A
NO APPLICABLE PATIENT	NAP
NOT DONE	N/D
WARD CLOSED AT TIME OF AUDIT	WC

Trust Quality Dashboard - March 2023

IPC	MEDICINES MANAGEMENT	NUTRICIAN & HYDRATION	ORAL CARE	PAIN MANAGEMENT	PATIENT EXPERIENCE	PHARMACY AUDIT (WARD & AREAS - pharmacy respomsiblit	TISSUE VIABILITY
93.1%	98.8%	N/A	N/A	N/A	93.8%	N/A	N/A
81.0%	77.4%	N/A	N/A	N/A	100.0%	N/A	N/A
100.0%	89.1%	100.0%	100.0%	100.0%	100.0%	N/D	100.0%
96.2%	97.7%	N/A	N/A	N/A	100.0%	N/D	N/A
95.5%	90.8%	N/A	N/A	N/A	N/D	N/D	N/A
72.2%	90.1%	86.7%	77.1%	100.0%	91.8%	N/D	N/D
83.3%	94.4%	90.4%	78.6%	100.0%	97.6%	N/D	N/A
99.4%	84.9%	100.0%	100.0%	100.0%	100.0%	N/D	100.0%
93.8%	91.4%	96.0%	100.0%	100.0%	90.3%	N/D	N/A
92.9%	92.2%	92.9%	73.3%	100.0%	96.2%	N/D	N/A
96.8%	89.7%	84.8%	100.0%	100.0%	93.2%	N/D	70.0%
89.3%	90.6%	81.7%	100.0%	75.0%	88.2%	N/D	97.1%
N/D	N/D	N/D	N/D	N/D	N/D	N/A	N/A
N/D	N/A	N/D	N/D	N/D	N/D	N/A	N/A
N/D	N/A	N/A	N/A	N/D	N/D	N/A	N/A
N/D	93.0%	N/A	N/A	N/D	N/D	N/D	N/D
N/D	N/A	N/A	N/A	N/D	N/D	N/D	N/A
100.0%	97.0%	88.1%	85.7%	100.0%	93.5%	N/D	58.3%
95.9%	93.2%	95.5%	87.9%	100.0%	96.2%	N/A	N/D
98.3%	91.6%	90.0%	83.3%	100.0%	N/D	N/D	96.7%
100.0%	92.5%	84.7%	85.2%	80.0%	N/D	N/D	N/D
86.3%	88.2%	100.0%	88.9%	N/D	N/D	N/A	N/A
81.0%	95.2%	N/D	75.0%	N/D	N/D	N/A	77.4%
100.0%	97.6%	95.8%	100.0%	100.0%	97.0%	N/A	N/A
99.3%	97.8%	94.7%	100.0%	100.0%	97.0%	N/D	N/A
93.9%	89.0%	N/D	57.1%	N/D	N/D	N/A	N/A
93.5%	86.2%	95.0%	100.0%	100.0%	88.2%	N/A	96.7%
81.8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
100.0%	100.0%	N/A	N/A	N/A	N/D	N/A	N/A
97.4%	96.9%	N/A	100.0%	100.0%	96.5%	N/D	N/A
89.5%	87.2%	90.0%	80.0%	100.0%	91.7%	N/A	N/D
100.0%	100.0%	N/A	N/A	N/A	N/D	N/A	N/A
100.0%	90.8%	79.2%	75.0%	80.0%	100.0%	N/D	N/A
100.0%	92.5%	92.3%	100.0%	100.0%	N/D	N/A	100.0%
90.9%	N/D	N/D	N/D	N/D	N/D	N/A	N/A
93.5%	94.5%	N/A	N/A	100.0%	100.0%	N/D	N/A
96.8%	93.1%	N/A	N/A	100.0%	97.2%	N/D	N/A
N/D	96.6%	N/A	N/A	N/A	N/D	N/A	N/A
100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
100.0%	95.4%	100.0%	94.4%	100.0%	N/D	100.0%	100.0%
100.0%	98.7%	95.0%	N/D	100.0%	100.0%	N/D	100.0%
95.2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

ED SPECFIC

C AUDIT

Item 14.11

Walsall Healthcare NHS Trust

Meeting of the Trust Board – in Public	
Meeting Date:	7 June 2023
Title of Report:	Patient Voice Annual Report
Action Requested:	Note the contents of the report
For the attention of the Board	
Assure	The NHS and Social Care Complaint regulations 2009 require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public.
Advise	The report references the Patient Experience Enabling Strategy published in Autumn 2022
Alert	NIL
Author and Responsible Director Contact Details:	Tel 01922 656463 garry.perry1@nhs.net Lisa Carroll, Director of Nursing
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care
Support our Colleagues	a) Improve overall staff engagement
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy
Effective Collaboration	a) Implement technological solutions that improve patient experience
Resource Implications:	'none'
Report Data Caveats	This report uses 12 month's data with the year end of March 2023. It may be subject to minor cleansing and revision later
CQC Domains	**Safe:** you are protected from abuse and avoidable harm **Effective:** your care, treatment and support achieve good outcomes, helps you to maintain quality of life and is based ono the best available evidence **Caring:** staff involve and treat you with compassion, kindness, dignity, and respect **Responsive:** services are organised so that they meet your needs
Equality and Diversity Impact	There are no legal or equality & diversity implications associated with this paper.
Risks: BAF/ TRR	None in this report
Risk: Appetite	None in this report
Public or Private:	Public
Other formal bodies involved:	Care Quality Commission
References	None in this report

Walsall Healthcare
NHS Trust

NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

1. Purpose of report

Seeking and acting on patient feedback is key to improving the quality of healthcare services. This paper provides the annual report for 2022/23 of the Trust's activity in response to the Patient Voice including concerns, complaints, and patient experience. The annual report also details significant patient involvement, engagement, and improvements to services as a result.

2. Background

The NHS and Social Care Complaint regulations 2009 require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public.

3. Details

See enclosed report.

4. RECOMMENDATIONS

- To note the activity.
- To note the level of engagement and involvement taken place including the excellent support of our volunteer service.
- To note the service improvements made because of Patient Voice feedback.

Walsall Healthcare NHS Trust

Patient Voice Annual Report

April 2022 - March 2023 -

Patient Relations, Experience & Voluntary Services

Patient Relations & Experience

Introduction

Garry Perry
Associate Director
Patient Relations and Experience

I am pleased to introduce the Patient Voice Annual Report 2022/2023 and in doing so reflecting on the diversity and depth of work undertaken by my teams supported by colleagues across the Trust. In the past year:

- We have produced and published the Patient experience Enabling Strategy in collaboration with our peers at the Royal Wolverhampton NHS Trust
- We have made great strides in embedding additional ways of providing feedback such as the 'mystery patient scheme' and initiating 'raise and praise' further capturing the views of those who use our services and are thankful for them.
- We launched 'It's OK to ask' promoting patient involvement in the care decisions about them.
- We have piloted the new National Complaints standards produced by the Parliamentary Health Service Ombudsman helping us provide consistency in approach to complaint handling.
- We increased voluntary opportunities for people from our communities to work with us resulting in a record breaking number of hours provided.
- We have formed new partnerships adding richness to our commitment to engage with others. Working with Walsall College, Walsall for All, NASHDOM, Walsall Black Sisters, Walsall Council, St Johns Ambulance, Birmingham and Solihull Mental Health Trust, MindKind CIC & Walsall Pride.
- We have supported staff and patient well-being at times of critical pressure delivered through our existing partnership with Manor Farm Community Association and Blessed 2 Bless.
- We delivered a safe and compassionate approach to visiting, reinforcing appropriate infection control practice whilst connecting patients with those closest to them.
- We introduced a new role seeking to ensure the voice of the unpaid carer is heard working closely with 'Forward Carers' and the Walsall Carers Hub.

To listen and value feedback is essential, ensuring that quality care is underpinned by clinical effectiveness, safety and experience. The outcomes listed are but a few examples that demonstrate what can be achieved when we take a collective approach to transform the feedback we receive into meaningful actions that improve the experiences of those who use our services.

Associate Director Patient Relations & Experience

Contents:

Section 1: Patient Relations (pages 4-13)

1. About us
1a Patient Relations Activity
1b. Timeframes
1c. Trend Analysis
1d. PHSO Cases and complaint outcome status
1e. Concerns & Trend Analysis
1f. Compliments
1g. Satisfaction Survey
1h. Learning Matters
1i. The new Complaint Standards

Section 2: Patient Experience (pages 14-18)

2a. Friends and Family Test
2b. Mystery Patient Scheme
2c. National Surveys
2d. The Welcome Hub

Section 3: Involvement and Engagement (pages 19-22)

3a. Patient Experience Enabling Strategy
3b. Patient Involvement Partners (PIP'S)
3c. Blessed 2 Bless
3d. Walsall Pride
3e. Its OK to ask

Section 4: Voluntary Services (pages 22-25)

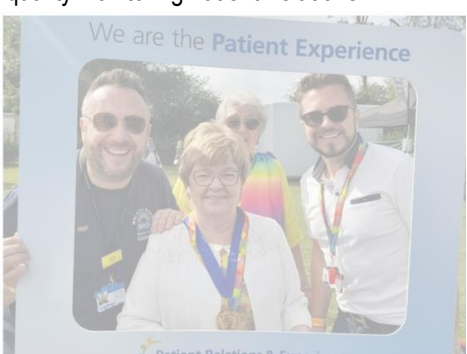
4a. The year of the volunteer
4b. Partnerships
4c. Volunteer awards

Section 5: Family and Carer Support (page 26)

5a. Commitment to Carers
5b. Family and Carer Support Officer

Section 6: Accessibility and Equality Monitoring (page 27-28)

6a. Interpreting and Translation
6b. Equality Monitoring Patient Experience
6c. Equality Monitoring Patient Relations



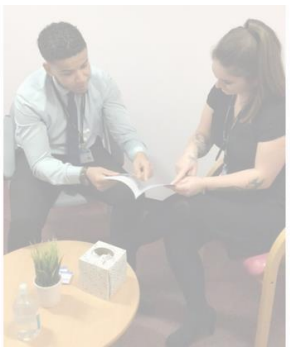
Section 1: About us

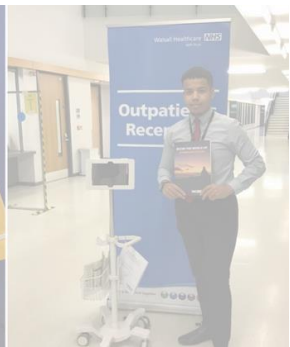
The Patient Relations & Experience Service is made up of the following teams.

- Patient Experience
- Voluntary Services
- Welcome Hub
- Family and Carers Support
- Patient Relations
- Spiritual, Pastoral and Religious Care inc. Bereavement (SPaRC)

The role of these teams is to support the organisation in the delivery, monitoring and improvement of the experience of our patients, families, and carers. The team ensures opportunity for patients, families, and carers to provide feedback, share their experiences and to have a voice in the care that they receive. The Patient Relations team focusses primarily on two key areas of feedback - concerns and complaints with the initial triage undertaken by the Patient Relations Support Officers (commonly known as PALS). Complaints are led by the Senior Patient Relations Officers.

Hospital Chaplains provide spiritual care to the hospital & community. They take their place alongside the multi-disciplinary team which seeks to provide holistic care for patients and those close to them. Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self- worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. SPaRC activity and engagement will be covered in their annual report due in the summer which will be a collaborative report with the Royal Wolverhampton NHS Trust.





Section 1: Patient Relations

1a: Activity

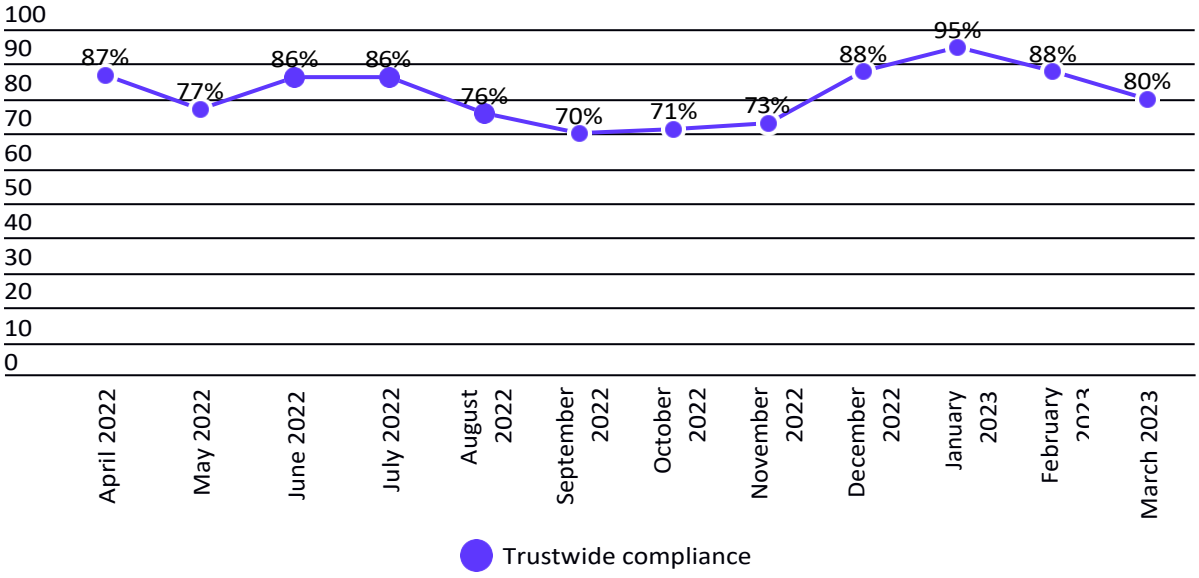
During 2022/2023 a total of 3532 contacts were received by the Patient Relations Team which included a total of 368 written complaints. In additional, the Trust received 6 informal to formal complaints and 13 MP letters. This is an increase of 6 complaints overall for the year compared to 2021-2022 and an average of 14.07 contacts per working day.

Contact Type	2020-2021	2021-2022	2022-2023
Complaint requiring a written response	280	361	368
Concern conversation to a complaint	7	7	6
Concern	2026	2420	2374
Complaint converted to a concern	16	33	64
Compliment	416	535	376
Website feedback - NHS Website/Healthwatch	967	721	331
MP letter	7	4	13
Total	3719	4082	3532

The total number of complaints resolved was during 2022/2023 was 360.

23 complaints were upheld with 63 not upheld and 226 partially upheld. 2 complaints were withdrawn within this period.

1b: Timeframe for responding



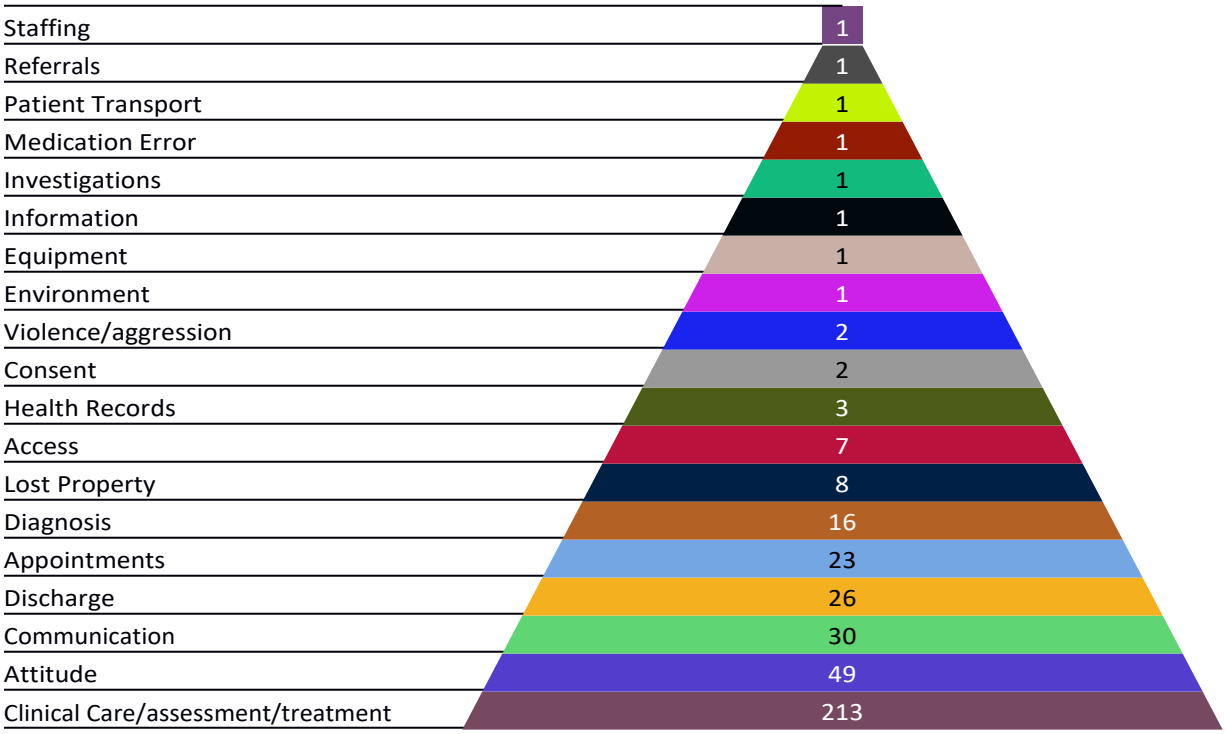
The average response rate during 2022/2023 was 81%. This is a slight increase in comparison to 2021/2022 (79.9%)

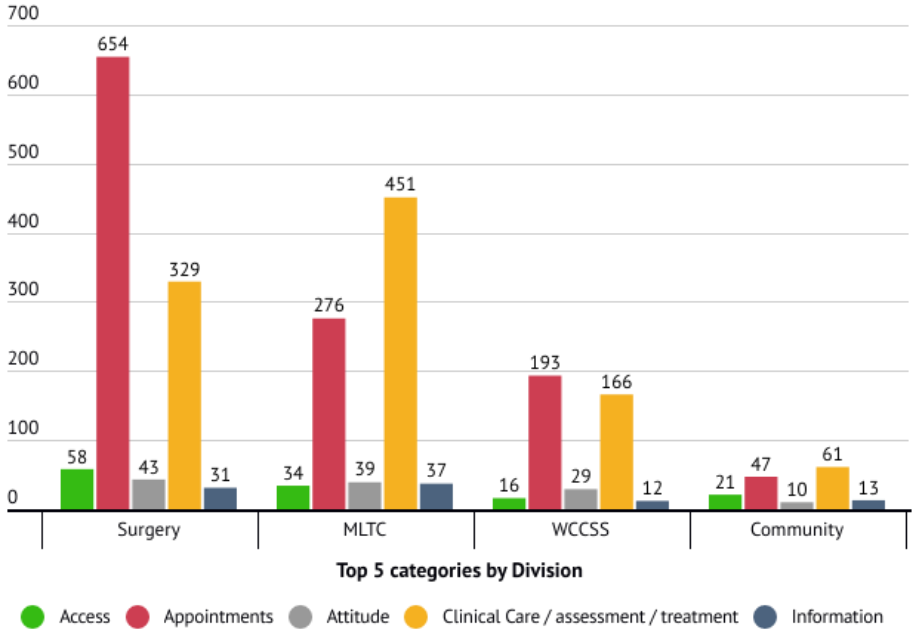
Based on the table below – the overall average score (number of days to complete) is 34.3 which given the current pressures this last year is an improvement of 2 days compared to 2021/2022.

Division	Average days to respond
Community	26.83
Corporate	18.75
Medicine & Long Term Conditions	33.29
Surgery	35.81
Women's Children's and Clinical Support Services	28.31

1c: Trend analysis

During 2022/2023, there were 373 complaints raised (including Formal complaints, Informal to Formal complaints and MP letters). The main theme emerging from formal complaints being Treatment, care and supervision. This accounted for 57.1% of all complaint categories, 213 complaints fell within this domain.





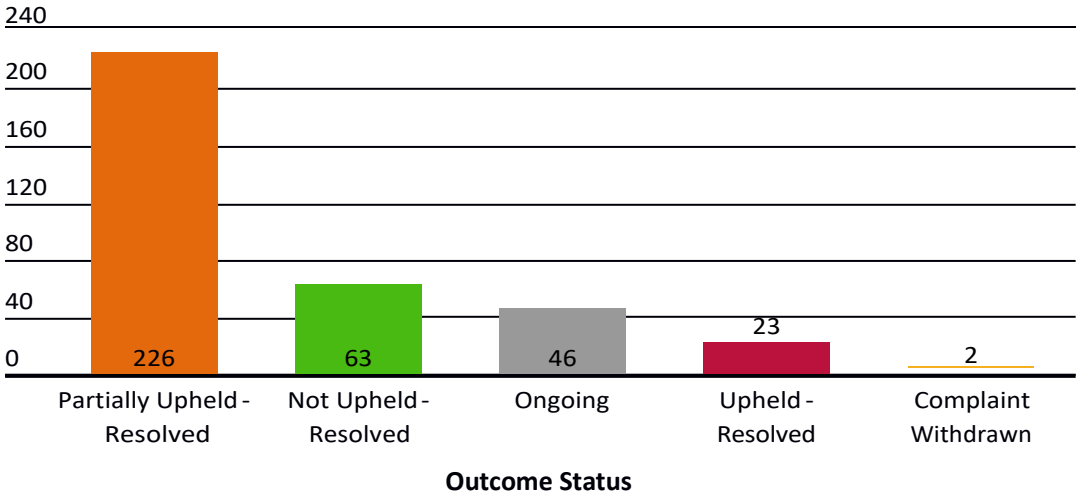
The highest number of contacts for Surgery Division were in relation to Appointments. The majority of the appointment related contacts were in relation to appointment queries with 240 contacts received. The second highest trend was in relation to delayed appointments with 213 contacts received. Urology received the most contacts overall in relation to appointments with 148, closely followed by T&O with 140.

The highest number of contacts for MLTC Division were in relation to Clinical Care / Assessment / Treatment. The majority of contacts were in relation to treatment advice / issues with 246 contacts received. Overall, the Emergency Department received the majority of the contacts received in relation to Clinical Care / assessment / Treatment with 125 contacts received.

The highest number of contacts for WCCSS Division were in relation to Appointments. The majority of the appointment related contacts were in relation to appointment queries with 91 contacts received. The second highest trend was in relation to delayed appointments with 59 contacts received. Imaging received the most contacts overall in relation to appointments with 61.

The highest number of contacts for Community Division were in relation to Clinical Care / Assessment / Treatment. The majority of contacts were in relation to treatment advice / issues with 40 contacts received. Overall, East District Nurses received the majority of the contacts received in relation to Clinical Care / assessment / Treatment with 11 contacts received.

The total number of complaints resolved was during 2022/2023 was 360. 23 complaints were upheld with 63 not upheld and 226 partially upheld. 2 complaints were withdrawn within this period.



1d: Parliamentary Health Service Ombudsman

In 2022/23 a total of 8 cases were accepted via the PHSO for investigation. This equates to 2.14% of all complaints received. Themes emerging include concerns highlighted about clinical care assessment and treatment, poor communication, inadequate pain management and poor nursing care. Of those closed in in 2022/2023. 2 cases were partially upheld and 1 not upheld.

1e: Concerns

Excluding formal complaints and compliments, a total of 2769 contacts were received during 2022/2023. This figure includes concerns (2374), formal to informal (64), comments, suggestions and queries and referred on (323), Losses and Compensation (4) and Health watch referrals (4).

Surgery equated for 36.97% (1306) of the total activity (including formal complaints and compliments), MLTC 32.19% (1137), WCCSS 14.89% (526) and Community 9.34% (330).

1f: Compliments

Compliments account for 11% of all contacts received in 2022/23, down by 2% on 2021/22. 375 compliments were received by the Trust.

Community		Medicine		Surgery		WCCSS*		Corporate Functions	
2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23
259	143 (-28.9%)	101	95 (-3.1%)	87	72 (-6.3%)	67	46 (-18.6%)	21	19 (-5%)

*Women's Children's Clinical Support Services

WCCSS

Thank you for looking after me during my second labour, I just can not thank you enough. You were calm, compassionate, professional, caring and amazing towards my partner and i. You listened to everything we wanted from our birth. You encouraged me every step of the way and listened to me when i felt i couldn't cope anymore. I feel utterly privileged to of had you look after us. thank you.

Medicine

To ward 16, there are no words to express our deep felt thanks. Your dedication, kindness, medical knowledge and skill have been a blessing to us. A big thank you to all the staff on ward 16.

Surgery

I would like to express my thanks to all the staff who helped me during the day surgery. Professional, polite and happy they made my stay very pleasant and i can only say thank you all for your help. 10 plus for a score

Community

I would like to express my sincere gratitude for the wonderful assistance, therapy and reassurance received from the Cannock Stroke Team. They have been brilliant and have helped massively in my rehabilitation since i had the stroke. My rock and guidance helping me to cope and get through this worrying ordeal and creativity assisted in my recovery. Thank you to all.

Corporate

I attend each week for day care infusion. I have assistance from the kind and caring welcome hub team to get me to the day case unit where the care for many weeks has been exemplary. The staff are always lovely they communicate and involve and I cant thank them enough - my family know I am in safe hands

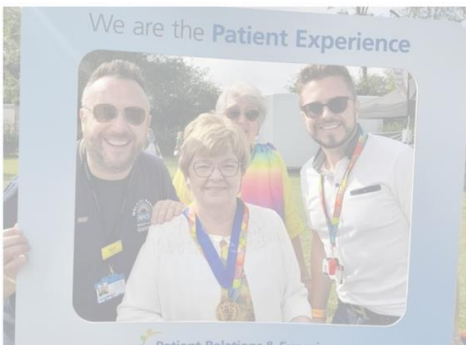
1g: Satisfaction Survey - Complaints

The Patient Relations Team Feedback Survey is purposed on feedback from those who use the complaint process. The purpose of the survey is to help us understand the feelings of services users throughout the different stages of the complaint process. This data allows us to see what we are doing well, but also where we need to improve.

Each question in the survey can be scored from 0 - 5, with 0 being completely disagree and 5 being completely agree.

This survey is anonymous and does not collect any sensitive data.

Contact Type	Average score
Making a complaint was straightforward	4.8
I knew I had the right to complain	4.8
I knew that my / the patinet's care would not be compromised by making a complaint	4.5
The member of staff who spoke to me were polite and helpful	4.8
My complaint was acknowledged within three working days of it being received by the Trust	4.8
I was informed about the complaints process and the timescales involved	4.4
I was informed of any delays and updated on any progress as appropriate	4.4
I received a resolution in a timescale relevant to my particular case	4.4
I am happy with the overall response timeframe to my complaint	4.2
I feel the Trust have taken my comments on board and have made the relevant changes to improve	4.5
I would complaint again if I felt I needed to	4.9
Overall score	4.6

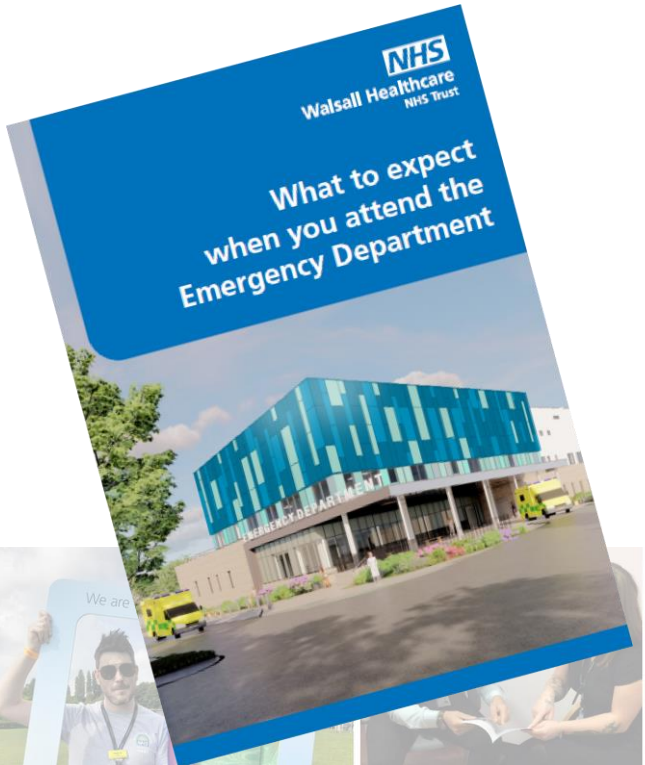


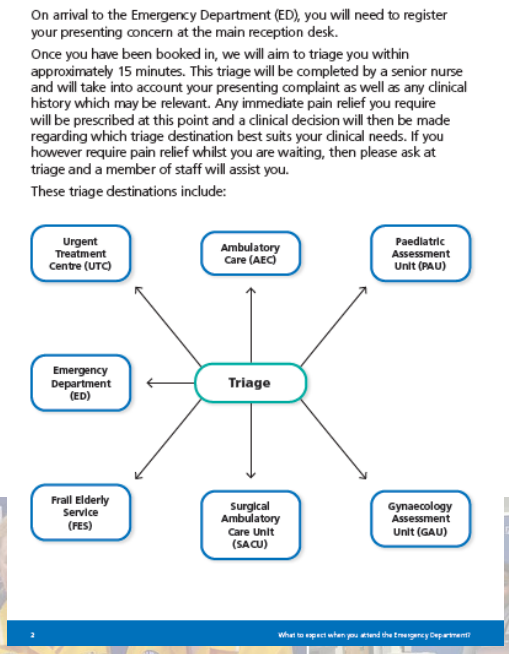
1h: Learning Matters

The team conducted a thematic review of the concerns received for ED over a 6 month period which involved a review of over 100 contacts (excluding compliments) ranging from formal complaints, to informal concerns and queries.

The overall theme in relation to the contacts received was in relation to communication, but at varying points throughout the patient journey. It is clear that patients do not have a clear understanding of the role of the Urgent Care Centre in comparison to ED. The feedback received also suggests that delays and waiting times are not always communicated in an effective way, and the offer of a beverage in the event of a delay does not always happen.

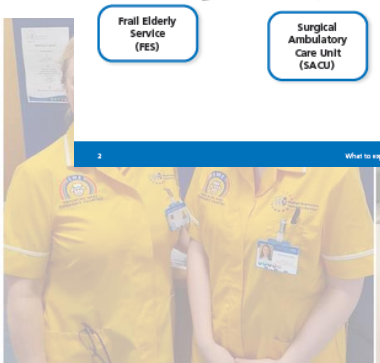
As a result, the team worked with the ED department to develop a leaflet around "what to expect when you attend the Emergency Department." This work was undertaken in collaboration with our Patient Involvement Partners who provided valuable feedback which helped to shape the final version of the leaflet.

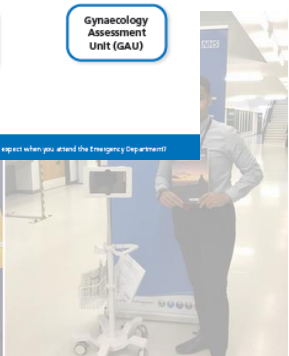



On arrival to the Emergency Department (ED), you will need to register your presenting concern at the main reception desk.

Once you have been booked in, we will aim to triage you within approximately 15 minutes. This triage will be completed by a senior nurse and will take into account your presenting complaint as well as any clinical history which may be relevant. Any immediate pain relief you require will be prescribed at this point and a clinical decision will then be made regarding which triage destination best suits your clinical needs. If you however require pain relief whilst you are waiting, then please ask at triage and a member of staff will assist you.

These triage destinations include:





A complaint was received from the parents of a child who were unhappy with doctor who heel pricked their son for blood. They felt excessive force was used and their sons foot/ankle was bruised as a result. They were shocked to see this and questioned if too much force was used.

Following the findings of the complaint handler's investigation, there has been a formal training session on blood sampling by heel-prick for all postgraduate doctors including the member of staff concerned.

The member of staff concerned also undertook reflection on the incident and the importance of communication with parents before and after any procedure.

Following receiving their complaint response the family wrote back to the Trust to thank us for the detailed investigation and expressed their gratitude that their complaint was investigated thoroughly and that actions had been implemented to prevent a similar occurrence in future.

A formal complaint was received in relation to a patient receiving the discharge paperwork of another patient in the post. A clinical incident was raised at the time and the patient returned the document. During the investigation it was identified that the printer within the department had unfortunately malfunctioned at the time of printing. There was a recognised delay in printing which subsequently created duplicate copies of the reports being printed.

Unfortunately the nurses in the room did not follow the departmental procedure, and although they signed to say they had checked the reports they did not notice that they were for the same patient. As a result of the complaint, the team have purchased new printers to prevent a similar malfunction occurring in future and a teaching session around documentation and specifically, the signing of documentation was arranged for the department involved.

1i: The new NHS Complaint Standards

The NHS Complaint Standards, model complaint handling procedure and guidance set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

Walsall Healthcare NHS Trust participated in the pilot of the new standards with early adopter status for implementation and collaborated with colleagues at the Royal Wolverhampton NHS Trust.

They have a strong focus on:

- early resolution by empowered and well-trained people
- all staff, particularly senior staff, regularly reviewing what learning can be taken from complaints
- how all staff, particularly senior staff, should use this learning to improve services.

Implementing the standards at Walsall

The Complaint Standards will support organisations to provide a quicker, simpler and more streamlined complaint handling service.

NHS Complaint Standards: Summary of expectations

- Completed the NHS assessment matrix - this breaks down the core expectations of the standards and allowed us to identify gaps in practice.
- Adopted the model complaint handling procedure - this describes how the standards will be put into practice and will replace the existing complaints and concerns policy.
- Reviewed the guidance modules and downloaded updated versions for dissemination.
- Undertaken a full review of our local templates to ensure compliance with the standards.
- Produced training modules around resolving concerns at a local level, a guide to an impactful Local Resolution Meeting, with a further module around the formal complaint investigation process currently in development.

Section 2: Patient Experience

2a. The Friends and Family Test

The friends and family test recommendation scores are illustrated in the tables below, these include percentage changes on 2021/22. The Trusts average recommendation score for 2022/23 was 86% which is a 4% increase on the previous year. When looking at the different touchpoints, there is a fluctuation of 33% with scores ranging between 99% and 66%.

Friends and Family Test	Inpatients				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2022/23	85%	86%	85%	88%	91%	91%	91%	92%	74%	76%	74%	84%	98%	99%	98%	98%
Difference	- 2%	+ 2%	=	+ 3%	=	- 1%	+ 1%	=	- 6%	=	- 8%	+ 7%	+ 4%	+ 5%	+ 3%	+ 2%
2021/22	87%	84%	85%	85%	91%	92%	90%	92%	80%	76%	78%	77%	94%	94%	95%	96%
Response Rate (22/23)	24.6	25	25	28.9	19.3	20.2	20.3	20.4	16.7	18.8	20.6	22.6	7.7	4.9	3.3	84.1

Friends and Family Test	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4 *	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2022/23	89%	81%	88%	92%	83%	80%	82%	90%	84%	83%	82%	85%	84%	88%	66%	86%
Difference	+ 2%	- 3%	+ 3%	+ 7%	- 8%	- 12%	- 8%	- 2%	+ 4%	+ 7%	+ 4%	+ 8%	- 10%	- 6%	- 29%	- 10%
2021/22	87%	84%	85%	85%	91%	92%	90%	92%	80%	76%	78%	77%	94%	94%	95%	96%
Response Rate (22/23)	15.6	12.3	11.7	12.1	19.4	18	18.2	23.9	11.8	10.6	10.4	16.6	11.3	9.8	7.3	15.5

* Q4 data subject to change inline with March 2023 data submissions for FFT being after reporting date

The below table illustrates the percentage difference between the Trusts average recommendation score for each touchpoint and the local ICB and National results. Whilst some areas require improvement when compared locally and national, Outpatients, ED, Community, Antenatal and Postnatal Ward all perform better on average locally, with Community and ED also outperforming the national average also.

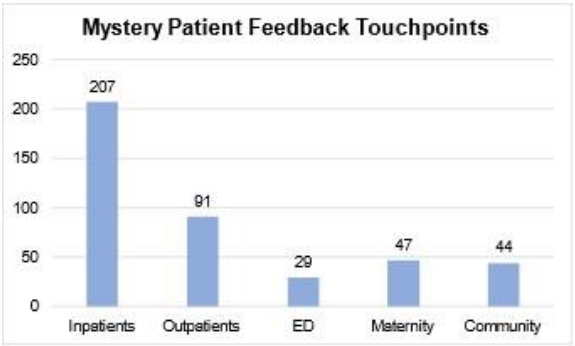
	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
ICB*	- 2%	+ 1.4%	+ 6.7 %	+ 4.8%	+ 3.4%	- 2.7%	+ 5.4%	- 3.4%
National	- 8.5%	- 1.4%	+ 0.9 %	+ 6.9%	- 2.2%	- 9.1%	- 10%	- 11%

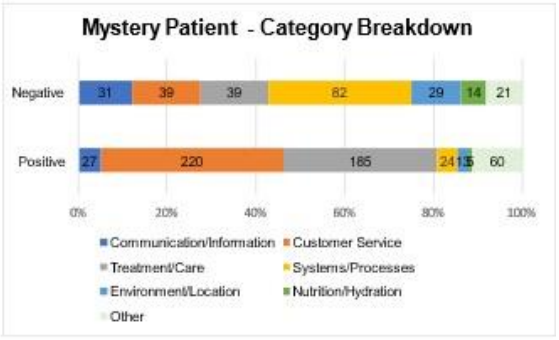
* The Black Country ICB

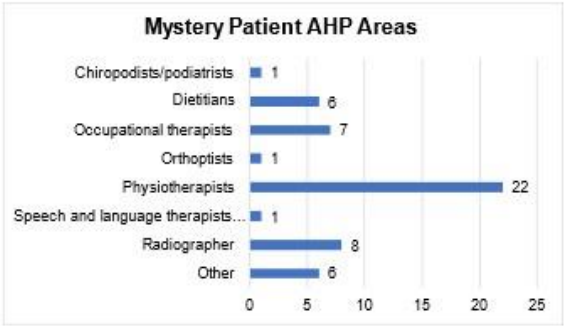
** The ICB and National data at time of reporting was taken over a 10-month period (April 2022 – January 2023).

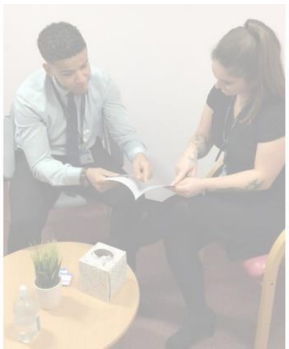
2b. Mystery Patient

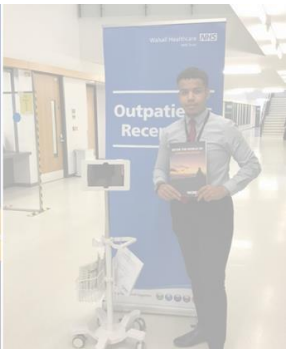
The Mystery Patient Scheme was first initiated in July 2021 as a feedback collection tool to support existing feedback methods such as the Friends and Family Test (FFT) and the national survey programme. It enables the trust to monitor different areas of experience, and for patients a way of providing feedback when they want, convenient to them and about what matters to them. The key performance indicators outlined in the table below are designed to support the trust in monitoring the improvement areas identified in the national patient survey. **418** patients provided feedback through the scheme in the last year.











2c. National Surveys

All eligible NHS trusts in England participate in the NHS CQC Patient Survey Programme, asking patients their views on their recent health care experiences. The findings from these surveys provide organisations with detailed patient feedback on standards of service and care and can be used to help set priorities for delivering a better service for patients.

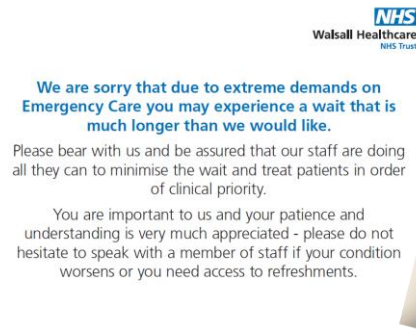
Three National Surveys were published during 2022/2023, The Adult Inpatient Survey 2021, The Maternity Survey and the National Cancer Survey 2021. Surveys are analsyed and benchmarked against national data, action planning is then undertaken and monitored by the Patient Experience Group and the Trust Quality, Safety and Experience Committee.

The Adult Inpatient Survey 2021

Compared to the 2020 results the Trust slightly improved its average score by 0.3%. Change from 2020-2021 – we scored better by 5% or more for 4 questions. Indicative National Comparisons place the Trust in the middle tier (same as band) for 38 questions and bottom 20% for 7 questions. (Improvement on 14 questions and by one for the somewhat worse band). The following questions saw a 5% improvement score – support at mealtimes, staff explaining how well an op/procedure had gone, hospital staff considering the family/home situation when planning to leave hospital, and information about what to do when a patient has left hospital. In response actions include:

- Distribution of sleep packs to all in-patient areas to accompany a re-launch of the noise at night protocol. (Re-audit of use currently underway given some recent FFT feedback).
- The Division of MLTC held a Ward Round Standards Workshop including a SWOT analysis of existing practice and an audit tool to assess and fine tune practice so ward rounds are more effective to patient discharge, involvement, and improved communication.
- Healthwatch Walsall have provided some early insight from their discharge survey. However, much is in place focussing on the Walsall Together collaboration response to the National Discharge Taskforce. The discharge lounge produced and shared guidance on planning for an effective discharge ‘Get AKTING, Think HOME’.
- Implementation of 'Thank you for your patience' card for delayed patients, focus on emergency admissions. Card designed and printed, to be used through ED and AMU.

- Sorry to disturb' you, cards printed - visual prompt to staff and an apology to patient to help reinforce communication when patients are transferred at night – being used on AMU/ED.



Maternity Survey 2022

The 2022 Maternity survey report was published on 11th January 2023 and shared with the senior team on 16th January 2023. The maternity survey is split into three sections that ask questions about antenatal care, labour and birth, postnatal care.

- 98 Walsall Healthcare NHS Trust patients responded to the survey with the response rate for Walsall Healthcare NHS Trust at 33.11% against a national response rate of 46.5%.
- 49% of respondents had given birth to their first baby.
- 66% of respondents where white.
- 23% Asian or Asian British.
- 7% Black or Black British.

It is worth acknowledging that within the final data set and with the national weighting applied – our response rate was 15% lower than the average and this will have also affected any meaningful comparison even with weighting. The Maternity team have disseminated the survey findings to all maternity staff groups and have carried out an experience of care survey to track the results against the retrospect survey findings. There is a Divisional Patient Experience template in place which supports the Trust wide enabling strategy – this has been completed with commitments against the three improvement pillars of Involvement, Engagement and Experience.

National Cancer Survey 2021

Tumour group action plans are in place led by the Cancer Nurse Specialists. The Trust has 3 questions below the expected range as a focus for improvement, and 6 questions reported above the expected range. Given the time lag in reporting, actions have been provided for preparation of the 2022 results and will be mapped to together as a continued action plan.

2d. Welcome Hub

This year saw the reintroduction of controlled visiting, after a temporary lifting in May and June 2021. Since its launch on 17th May 2021, The Welcome Hub has consistently operated a 7 day service and continues to do so, adapting to the changing environment we see today. Whilst visiting restrictions have now been lifted at the Trust, its is because of the dedication and commitment of the Welcome Hub team that we have been able to support our patients, staff and communities. We were also highlighted by NHSE for 'compassionate' approaches that was followed by many other Trusts when visiting restrictions began to be lifted.

2022/23 Review

Parcels to Patients	Video Calls	Compassionate Visits
5,040	7,545	1,209

Welcome Hub Booked Visits

94,887

Section 3: Involvement and Engagement

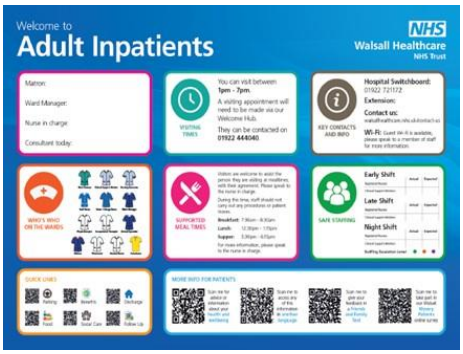
3a. Enabling Strategy

We published our Patient Experience Enabling Strategy in collaboration with the Royal Wolverhampton NHS Trust. The strategy sets out our priorities for improving patient experience in the next 3 years. Three pillars of improvement have been identified. These are Involvement, Engagement and Experience. These pillars have been guided and informed by the patient voice – using feedback and insight gained from our patients, families, and carers who either completed a national or local survey, took part in the Friends and Family Test, provided positive feedback, or raised a concern or complaint. We have set ourselves several priorities which will underpin each of the three pillars of improvement.

3b. Patient Involvement Partners (PIPS)

The purpose of our Patient involvement Partners (PIPS) is to support inclusive patient and carer engagement across the Trust. Seeking to ensure that patients and carers are actively involved in shaping and developing services and to review Trust performance addressing issues identified as important by patients, carers, and relevant stakeholders.

The Patient Partner programme was introduced in 2021 and continues to evolve.



Patient partners have been involved in the development and co-design of new ward Information Boards completed in October 2022.

A patient partner and our new chaplaincy volunteers were actively involved in a faith-based improvement that has seen us provided faith resource boxes available in key locations across acute and community.

The resource boxes include religious books, icons and key information to support staff and patients to access religious care by request.

The patient readers panel reviewed a combined VTE leaflet, the Goscote Hospice leaflet, Patient Initiated Follow–Up leaflet, lymphoedema, 3rd primary dose of vaccine, post picc line insertion information leaflet.

In addition, our partners have been involved in PLACE assessments, quality improvement work and action monitoring in response to National Surveys. The Patient Partners received a presentation on Duty of Candour explaining that the template followed is considered to not be user friendly. The partners attended a Duty of Candour workshop to co-design changes to the current process, to improve documentation and help with the production of a new leaflet.

3c. Blessed 2 Bless

Our partnership with the 'Blessed to Bless', charity that helps feed the homeless and those that are struggling financially has been extended to support staff through the running of a staff foodbank.

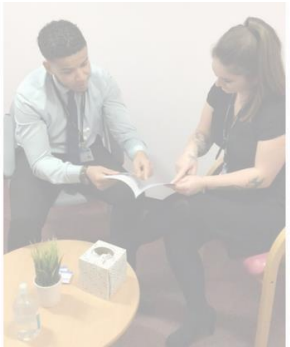
Blessed to Bless also continues to support us with our 'Hospital to Home' Discharge programme based on the discharge lounge - where a food parcel is provided to vulnerable patients leaving hospital with no means of accessing shops or no support network in place.

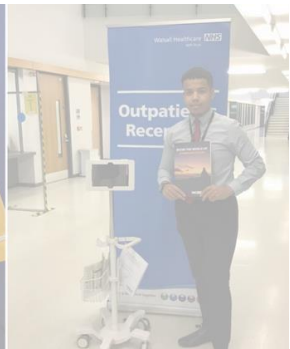
The food parcel supplies an initial provision of long-life milk, sugar, tea/coffee/, juice, biscuits, cereal, pasta, soup, and sauce. Those who agree are also referred to a local network hub for ongoing support such as be-friending and assistance with welfare and benefit maximisation. We are grateful for all that Blessed 2 Bless deliver for and on behalf of the people of Walsall.

3d. Walsall Pride

In August the team attended Walsall Pride, armed with a '**We are the Patient Experience'** selfie frame, the team sought to consult on the Patient Experience Enabling Strategy and advertise involvement roles at the Trust.

Walsall Pride is an event for the whole community, Pride inspires everyone to embrace equality and demonstrates that people from all walks of life can join and celebrate diversity.





3e. 'It's OK to ask'

In November we introduced 'It's OK to ask' which helps patients find out more about their care so they can better understand what is being recommended to them. It prompts three main questions for patients to consider:

· What is my main problem?
· What do I need to do?
· Why is it important I do this?

Each patient accessing Trust services were offered a bookmark telling them 'It's OK to ask' and explaining why it's so important they understand their care and are involved in the process.
The campaign continues to be promoted and additional staff groups engaged in the reason for doing this and how they can make small changes to ensure patient involvement in decisions about their care are considered at every level.

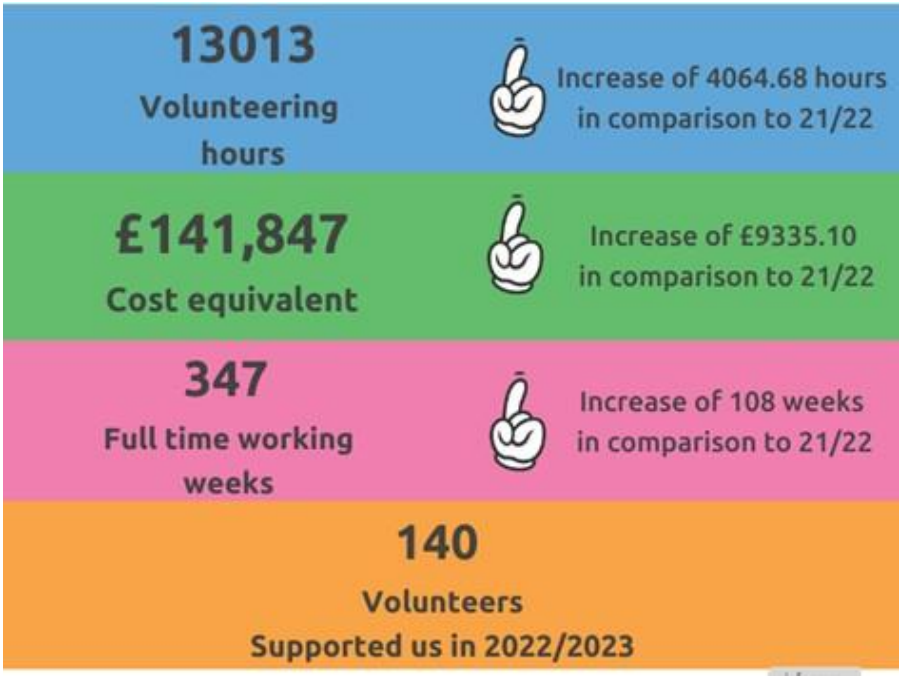
Monitored against the survey score for 2021 (6.5) our score for mystery patients for the involvement question puts us currently at 9 averaging 8.0 since publication of the in-patient survey.

Scored Questions	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Involvement in decisions about your care and treatment	8.9	7.5	6.4	6.8	9	9	9



Section 4: Voluntary Services

4a. The year of the volunteer



4b. Partnerships

Throughout the year the trust has strengthened existing partnerships with Juniper Training, through the EWE programme, and Manor Farm CA, through the Manor Wellbeing Support lounge. A new partnership for 2022/23 is with St John Ambulance and the NHS Cadets, a year long advanced programme supporting young people across the black country in the early stages of there career choices.

As we move into 2023, foundations have been laid for a new partnership with Walsall College, and we look forward to welcoming students to the hospital in the coming year.

4c. Volunteer Awards

This year saw the return of the Volunteer Awards held at Calderfields Golf and Country Club. Over 100 guest, including volunteers and staff supporters, were in attendance alongside Mayor of Walsall Councillor Rose Martin and Group Chief Executive Professor David Loughton.

The award categories included:

· Bronze award for one year of service.
· Silver award for five years of service.
· Gold award for 10 years of service.
· Special recognition for over 15 years of service.

VOLUNTEER AWARDS
Celebrating our volunteer heroes

We look forward to celebrating our amazing volunteers at the next Awards being held June 16th 2023 at Pelsall Community Centre

Section 5. Family and Carer Support

5a. Commitment to carers

This year the Trust launched its Commitment To Carers, outlining key priorities the Trust will take to **Identify**, **Recognise**, **Support** and **Collaborate** with Carers.

This new service will support staff working with patients who have existing unpaid carers, or due to the reasons they are in hospital will rely on the support of an unpaid carer following discharge.

The services is supported by the Family and Carer Support Officer and will see growth as we move through 2023.

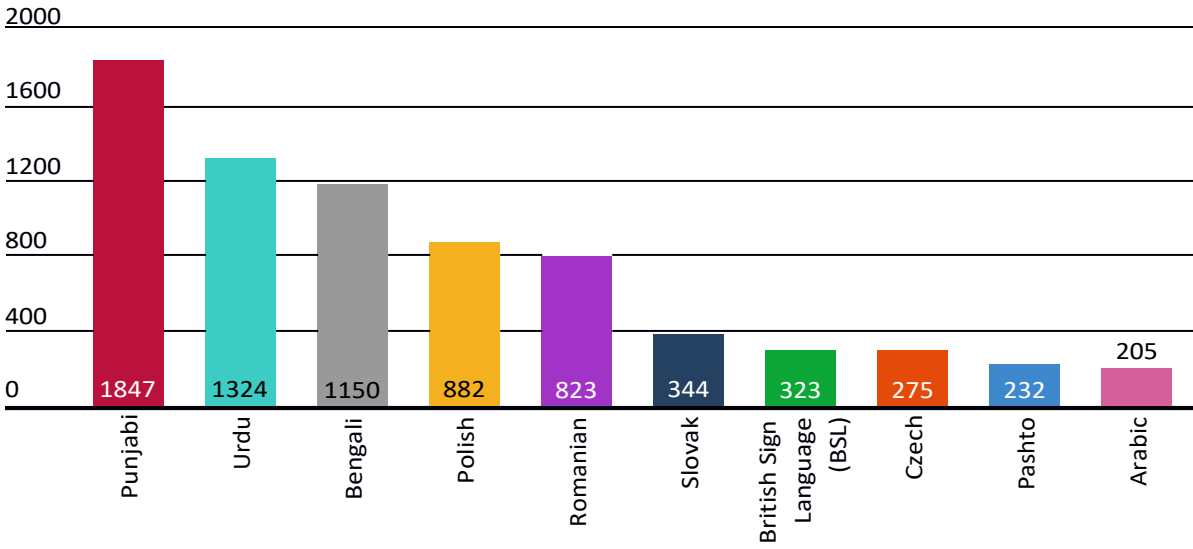
5b. Family and Carer Support Officer

Since the service was introduced in December 2022 support has been provided in the following ways.

Section 6: Equality and Accessibility Monitoring

6a. Interpreting & Translation

9371 bookings were arranged during 2022/2023. This is a slight decrease in comparison to 2021/2022 (9445) 33% (3094 sessions) of these have been telephone, 66% (6267 sessions) face to face and 0.4% (40 sessions) video on demand calls. 492 patients/users completed feedback. This is an increase of 261 in comparison to the previous year (231). the average score was 4.75 out of a maximum score of 5.



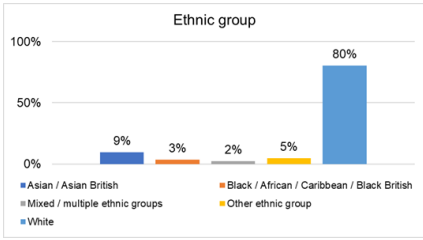
Top 10 Languages Trustwide

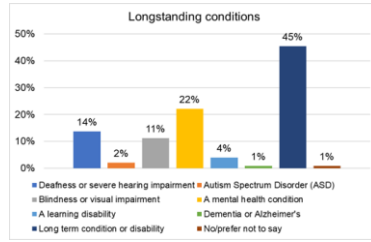
- The Trust took part in the filming of a instructional video with Word 360 2022, which showcases the benefits of using the service whilst also showcasing our staff using the various methods of translation available to us.

- Inbound call interpreting (Wordskii connect) is being trialled in Antenatal - currently awaiting a "go live" date.

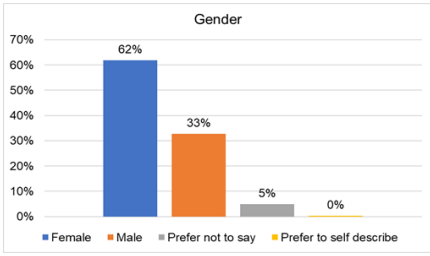
- Work currently ongoing with the Imaging team to reduce the number of face bookings by using a mobile device for interpreting.

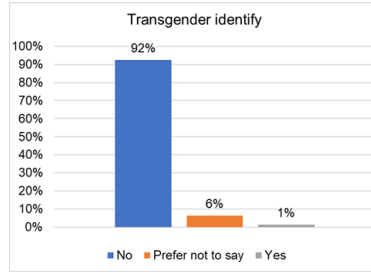
6b. Equality Monitoring Patient Experience

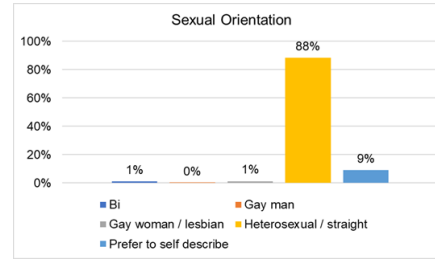




Patient Experience data relates to data collection where the patient has made the decision to provide this.







- 80% identified as White/British.
- 9% as Asian/Asian British.
- 3% as Black/African/Caribbean/Black British.
- 62% were female.
- 45% identified a long term condition.
- 1% identified as Transgender.
- 88% were heterosexual.

Links have been made with groups representative of the community and from protected groups who are supporting improvement work such as the 'Did Not Attend' improvement programme - seeking to better undertsand the reasons why people do not attend their appointments.

Our Patient Partner programme also seeks representative membership.

6c. Equality Monitoring - Complaints & Concerns

With the Equality Monitoring survey, the aim is to understand who we are reaching out to from local protected groups, to help the Trust monitor who accesses our complaints service in line with the nine protected characteristics under the Equality Act 2010. This is a multiple-choice survey.

- Ethnicity: 56.67% of respondents identified themselves as White British, 10% Bangladeshi, 6.67% Caribbean, 3.3% African, Indian 3.3%, 3.3% Pakistani and 16.75% of respondents declined to complete.
- Age: 32.35% were aged 18 to 24, 17.65% were aged 25 to 49, 17.65% were aged 50 to 64, 14.71% were 65 to 74, 2.94% were aged 75 to 84 and 14,71% of respondents declined to complete.
- Religion or belief: 36.67% Christianity, 30% no religion, 6.67% Islam, 6.67% Sikhism, 3.3% Church of England. 16.67% of respondents declined to complete.
- Sexual Orientation: 80% Heterosexual, 3.3% Homosexual/Gay man and 16.67% of respondents declined to complete.
- Gender: Male 46.67%, Female 36.67%, 16.67% of respondents declined to complete.
- Gender re-assignment: 80% No, 3.3% prefer not to say and 16.67% of respondents declined to complete.
- Relationship status: 51.72% Married, 13.79% Single, 10.34% Living with partner, 3.45% Widowed, 3.45% Divorced and 17.24% of respondents declined to complete.
- Pregnancy: 3.3% were pregnant at the time of making a complaint, 56.67% were not. 26.67 of respondents felt the question was not applicable and 13.3% declined to complete.
- 46.6% of patients do not consider themselves to have a longstanding condition, 23.3% of patients do and 6.67% prefer not to say and 23.3% declined to complete.

Item 14.11.1

Walsall Healthcare NHS Trust

TRUST BOARD	
Meeting Date:	7 June 2023
Title of Report:	Patient Experience Enabling Strategy
Action Requested:	Approve
For the attention of the Board	
Assure	The development of this enabling strategy involved a thematic review of the patient voice – feedback received via national or local surveys, the Friends and Family Test and concerns and complaints.
Advise	The Patient and Partner Experience Group and the Quality, Patient Experience Group have received and agreed the strategy
Alert	3-year delivery action plan in place
Author and Responsible Director Contact Details:	Tel 01922 656463 garry.perry1@nhs.net Lisa Carroll, Director of Nursing
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	Embed a culture of learning and continuous improvement Safe and responsive urgent and emergency care
Support our Colleagues	Improve overall staff engagement
Improve the Healthcare of our Communities	Develop a health inequalities strategy Deliver improvements at PLACE in the health of our communities
Effective Collaboration	Implement technological solutions that improve patient experience Progress joint working across Wolverhampton and Walsall
Resource Implications:	There are no resource implications associated with this report.
Report Data Caveats	NIL
CQC Domains	**Safe:** you are protected from abuse and avoidable harm **Effective:** your care, treatment and support achieve good outcomes, helps you to maintain quality of life and is based ono the best available evidence **Caring:** staff involve and treat you with compassion, kindness, dignity, and respect **Responsive:** services are organised so that they meet your needs
Equality and Diversity Impact	There are no legal or equality & diversity implications associated with this paper.
Risks: BAF/ TRR	
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	Shared with the Care Quality Commission & Healthwatch during development
References	If required/appropriate e.g. if addressing a national policy priority.

Walsall Healthcare NHS Trust

NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

1. PURPOSE OF REPORT

The purpose of this report is to introduce the Patient Experience Enabling Strategy which sets out our priorities for improving patient experience in the next 3 years. This is a joint strategy that has been developed in partnership with the Royal Wolverhampton NHS Trust.

2. BACKGROUND

The strategy sets out how both Trusts will strengthen its approach to patient experience, engagement, public involvement, and co-production. The strategy also encompasses the Trusts overall objectives and ambition to become an Integrated Care System with the aim to work in partnership with local councils and others, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population served.

This enabling strategy sets out our priorities for improving patient experience in the next 3 years. Three pillars of improvement have been identified. These are Involvement, Engagement and Experience. These pillars have been guided and informed by the patient voice – using feedback and insight gained from our patients, families, and carers who either completed a national or local survey, took part in the Friends and Family Test, or raised a concern or complaint. We have set ourselves several priorities which will underpin each of the three pillars of improvement. The strategy also outlines how the patient voice will inform the work of both Trusts, describes why it is important to engage with patients and the public, and defines the accountability structure and proposed measurements of success

3. DETAILS

The enclosed strategy outlines our forward view of how we will respond to the feedback we have heard using a thematic approach to the information we have received in addition to stakeholder involvement from our patient involvement partners, patients, families, carers, staff and various external organisations through the completion of online surveys.

4. RECOMMENDATIONS

Board members are asked to approve the Patient Experience Enabling Strategy 2022-2025

Patient Experience Enabling Strategy 2022-2025

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

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Foreword

We are delighted to introduce the Patient Experience Enabling Strategy (2022 - 2025), which will support and empower all staff within our respective Trusts to put patient experience at the heart of everything we do.

The heart of our success as an organisation is the involvement of our patients, their relatives, carers and the community to give them the best experience of care possible for we are the patient experience.

We aim to be Providers of Healthcare that continually strive to improve patient experiences and outcomes, aligned with an outstanding patient experience that meets expectations.

The NHS Confederation (2011) states that whilst good clinical outcomes and processes are important elements of patient experience, it is far more than this. It states that experience is also determined by the physical environment patients are in and how they feel about the care they receive, including the way staff interact with them. Improving the experiences for all patients starts by treating each of them individually to ensure they receive the right care at the right time, in the right way for them.

We know that a positive experience during each interaction of care leads to positive clinical outcomes. If a patient feels listened to, involved in their care, respected and looked after, they will respond better to healthcare interventions and also be more able to manage their own journey through care.

Therefore, we pledge to actively seek, listen and act on feedback received from our patients, staff, and other key stakeholder groups. This Patient Experience Enabling Strategy has been co-produced with our patients, our staff and our partners and it reflects the needs of our local populations.

The strategy builds on our journey and cultural shift from 'doing to' patients, to 'working with' patients and carers. We aim to ensure that all patients and carers have a central role in all aspects of care, service design and improvement across the organisation.

The Trust is truly committed to the delivery of high-quality care. In order to achieve this, we must listen to our patient and carers feedback, ensuring that we learn and respond to continuously improve our services.

This joint strategy shows both Trust's commitment to improve outcomes for patients and efficiency of process through closer collaboration between the two Trusts.

Lisa Carroll,
Director of Nursing
Walsall Healthcare NHS Trust (WHT)

Debra Hickman,
Director of Nursing
The Royal Wolverhampton NHS Trust (RWT)

1.0 Introduction

This strategy sets out how both Trusts will strengthen its approach to patient experience, engagement, public involvement and co-production.

The strategy also encompasses the Trusts overall objectives and ambition to become an Integrated Care System with the aim to work in partnership with local authorities and others, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population served.

This strategy will set out our priorities for improving patient experience in the next 3 years. Three pillars of improvement have been identified. These are Involvement, Engagement and Experience.

These pillars have been guided and informed by the patient voice – using feedback and insight gained from our patients, families, and carers who either completed a national or local survey, took part in the Friends and Family Test, provided positive feedback or raised a concern or complaint. We have set ourselves several priorities which will underpin each of the three pillars of improvement. The strategy also outlines how the patient voice will inform the work of both Trusts, describes why it is important to engage with patients and the public, and defines the accountability structure and proposed measurements of success.

1.1 Developing this strategy

This strategy outlines our forward view of how we will respond to the feedback we have heard using a thematic approach to the information we have received in addition to stakeholder involvement from our patient involvement partners, patients, families, carers, staff and various external organisations through the completion of online surveys.

We asked the following questions:

1. What makes a good experience for you as a patient or carer?
2. What could we do better to improve the patient and carer experience?
3. Do you agree with the areas that have been identified for improvement?
4. Have we missed anything that you consider needs improving?
5. Do you think that the Patient Experience Enabling Strategy shows commitment to work with patients to listen to them and to learn and develop the services that they want to receive?
6. Is what matters to you most reflected in the current strategy?
7. As a result of the strategy, do you feel that the Trust has reached out to you, listened, learned and made changes to services as a result?
8. Which of the current work areas do you think that the Patient Experience Enabling Strategy should focus on?

1.2 Patient Participation and Involvement

We met with our Patient Representative Groups and shared the patient voice feedback, the improvement pillars and how these were decided upon. Our partners provided valuable feedback in support of the pillars and how they will involve themselves in seeking assurance on the improvement actions and measuring outcomes.

For Walsall Healthcare NHS Trust (WHT) - When we asked question 1, we received some really engaging feedback from our Patient Involvement Partners. Key points were made around civility, ensuring patients are listened to and ensuring staff are communicating well and giving relevant information to our patients.

Our Patient Involvement Partners explained, regarding question 2, they believe care in the hospital should be patient centred as everyone requires different levels of care and treatment. Whilst also making sure preference is a key factor.

All Patient Involvement Partners agreed with question 3 and that all the areas have been identified for improvement are correct.

Our members touched on time management as an area they consider needs improving in question 4. They trust that using time management more effectively will enable patients to have an opportunity to ask any questions relating to their treatment and to understand the next steps of their care if they are unsure.

For The Royal Wolverhampton NHS Trust(RWT) – 65% of the patients who responded were familiar with the current strategy and felt that it shows commitment to work with patients to listen to them and to learn and develop the services that they want to receive.

We asked our patients what matters to them the most when they receive NHS services. They responded that the service needed to be right to suit the needs of the patient and they wanted to be treated quickly.

We also asked them what areas could be specifically focus on and an over arching 76% wanted us to develop and produce services from start to finish by engaging meaningfully with patients and other stakeholders. They wanted us to learn from complaints and encourage better attitudes and practice from employees.

It was felt that patients related to the areas on which the strategy focuses. That they are relevant and assist to the development of the Trust to provide services which are truly patient-centred.

The Patient Experience Enabling Strategy links to both Trusts strategic vision working in partnership with each other: “To deliver exceptional care together to improve the health and wellbeing of our communities”.

Care	Excel in the delivery of **Care**
Colleagues	Support our **Colleagues**
Collaboration	Effective **Collaboration**
Communities	Improve the health and wellbeing of our **Communities**

Because of the thematic review, both Trust's have set several priorities which will underpin each of the three pillars of improvement, Involvement, Engagement and Experience. Each pillar is headed by a 'We statement' this statement of intent sets out a clear objective of improvement underpinned by a series of improvement actions and measurements.

1.3 Survey Feedback

An online survey was carried out during July and August for each Trust with variances to questions based on specific demographics of patient groups and data already gathered. Responses were received from a variety of Patients, Family members, carers staff members and members of the public or other.

Appendix 1 and 2 shows the responses received for each Trust.

For WHT

- 57% of respondents agreed with the areas identified for improvement
- 40% of respondents agreed to some extent with the areas identified for improvement
- 67% of respondents offered commentary on the identified areas for improvement
- 75% of respondents provided additional comments in relation to further improvements

For RWT

- 55% of those surveyed at RWT were either patient or family member/carer. The remainder responses were from staff
- Those surveyed were given a list of options to let us know what they believed were the highest priority for improvement. Those key areas chosen are featured in our priorities for the next three years
- 64% were familiar with the current strategy
- 70% of those who responded believe the strategy demonstrates commitment to work with patients to listen, learn and develop desired services
- 61% said that what matters to them is reflected in the strategy

Our Patient Experience Enabling Strategy – 2022-2025

Quality, Clinical Effectiveness and Safety

Involvement
We will involve patients and families in decisions about their treatment, care and discharge plans.

Engagement
We will develop our Patient Partner programme using the patient voice and the input this provides to inform service change and improvements across the organisation.

Experience
We will support our staff to develop a culture of learning to improve care and experience for every patient.

Patient Voice
Local and National Surveys – Friends and Family – Concerns, Complaints and Compliments

1.4 What is Patient Experience?

Patient experience' is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care (NHS Institute for Innovation and Improvement 2013).

The Department of Health and Social Care defines a positive patient experience as: "Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal and being treated with honesty, respect and dignity" (Department of Health (2005) 'Now I feel tall – what a patient-centred NHS looks like').

1.5 What is patient and public engagement?

It is the active participation of patients, carers, community representatives, community groups and the public in how services are planned, delivered, and evaluated. It is broader and deeper than traditional consultation. It involves the ongoing process of developing and sustaining constructive relationships, building strong, active partnerships, and holding a meaningful dialogue with stakeholders. 1) Engaging with patients and the public can happen at two levels: individual level – 'my say' in decisions about my own care and treatment. 2) Collective level – 'my' or 'our say' in decisions about commissioning and delivery of services.

Effective patient engagement means involving patient cohorts (patients with common conditions) in helping to get the service right for them. It is also about engaging the public in decisions about the commissioning, planning, design and reconfiguration of health services, either pro-actively as design partners, or reactively, through consultation.

1.6 Why is this important?

Effective engagement leads to improvements in health services and is part of everyone's role in the NHS. Improving patient experience is about working with the people who use services to make these services better. It is about designing services that meet their needs and it requires a commitment to doing this on an ongoing basis, day-by-day and year-by-year.

2.0 The Patient Voice

We have undertaken thematic reviews using feedback received over a 12-month period from patients/public who either completed a national or local survey, took part in the Friends and Family Test, or raised a concern or complaint. Each theme highlights areas where change and improvement are required. The following themes are consistent for 86% of all feedback where improvements could be made (negative feedback) highlighting key areas to focus on.

Highlighted themes from patient feedback

1. Treatment and care
2. Communication and information
3. Appointments and admission
4. Environment and hospital access
5. Systems and processes
6. Customer service

2.1 Patient Voice Thematic Review

Appointments & Admission

Clear appointment letters and communications.

Reduce delayed or cancelled appointments.

Manage clinic cancellations before booking appointments.

Ensure appointments are required and appropriate for the needs of the patient.

Treatment & Care

Treat patients as individuals.

Support patients getting attention when they need help.

Listen to patients worries and fears.

Ensure patients feel safe.

Treat in a way that instils confidence in healthcare professionals.

Deliver safe staffing levels.

Involve patients in all treatment decisions.

Getting the right service to treat the patients needs

Systems & Processes

Discharged at the right time.

A discharge process from the point of admission.

Reduce waiting times and communicate what they are.

Communicate discharge at the right time.

A safe discharge where patients feel prepared.

Discharge plans that involve family and carers.

Having everything ready at the time of discharge.

Customer Service

Treat patients with respect and dignity.

Ensure patients do not feel a burden.

Act in a friendly, professional manner.

Respect patient views and beliefs.

Deliver compassionate care.

Communication & Information

A clear treatment plan patients can understand.

Patients involved in decisions around their treatment and care.

Involvement and clear communication with patients & family/carer.

Understand a patient's medical history to avoid repeating.

Give clear explanation of any changes or cancellations.

Clear and easy to understand after care information.

Avoid conflicting information that confuses patients.

Clear information around what to do at home.

Informed of discharge plan and information.

Clear communication around discharge.

Communicating waiting times.

Good communication verbal and non-verbal

Environment and Hospital Access

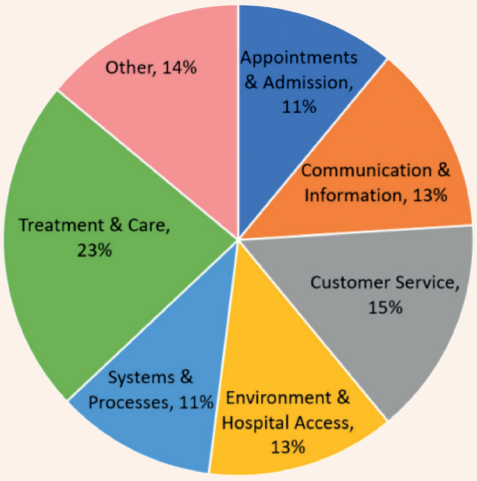
Ensure the environment feels safe.

Deliver a clean environment.

Maintain a hospital environment that is comfortable.

Safe access for disabled and immobile patients and visitors.

Reduce and manage noise and disturbances.



From our engagement sessions and thematic review, we have highlighted the following Strengths, weaknesses, Opportunities and Threats to the patient experience at our Trusts.

Strengths

- Excellent Leadership
- Compassionate and kind staff
- Greater confidence in patient care
- Improved patient care
- Reliable, consistent, health care provided, safe environment, great building and equipment, well trained staff
- Carers priorities in line with the NHS Long term plan

Weaknesses

- Inconsistent approach, decrease of communication, increase of risk
- Poor communication with our patients
- Efficient discharge of medically fit patients
- Patients not involved in their care plans

Opportunities

- Further build on patient involvement and co production;
- Collaboratively working with neighbouring Trusts
- Enhancing care using digital innovation
- Pro actively seek feedback
- Understand the demographics of our patients and improve health inequalities
- Opportunities to create friendships/ social interaction using volunteers aiming to reduce re admittance

Threats

- Impact of COVID-19 on staff, patients, families
- External factors outside of our jurisdiction e.g. packages of care
- Losing a patient's trust
- High costs (new technologies)
- Financial constraints
- Risk management
- Staffing ratio

3.0 Improvement Pillars

Three pillars of improvement have been identified. These are Involvement, Engagement and Experience.

3.1 Pillar one – Involvement

Pillar one – Involvement

We will involve patients and families in decisions about their treatment, care, and discharge plans.

Our Commitment to you:

- Involvement and clear communication with patients & family/carer.
- Clear and easy to understand after care information.
- Listen to patients worries and fears.
- Clear information around what to do at home.
- Informed of discharge plan and information.
- Clear communication around discharge.
- Systems & Processes Discharged at the right time.
- A discharge process from the point of admission.
- Communicate discharge at the right time
- A safe discharge where patients feel prepared.
- Discharge plans that involve family and carers.
- Having everything ready at the time of discharge.

How we will deliver this:

- By providing patient information in an accessible format and in a way, it can be understood.
- By empowering patients to ask questions to their health professional in any setting
- By valuing patients time, treating them with dignity, respect, and compassion
- By ensuring we learn from and improve our patients discharge experiences by actively asking for and using feedback
- By encouraging our patients to share their needs and preferences with us and to ensure they are the centre of the decision making for their care and treatment
- Ensuring that people from minorities (ethnic minorities, disabilities, religious groups, LGBT+ groups) have services that do not discriminate and equally meet their needs alongside others

Measuring success

✓ To be in the top 20% of all Trusts overall for 'patients feeling they were treated with dignity and respect' (National Inpatient Survey)

✓ To be in the top 20% of all Trusts for 'did hospital staff take your family or home situation into account when planning for you to leave hospital? (National Inpatient Survey)

✓ All our essential patient information leaflets to be available in easy read, large print and translated by the end of 2023

✓ To be in the top 20% of Trusts for 'Did you feel able to talk to members of hospital staff about your worries or fears?'

3.2 Pillar two – Engagement

Pillar two – Engagement

We will develop our Patient Partner programme using the patient voice and the input this provides to inform service change and improvements across the organisation.

Our Commitment to you:

- Clear appointment letters and communications
- Reduce delayed or cancelled appointments
- Manage clinic cancellations before booking appointments
- Ensure appointments are required and appropriate for the needs of the patient
- Communicating waiting times.
- Avoid conflicting information that confuses patients
- Deliver a clean environment
- Maintain a hospital environment that is comfortable
- Safe access for disabled and immobile patients and visitors.
- Reduce waiting times and communicate what they are

How we will deliver this:

- By actively increasing the number and diversity of volunteers that support our services including those who will support asking for and recording patient feedback
- Recruiting, training, implementing and developing volunteers more widely with a program aiming to get young volunteers into paid employment
- By maximising the ways in which we engage with people which may be face to face, digitally, online surveys and seeking new partnerships with community groups
- By encouraging more patients to attend our Patient and Partner Experience Group and to emulate this across other Trust committees and meetings with allocated patient membership
- By involving our community partners on projects and initiatives that improve patient experience using co-design principles
- By ensuring Patient participation groups (primary care) Staff focus groups (all services) Long term condition - expert patient groups
- Developing and producing services from start to finish by engaging meaningfully with patients and other stakeholders

Measuring success

✓ A Patient Involvement and Engagement Hub that provides patients with an interactive involvement experience to improve Trust services by January 2023

✓ A systematic approach towards co-design, with a focus to embed this approach in all directorates.

✓ Improved positive communication to our patients - we will gather and evaluate feedback.

3.3 Pillar three – Experience

Pillar three – Experience

We will support our staff to develop a culture of learning to improve care and experience for every patient.

Our Commitment to you:

- Treat patients as individuals
- A clear treatment plan patients can understand
- Understand a patient's medical history to avoid repeating
- Support patients getting attention when they need help
- Ensure patients feel safe
- Treat in a way that instils confidence in healthcare professionals
- Deliver safe staffing levels
- Treat patients with respect and dignity
- Ensure patients do not feel a burden
- Act in a friendly, professional manner
- Respect patient views and beliefs
- Deliver compassionate care
- Ensure the environment feels safe

How we will deliver this:

- By using our Patient and Partner Experience Group meeting to gain assurance, monitor and manage patient experience workstreams and initiatives
- By supporting staff to place the patient voice at the centre of all we do. We will use feedback and insight to 'make every moment' count ensuring our hospital values are maintained and included in all interactions with patients, carers, and families
- By developing, building, and learning from National and regional best practice – benchmarking ourselves against other organisations
- By extending our 15 steps programme sharing the learning experienced by our patients and those who use our services
- Working with staff to develop communication and interpersonal skills
- Reduce the number of complaints relating to staff attitude and behaviour

Measuring success

- ✓ Have a system in place to monitor and record the actions taken as a result of feedback from national patient surveys
- ✓ 100% of in-patient wards to mandatory display information of improvements made from patient feedback
- ✓ 95% of patients would recommend us in the Friends and Family Test
- ✓ Reducing complaints, learning from them and encouraging better attitudes and practice from employees
- ✓ We are in the top 20% of Trusts for patients having confidence and Trust in the people caring for them (Doctors and Nurses)

4.0 Governance and Leadership

Both Trust's Patient Experience Groups have been strengthened by the Patient Involvement Partners Forum, and the Patient Feedback Oversight Group and acts as the catalyst for the Patient Voice at a strategic level, embedding quality and patient experience initiatives across the Trusts.

- Divisional Directors and Senior Managers are responsible for performance monitoring of patient experience taking place in their divisions which is measured through FFT, national and local surveys and complaints monitoring. Patient Experience should be an agenda item at all divisional quality boards.

- The Patient Experience Teams will support the patient experience agenda by: implementing and meeting Key Performance Indicators including those set nationally and locally by the commissioners; collection, analysis and dissemination of the findings across the Trusts; encouraging staff engagement to lead to better patient outcomes and better use of resources; identifying learning and improvement outcomes; developing systems for supporting action plans to close the feedback loop; offering good quality reporting that is themed with other key patient experience indicators.

- The Directors of Nursing are the Trust Board leads for Patient Experience and have specific responsibility for advising the Boards on all aspects of this strategy.

- The Trusts Non-Executive Directors who are the Trust Patient Experience Champion ensures that both the Boards and the Trusts act in the best interests of patients and the public; that patients and service users are treated with dignity and respect at all times, and that the patient voice is central to Trust decision making.

- Divisional Teams are responsible for ensuring that the views of patients, relatives, carers and the public are considered in all service development plans in a timely and effective manner and reports provided to the Patient Experience Teams.

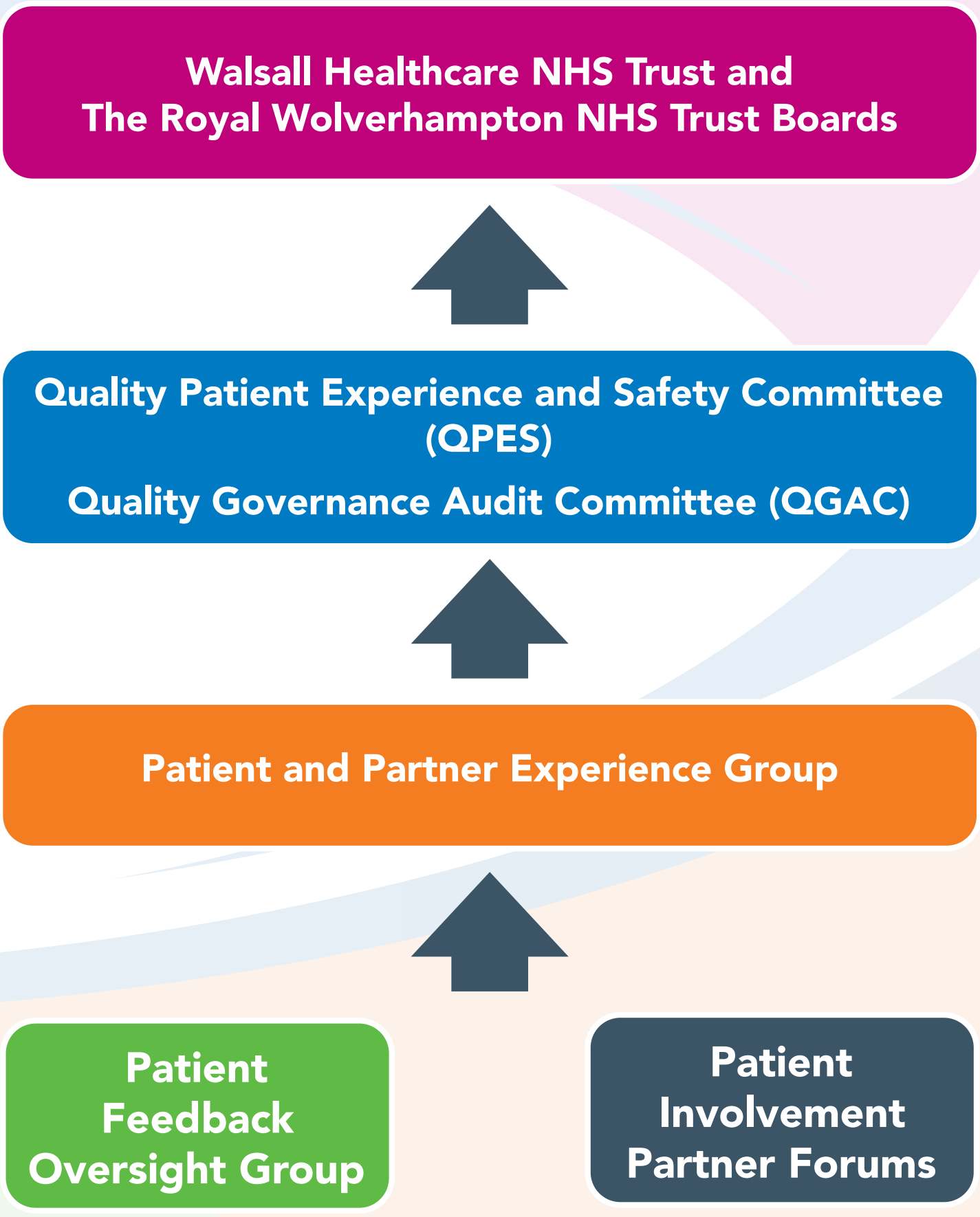
- Patient Experience Groups receive regular progress reports from divisions and thematic work streams.

- WHC's Quality Patient Experience and Safety Committee (QPES) and RWT's Quality Governance Audit Committee (QGAC) receive monthly updates via bi-monthly reports of triangulated feedback and progress against plan.

- Both Trust Boards receive a summary from Quality Patient Experience and Safety. Each Trust Board is responsible for ensuring it receives and acts appropriately on information about the areas of public concern and assuring itself that engagement with patients, relatives, carers and the public has taken place.

- Both Trusts will provide a patient experience annual report detailing progress of this strategy, all other patient experience metrics and initiatives.

Whilst the above have the responsibilities described, all Trust staff at every level has a responsibility to promote positive patient experience and the principles of this strategy.


Walsall Healthcare NHS Trust and
The Royal Wolverhampton NHS Trust Boards
Quality Patient Experience and Safety Committee (QPES)
Quality Governance Audit Committee (QGAC)
Patient and Partner Experience Group
Patient Feedback Oversight Group
Patient Involvement Partner Forums

5.0 Equality Impact Assessment

This Patient Experience Enabling Strategy will be equality impact assessed to ensure that the guidance provided does not place at a disadvantage any service, population or workforce over another.

6.0 Risks and Mitigations

Risks	Mitigations
Lack of staff to engagement in or prioritisation of good patient experience.	Staff receive the necessary training and are supported to understand/undertake patient experience activities.
Failing to meet the recommended measure based on average national target for FFT.	Promotion of the FFT ensuring that patients have an opportunity to take part and are encouraged to provide honest feedback. Publication of the results and outcomes including service improvement.
Trust failure to demonstrate improvement in patient experience against national standards.	The creation of an environment in which staff are encouraged to report learning and improvements from engaging with patients.
Failure to monitor patient experience and making changes as a consequence of feedback received.	Focusing on patient experience, measuring it and acting on the results of that measurement and identifying any associated cost. Identification of the factors that influence patient experience including those that may need new investment or those where better use of existing resources may be appropriate.

7.0 Conclusion

Both Trusts aim to actively improve the patient experience by implementing the aims outlined in this Patient Experience Enabling Strategy.

Key focused themes from all the data at our disposal have been identified which should impact upon and improve patient experience and fulfil the priorities that we have set for ourselves.

8.0 Reviewing this Strategy

This is a 3-year strategy underpinned by an Implementation Plan. The Plan will be reviewed on an annual basis.

For this strategy to me meaningful for our patients, the implementation will be measured on it's delivery. A detailed delivery plan has been developed by each Trust which sets out the key activities, success measures and timescales to achieve our aims. The Plans will be reviewed annually, responding to any new and emerging priorities.

Designed and produced by The Department of Clinical Illustration, New Cross Hospital, Wolverhampton - Tel: 01902 695377 MI_10688014_11.11.22_V_2

Walsall Healthcare NHS Trust

Public Trust Board Meeting	
Meeting Date:	07.06.2023
Title of Report:	Safeguarding Update Report: Q4 (January-March 2023)
Action Requested:	The Safeguarding report is presented to the Committee for information and assurance of progress.
For the attention of the Board	
Assure	• The recruitment to outstanding safeguarding posts was progressed during Q4. Two Named Nurses for Safeguarding are expected to start in Q1 and the recruitment to administration posts (Band 3 and 4) are in process. • WHT have worked with ICB and Walsall Partnership to complete an action plan following the Walsall Local Authority Joint Targeted Area Inspection (JTAI) in November 2022 Q3. The 2 actions for WHT are to ensure that staff receive formalised safeguarding supervision (in specific child areas of the Trust) and to update IT systems within WHT with the introduction of a one health records system. • WHT and Royal Wolverhampton Hospital NHS Trust (RWT) safeguarding team are working jointly to develop a variety of training packages to increase staff access to the training programmes within both organisations. • The national training package for children level 3 is being rolled out in WHT providing an additional resource option. • Safeguarding Adult Level 3 training compliance has increased slightly in Q4 to above 82.59% in March 2023. At the time of writing this report (on 27.04.23) the training figures for level 3 training had increased another 5%. • The Safeguarding Champions (12-month training) programme starts on the 05.06.23. The training will focus on all areas of safeguarding support within the Trust (adults/ children/LD). • During Q4 the safeguarding team liaised with Lincoln Health Trust MCA Lead to consider adopting their successful model of mental capacity assessment oversight. Further work is being progressed across WHT and RWT to develop a different approach in advance of a new IT system being implemented in 2024. • Flagging has started within the Trust for people with learning Disability and/or Autism. These flags are being added to people who have attended the hospital and are known to have a diagnosis. • Following a review of the RESPECT audit this will be completed by ward managers from May/June 2023.
Advise	• The Trust has commenced the roll out of Oliver McGowan LD training (e-learning) Level 1 training from March 2023. The Trust is awaiting further guidance on the plan to roll out the Oliver McGowan LD Level 2 training programme. Compliance figures will be reported from Q1. • In Q4 an Independent Domestic Violence Advocate (IDVA) has commenced post at ED. The IDVA provides bespoke training and

	advice to staff in ED. A reporting framework is in development. • During Q4, there was a planned external review of WHT ED by the Walsall placed ICB which included oversight of safeguarding processes. There were no actions required for WHT.
Alert	• The current WHT Named Midwife for Safeguarding will leave her post in Q1. A replacement postholder has been recruited to. • West Midlands 'Operation Satchel' has resulted in twenty-one people being convicted of serious sexual offences against children in Walsall the largest child sexual abuse investigation conducted by West Midlands police. A further four are due to attend court in May. WSP have received a FOI request as well as media interest. There are no actions for WHT. • The business case for expansion to the WHT Learning Disability and Autism team has been progressed during Q4. • There is a forthcoming CQC inspection of adult social care planned in Walsall. WHT will be participating in this inspection. • There is a Walsall Youth Justice Inspection planned for Q2. WHT will be requested to participate in relevant focus groups and to provide health information in regard to cases identified for thematic review.
Author and Responsible Director Contact Details:	Author Mak Inayat Email: Mak.Inayat@nhs.net Responsible Director Lisa Carroll Email: Lisa.carroll@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Safe and responsive urgent and emergency care c) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	a) Develop a health inequality strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability. c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care

Resource Implications:	none
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	This report relates to adults and children and considers disability and the impact of abuse
Risks: BAF/ TRR	
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	ICB Matrons, Senior Nurses, Midwives and Health Visitors Trust Safeguarding Group Walsall Partnership
References	A variety of references apply to the topics outlined in this report.
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Safeguarding Update Report Q4 (Jan – Mar 2023)

1. PURPOSE OF REPORT

The purpose of the report is to provide information and evidence of the Trust's continued commitment to good safeguarding measures. It refers to the attached standards outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) 2021 – 2022 and is aligned to national and local safeguarding standards including the requirements from CQC, NHS Learning Disability Standards and Walsall Safeguarding Partnership.

2. DETAILS

- A joint RWT/WHT 'Managing Allegations of Behaviour Indicating Unsuitability to Work with Children and Adults with Care and Support Needs' policy is currently being scoped for conclusion in Q1.
- In Q4, recruitment has commenced for the three Band 3 safeguarding administrators and Band 4 safeguarding administrative team leader six months secondment.
- Recruitment has been successful for the Named Midwife post and is due to start in Q2. The current Named Midwife will leave her post in Q1.
- WHT have worked with ICB and Walsall Partnership to complete an action plan following the Walsall Local Authority Joint Targeted Area Inspection (JTAI) in November 2022 Q3. WHT actions include that staff receive formalised safeguarding supervision, and to update IT systems within WHT with the introduction of one health records system.
- During Q4 Safeguarding Children Training Level 1 and 2 compliance was over 94.76% and 94.16% respectively. Level 3 overall compliance has reduced in Q4 to 84.54% from 87.51% in December 2022, this is most likely due to the additional workforce pressures and strikes in Q4.
- During Q4 the compliance for Safeguarding Adult Level 1 and 2 training remained constant with over 95.48% for Level 1 and 92.54% for Level 2. Level 3 training compliance has been increasing slightly in Q4 to above 82.59% in March 2023. At the time of writing this report on 27.04.23 the training figures for level 3 training had increased another 5%. This is because of additional L3 adult training dates being provided and all staff presented with the dates via Trust Comms and divisional meetings.
- The attendance at Prevent Training has reduced slightly in Q4 to 95.8% this may be due to work pressures and strikes.
- Safeguarding champions 12-month programme starts on the 5th of June. The training will cover all areas of safeguarding (adults/ children/LD).

- The ICB are leading on providing group safeguarding supervision and restorative supervision across ICB footprint for the named nurses and separately for the administrative team working in MASH this is due to commence in Q1.
- Health Visitor and School Nurse supervision compliance has improved in Q4 for both Health visitors and School nurses.
- During Q4 practitioners in Paediatric Emergency Department, Community Children's Team and Acute Paediatrics have had access to the 6 weekly safeguarding supervision sessions. These have previously been poorly attended due to staff acuity, however in Q4 the attendance continues to improve in the paediatric areas.
- In addition to 2 places being agreed for community midwives another 3 nurses from the paediatric wards will be attending the NSPCC supervision training during 2023. They will also be enrolling as safeguarding champions.
- WHT have contributed to the chronologies, reports and participated in the multi-agencies' discussion following the death of 5 children, 1 of these children recently became a child in care is now progressing to a Child Safeguarding Practice Review. The early learning identified for WHT is professional curiosity, discharge planning particularly when a child in new to the care system and escalation. The safeguarding team supported and worked closely with divisional leads with the internal review process.
- Three adult scoping referrals have been submitted to Walsall Practice Review Group during Q4. One referral did not meet the criteria, one met the criteria for a SAR under the new process. The third scoping's has been delayed due to police not being present at the meeting. This has subsequently been reconvened on 28.04.23 there was a unanimous decision by the panel that it did not meet the criteria for a SAR.
- During Q4, 4 notifications were made by the Trust as part of the 'Learning from the lives and deaths' programme (LeDeR). There are no outstanding actions for the Trust, but work continues to ensure the sustainability of previous actions. The Trust is represented at the regional LeDeR Strategic Group.
- During Q4 the safeguarding Children Team received 76 contacts (compared to 67 contacts received during Q3) from practitioners requiring advice, support, and guidance. Themes included children with mental health concerns; domestic abuse; escalation of cases and information sharing. Parental mental health and children not being brought to their appointments.
- There was a 35% rise in MASH checks being completed. In Q4 there was 2156 Amber checks completed compared to 1592 in Q3.
- There was decrease of 13% for red MASH checks. There were 429 children red checks completed compared to 493 in Q3.
- 10 maternity staff have been identified to be 'safeguarding champions' the 12-month programme starts on the 5th June. This is a champion training event that will cover all areas of safeguarding (including adults/ children/LD).

- 114 DoLS applications were submitted during Q4 (Jan = 35, Feb = 33 March = 46). The safeguarding team have continued to provide regular ward support in completing DoLS applications including bespoke ad hoc training regarding mental capacity assessment processes throughout Q4.
- During Q4 the safeguarding team were notified of 85 safeguarding adult referrals. The overarching themes included unsafe discharge, pressure ulcers, medication errors, self-neglect, sexual abuse, and domestic abuse.
- The team liaised with Lincoln Healthcare Trust MCA lead to consider adopting their MCA processes in WHT due to their success rate. There is ongoing work in regard to raising the profile of undertaking capacity assessments in WHT.
- The business case for expansion to the Learning Disability and Autism team within WHT was developed in Q3 and progressed during Q4.
- Flagging has started within the Trust for people with learning Disability and/or Autism. These flags are being added to people who have attended the hospital and are known to have a diagnosis. During Q4 work has started to establish a sharing of information agreement between the ICB and WHT for the GPs to share their learning disability registers to enable the flagging on the electronic patient records.
- The Trust can flag autistic people who use WHT services. Flags are being added by the paediatric consultants as part of the diagnostic pathway.
- Following a review of the RESPECT audit process within the Trust, from June 2023 this will be completed by ward managers.
- The Trust has commenced the roll out of Oliver McGowan LD training e-learning Level 1 training from March 2023. The Trust is awaiting further guidance on the plan to roll out the Oliver McGowan LD Level 2 training programme. Compliance figures will be reported from Q1 as part of the monthly DASHBOARD to the Trust and CQRM.
- In Q4 an Independent Domestic Violence Advocate (IDVA) commenced in post, based in ED. The IDVA provides bespoke training and advice to staff in ED. A reporting framework is in development.
- There is a forthcoming CQC inspection of adult social care planned in Walsall. WHT will participating in this inspection.
- There is a Walsall Youth Justice Inspection planned for Q2. WHT will be requested to participate in relevant focus groups and to provide health information regarding cases identified for thematic review.
- During Q4, WHT Head of Safeguarding attended the regional Named Nurse professionals network meeting in Telford. Feedback at this event from other health providers was in regard to themes from CQC inspections which described a particular focus on LD/Autism provision, the management of mental health patients in unscheduled care and how health Trusts manage patients who go ‘missing’ from ED.

3. RECOMMENDATIONS

The committee is asked to receive the report for information and assurance.

Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs)

This Q4 2022/2023 report seeks to provide information and evidence of the Trust's continued commitment to good safeguarding measures. It refers to the standards outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) 2021-2022 and is aligned to national and local safeguarding standards including the requirements from CQC, NHS Learning Disability Standards and Walsall Safeguarding Partnership.

1	a. Health providers are required to demonstrate clear governance arrangements and that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, the Safeguarding Partnerships/and SABs priorities, and in regular monitoring meetings with commissioners. b. Health providers are required to demonstrate that there is a Board Level Executive Director who holds accountability within the organisation for safeguarding (including Children and Young People in Care) and Prevent in line with Intercollegiate Documents and National Guidance c. Health providers are required to demonstrate that the organisation complies fully with information requests and safeguarding informatics returns to NHSE/I and Commissioning organisations.
Annual Submission	
Q4 Update: Annual report completed and presented to Trust in July 2022. Data provided accordingly. Annual report for 2022/2023 will be presented in Q3.	

d. All health providers are required to have effective arrangements in place to safeguard Children and Adults at risk of abuse or neglect; are compliant with the Counter-Terrorism and Security Act 2015, and to assure themselves, regulators and their commissioner that these are working. These arrangements include:

- Safe recruitment practices (to include safe recruitment standards – DBS) and arrangements for dealing with allegations against people who work with adults, children or vulnerable children as appropriate.
- Safeguarding responsibilities are included in all staff job descriptions.
- A suite of safeguarding policies.
- Effective arrangements for engaging and working in partnership with other agencies.
- Demonstrate that the organisation is managing allegations against staff in line with Safeguarding Partnerships and Safeguarding Adult Boards (this must include reference to risk assessments and clear process when protection thresholds in the local authority are not met). This includes referrals to the Local Authority Designated Officer for concerns around children's safeguarding and referrals relating to persons in position of trust in relation to adults. This must also include review of Prevent concerns around staff.
- Identification of a Named Doctor and Named Nurse (and a Named Midwife if the organisation provides maternity services) for safeguarding children and adults. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professionals from any relevant health or social care background.
- Evidence that there is a safeguarding team in place in accordance with specifications set out in the Intercollegiate Documents for Adults (2018), Children (2019) and Working Together (2018).
- Named professionals for Children and Young People in Care.
- Identification of a Named Lead for Adult Safeguarding.
- MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.
- Prevent Lead.

- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- Information sharing (including Duty of Candour) in line with local, regional and national requirements.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the MCA 2005 and Children Acts 1989/2004.
- Demonstrate that safer recruitment standards are monitored by the Executive Director and action taken where they fall short of expectations (i.e., charity visitors, volunteers, celebrities and agencies are monitored by the Executive Director and are consistent with their own HR internal policies).
- Demonstrate how the organisation manages requests for access from volunteers, paid/unpaid charity fundraisers, celebrities and 'friends' of the organisation and has a policy in place to reflect this.
- Demonstrate that there are systems in place to report unsafe practice to external professional bodies (i.e., Police, DBS, NMC, GMC).
- Demonstrate that the organisation has a policy regarding internet and social media use which addresses safeguarding.

Annual Submission

Q4 Update

There is a current review of all safeguarding policies. WHT and RWT are working collaboratively to complete outstanding policy work. The policy tracker is discussed at the Trust Safeguarding Group (TSG). Joint policy work has progressed between WHT and RWT. (**Appendix 1**).

- A joint RWT/WHT 'Managing Allegations of Behaviour Indicating Unsuitability to Work with Children and Adults with Care and Support Needs' policy is currently being scoped for conclusion in Q1.
- The safeguarding team has expanded during Q4 to include the internal secondment to the post of Safeguarding Business Support Manager Band 5
- The two outstanding Named Nurses Safeguarding Children posts have been successfully recruited to with an expected start date of June 2023.
- The safeguarding administration team have commenced recruitment for Band 4 and Band 3 vacancies.

- The Named Midwife will leave her post in Q1, recruitment for this post has commenced in Q4. The safeguarding team have reviewed the Named Midwives responsibilities, including safeguarding supervision and these will covered by the corporate safeguarding team.

- There is ongoing work for WHT to provide assurance against the DBS recording process. The RWT and WHT joint working group which reconvened during January 2023 and are working on staff requiring DBS checks aligned to the national guidance that has been disseminated during Q2. The reporting of the DBS for new starters has increased from 85.1% in Dec 2022 to 92.47% in March 23. The reporting of DBS for existing staff has similarly increased from 92.71% in Dec 2022 rising to 93.13% in March 2023.

- WHT have worked with ICB and Walsall Partnership colleagues during Q4 in attending key meetings (to ensure full commitment, attendance, and participation). Feedback and key actions are presented along with the progress on relevant implementation plans to the Trust Safeguarding Group.

- In Q4 WHT have worked with ICB and Walsall Partnership to complete an action plan following the Walsall Local Authority Joint Targeted Area Inspection (JTAI) in November 2022 Q3. There were two pertinent actions for WHT. Firstly, for staff to have consistent access to formalised safeguarding supervision, and the safeguarding team are working with the relevant service areas to support this delivery, and this will be referenced in the safeguarding supervision policy which is currently under review. Secondly to update IT systems within WHT by the introduction of a one health records system accessed via the electronic patient record. This is being implemented in Walsall MASH to support the Named Safeguarding Nurses for collating information.

Actions:

- To complete the recruitment of the Internal Band 4 safeguarding administrator team leader post and Band 3 safeguarding administrator post in Q1. To complete recruitment to the Named Midwife post in Q2.
- To work collaboratively with RWT to ensure all policies are updated by the end of Q1.
- To ensure any actions from the JTAI inspection are concluded in Q1.
- To monitor the impact of One Health record on Named Nurses workload in MASH.

2 a. Health providers must ensure the effective training of all staff commensurate with their role and in accordance with intercollegiate competencies relating to:

- Safeguarding Adults
- Safeguarding Children

- Children and Young People in Care
- Prevent
- Domestic Violence
- MCA and DOLS
- Learning Disabilities

b. Health Providers must have a safeguarding training strategy and compliance percentage in line with the safeguarding performance framework. This must cover requirements for all staff, volunteers and external contractors.

Q4 Update

- WHT/RWT are reviewing their joint training needs analysis to ensure competencies for healthcare staff remain in line with the Intercollegiate Document for Children (2019) and Adults (2018). This will be completed by Q1. The WHT/RWT training packages are currently under review to develop additional eLearning and face to face delivery options. WHT/RWT safeguarding team are working jointly to consider a variety of training packages including the content to increase staff access to the training programmes. The national training package for children level 3 is being rolled out in WHT providing an additional option. The completed training needs analysis (TNA) will be presented to both Trust Safeguarding Groups for approval.

- The safeguarding training compliance is reported monthly at the TSG (for each Division) and via the Safeguarding Dashboard presented to CQRM monthly which provides overall training compliance across the Trust (**Appendix 2**). The safeguarding team have provided additional dates for training and there is a strong focus on managers to release staff for training.

- During Q4 Safeguarding Children Training Level 1 and 2 compliance was over 94.76% and 94.16% respectively. Level 3 overall compliance has reduced in Q4 to 84.54% from 87.51% in December 2022, this is most likely due to the additional workforce pressures and strikes in Q4. WHT and RWT task and finish group are developing various packages of safeguarding training to increase access including the national e-learning package to the current programme.

- During Q4 the compliance for Safeguarding Adult Level 1 and 2 training remained constant with over 95.48% for Level 1 and 92.54% for Level 2. Level 3 training compliance has been increasing slightly during Q4 to above 82.59% in March 2023. At the time of writing this report (27.04.23) the training figures for level 3 training have increased by a further 5%. This is due to additional L3 adult training dates being provided, and all staff presented with the dates via Trust Comms and divisional meetings.

- Attendance at the Mental Capacity Act training has remained at over 93.22%. To note that additional ward training has also been provided by the

safeguarding team to raise awareness of the subject area as part of the continued work. It has been confirmed the Liberty Protection Safeguard (LPS) has now been delayed until the next parliament.

- The Safeguarding Team personal training compliance has varied. Adult Level 4 training (2 x Named Nurses) is 50% with 1 staff member outstanding. Children level 4 training (5 x Named Nurses) is 80% the staff outstanding are booked on training in Q1. All staff are expected to attend regular L4 training updates.

- The Safeguarding Team have continued to provide bespoke training for ward and community staff as required and on request. Additional support and/or bespoke training requests are managed regularly in the weekly leads' meetings.

- The Trust has commenced the roll out of Oliver McGowan LD training e-learning Level 1 training from March 2023. The Trust is awaiting further guidance on the plan to roll out the Oliver McGowan LD Level 2 training programme. Compliance figures will be reported from Q1. These training packages are mandatory across all health Trusts during 2023. At the time of this report it has been confirmed that 29% of WHT staff have completed Level 1 training.

- Domestic Violence Training is included in both Adult and Children Safeguarding Level 3. Additional training has been offered during Q3 via the Walsall Partnership. In Q4 an Independent Domestic Violence Advocate (IDVA) has commenced post based in ED. The IDVA provides bespoke training and advice to staff in ED.

- The attendance at Prevent Training has reduced slightly in Q4 to 95.8% this may be due to work pressures and strikes.

- WHT Board children and adult training was delivered in November 2022. This now stands at 100% compliance.

A**ctions**:

- Safeguarding Training compliance will continue to be monitored during Q1 and additional training dates will be provided as necessary to meet the needs of the Trust.
- The Oliver McGowan LD Level 1 training compliance will be monitored and reported on from Q1. The Trust will seek guidance from ICB and NHSE in delivering Oliver McGowan LD Level 2 which requires face to face patients' stories as part of the delivery package.

3. a. Safeguarding Named Doctor/Nurse/Midwife/Named Professionals/Safeguarding Specialists should have access to advice

and support and a minimum of quarterly safeguarding supervision with Designated Professionals.

b. Professionals supervising staff or working on a day-to-day basis with adults, children and families should have child and adult safeguarding supervision available to them, appropriate to their role and responsibility in order to promote good standards of practice.

Q4 Update:

- During Q4, the Safeguarding Team specialists, including Named Doctors have been offered or have had access to safeguarding supervision including the Named Safeguarding Midwife. It is noted that for most safeguarding professionals this supervision is provided externally by the ICB or other professional experts.

- The ICB are leading on providing group safeguarding supervision and restorative supervision across ICB footprint for the named nurses and separately for the administrative team working in MASH this is due to commence in Q1.

Total number of Community Staff/midwives identified to receive safeguarding supervision within Q4	**Q4 Compliance**
Health Visitors: **33**	24 = **73%** 3 of the practitioners were off sick and 2 cancelled and rebooked in Q1 2023-2024.
School Nurses: **30**	21 = **70%** There are 9 practitioners overdue however the overall compliance has increased compared to Q3 (53%).
Community Midwives (Group): **30**	28 = **93%** The two outstanding midwives were unable to attend due to clinical care commitments. These midwives have now had their safeguarding supervision at the time of writing this report.

- Health Visitor and School Nurse supervision compliance has improved in Q4 for both Health visitors and School nurses. All practitioners that are outstanding have been prioritised and scheduled to be seen.

- Throughout Q4 the safeguarding children team have continued to provide group safeguarding children supervision to support staff working in the 0-19 Service.

- During Q4 practitioners in Paediatric Emergency Department, Community Children's Team and Acute Paediatrics have had access to the 6 weekly safeguarding supervision sessions. These have previously been poorly attended due to staff acuity, however in Q4 the attendance continues to improve in the paediatric areas.

- During Q4 practitioners in Paediatric Emergency Department, Community Children's Team and Acute Paediatrics have had access to the 6 weekly safeguarding supervision sessions. These have previously been poorly attended due to staff acuity, however in Q4 the attendance continues to improve in the paediatric areas.

- The safeguarding team (children and adult service) have also undertaken safeguarding weekly floor walks which provides additional opportunistic case reflection and support and guidance discussed TSG.

- Midwives have received a range of one to one, group supervision during the period and compliance has remained excellent. In Q4 93% of midwives received safeguarding supervision with two staff remaining as outstanding. There are 4 midwives in addition to the Named Midwife skilled to deliver safeguarding supervision.

- In addition to 2 places being agreed for community midwives another 3 nurses from the paediatric wards will be attending the NSPCC supervision training during 2023. They will also be enrolling as safeguarding champions.

- The Safeguarding Champions programme (children and adults) is due to commence on the 5th of June. The Safeguarding Champions will be offered additional bi-monthly safeguarding supervision.

- The Deputy Head of Safeguarding is continuing with her action research to develop a model of supervision to support the acute services, the findings should inform how supervision is accessed and delivered. The findings will be reflected in WHT safeguarding supervision policy which is under review.

Actions:

- To monitor supervision compliance and ensure outstanding supervision is completed.
- To promote safeguarding children supervision across acute paediatrics.
- To monitor and evaluate Safeguarding Champions programme.
- Review and develop safeguarding supervision policy and process Q2.

4 a. Health providers are required to provide chronologies and reports for Section 42 Enquires, Child Practice Reviews, Child Death Reviews, Domestic Homicide Reviews, Safeguarding Adult Reviews and any other learning reviews as required, on time and in line with Safeguarding Partnerships, SAB's , Community Safety Partnerships Terms of Reference and templates. Resulting organisational action plans must be addressed as agreed by the Safeguarding Partnerships/SAB's and DHR Standing Panels.

b. Health providers are required to fully engage with the Learning Disability Mortality Programme (LeDeR) by reporting deaths, identifying suitable reviewers, completing reviews, implement subsequent local and national learning and allowing timely access to patient information as part of the LeDeR process.

Q4 Update:

- During Q4, WHT have attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR). The Deputy Head of Safeguarding attends the Walsall Practice Review Group (PRG). The findings and updates are shared through the TSG (**Appendix 3**).

- There is a total of 16 reviews in the WSP system.
  - 4 Child reviews (SCR/LCSPR)
  - 5 Adult reviews (SAR)
  - 2 DHR's
  - 1 Child CSA tabletop review
  - 1 Child Neglect Thematic Review
  - 1 Adult Learning Review
  - 2 Adult referral pending decision making scoping meeting.

- WHT has contributed to chronologies, reports and participated in the multi-agencies' discussion following the death of 5 children, 1 of these children recently became a child in care is now progressing to a Child Safeguarding Practice Review. The early learning identified for WHT is professional curiosity, discharge planning particularly when a child in new to the care system and escalation. The safeguarding team supported and worked closely with divisional leads with the internal review process.

- Learning has been disseminated via training; supervision, 7-minute briefings and team operational meetings.

- Three adult scoping referrals have been submitted to Walsall Practice Review Group during Q4. The scoping panels were conducted under the new Rapid Review process which aims to resolve and disseminate learning at the

earliest opportunity. One referral did not meet the criteria, one met the criteria for a SAR under the new process. The third scoping's has been delayed due to police not being present at the meeting. This has subsequently been reconvened on 28.04.23 there was a unanimous decision by the panel is did not meet the criteria for a SAR.

- During Q4, 4 notifications were made by the Trust as part of the 'Learning from the lives and deaths' (LeDeR) programme. There are no outstanding actions for the Trust, but work continues to ensure the sustainability of previous actions. The Trust is represented at the regional LeDeR Strategic Group.

- Operation satchel has resulted in twenty-one people being convicted of serious sexual offences against children in Walsall the largest child sexual abuse investigation conducted by West Midlands police. A further four are due to attend court in May. WSP have received a FOI request as well as media interest.

Actions:

- To continue working with the Divisions following a Significant Incident and/or death of a child/adult to ensure learning is disseminated.
- To undertake audits with the Services to aid assurance that learning is embedded and there has been a change in practice.
- For WHT to review their internal notification and quality assurance process in relation to escalation of new cases to ensure consistency with information coming in and out of the Trust.
- To ensure any case action plans are completed within timescale.
- To continue to disseminate learning from PRG meetings.
- To support the WSP with learning following Operation Satchell.

4 c. Health providers are required to demonstrate that recommendations and learning from all types of learning reviews and enquiries are distributed to relevant staff and there is evidence of practice change.

Q4 Update:

During Q4 WHT has ensured that learning from all types of reviews has been disseminated Trust wide via:

- Trust brief
- Daily Dose
- 7 Minute briefings
- Bespoke/Training
- Specific targeting of professionals/wards
- Team operational meetings

Recommendations are also embedded within mandatory and bespoke safeguarding training.

Single agency action plans have also been discussed and updated at:

- The Trust Safeguarding Group during Q4
- Divisional Governance meetings (Safeguarding and Trust wide)
- Matrons and Heads of Nursing meeting
- Practice Review Group
- WHT internal CSPR/SAR/DHR Meeting (PRG)
- Operational Meetings (Safeguarding Children, CYPiC, Learning Disability and Safeguarding Adults)

Learning from reviews is also embedded within the safeguarding supervision process across the service.

The WHT internal practice review group have updated most of the actions that were outstanding and provided evidence accordingly and will also be included within the agenda of the newly formed Trust Children and Young People Group.

Actions:

- To continue to communicate during Q1 information across the Trust in regard to new cases or actions.

5. a. Health providers are required to provide evidence that staff are aware of the importance of listening to children, young people and adults with care and support needs.
b. Evidence that the organisation ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding.

Annual Submission

Annual report completed and presented to Trust in July 2022. Data provided accordingly. Annual report for 2022/2023 will be presented in Q3.

6. Health providers are required to provide evidence that patient assessment processes within the organisation identify appropriate risk and need, and result in an appropriate response; including where the criteria for statutory enquiries are not met.

Q4 Update:

Childrens Update

- During Q4 the safeguarding team are expanding their scope of offering additional safeguarding supervision to specialist services in the acute and community. This will be monitored through the compliance monthly reports to the TSG.

- During Q4 the safeguarding Children Team received 76 contacts (in Q3 67 contacts received) from practitioners requiring advice, support, and guidance. Themes included children with mental health concerns; domestic abuse; escalation of cases and information sharing. Parental mental health and children not being brought to their appointments.

- During Q4 the Safeguarding Children Team supported staff with 29 court statements these requests were from the 0-19 Service: the acute paediatrics and midwives.

- There has been a 3% rise in MARAC cases. 135 MARAC cases were discussed in Q4 involving 278 children (131 MARAC cases were discussed in Q3 involving 231). There was no increase in MARAC referrals for women who were pregnant. MARAC process is under review.

- Daily Domestic Abuse Triage in MASH remains a key part of the safeguarding children team's work. During Q4, 1093 cases were discussed compared to 880 in Q3. There has also been a slight increase of domestic abuse cases of women who are pregnant in Q4 32 compared to Q3 27.

- There was a 35% rise in MASH checks being completed. In Q4 there was 2156 Amber checks completed compared to 1592 in Q3.

- There was decrease of 13% for red MASH checks. There were 429 children red checks completed compared to 493 in Q3.

- There was a decrease of 19% of strategy meetings which the Named Nurse attended in Q4. There were 51 strategy meetings the Named Nurses attended compared to 63 in Q3.

- In Q4 the completion of checks remain within timescale as a result of the internal monitoring and escalation process.

- There was a decrease in in Child and family assessments (CAFA) for women who were pregnant however, there was an increase in lateral checks with children's services 96 in Q4 compared to 72 in Q3.

- During Q4 12 women had FGM recorded in notes.

- The Named Midwife continues to lead on the Maternity clinical update day (MCU) which are 1 hour monthly safeguarding training sessions available to all maternity staff. Themes covered in Q4 are Walsall Partnership services and training, Muli agency audits/CSPR/rapid reviews, a case scenario, think family approach, documentation, and professional curiosity.

- 10 maternity staff have been identified to be part of the safeguarding champions programme which is a 12-month programme that starts on the 5th June. This is a champion training that will cover all areas of safeguarding (adults/ children/LD)

Adults update.

- 114 DoLS applications were submitted during Q4 (Jan = 35, Feb = 33 March = 46). The safeguarding team have continued to provide regular ward support in completing DoLS applications including bespoke ad hoc training regarding mental capacity assessment processes throughout Q4. MCA and DoLS is also covered in Level 3 Mandatory Safeguarding Adults Training.

- In Q4 there have been no Prevent referrals. The safeguarding team promoted raising Prevent awareness in Q4 supported by Community Safety Partnership Prevent lead.

- Prevent returns (to NHSE) has been completed within timescale for Q4.

- During Q4 the safeguarding team were notified of 85 safeguarding adult referrals themes were unsafe discharge, pressure ulcers, medication errors, self-neglect, sexual abuse, and domestic abuse. West Midlands Ambulance Service were the biggest referrers.

- During Q4 WHT safeguarding team were asked to look at the impact of LPS which has now been delayed until the next parliament. As part of this work, WHT met with Lincoln NHS Trust MCA lead to discuss their processes to consider relevant learning for WHT. An MCA/DoLS action plan has been drafted to support this work and progress is reported to the TSG on a monthly basis.

- During Q4 the monthly RESPCT audit was completed by the safeguarding team and reported back to each division. The focus of RESPECT is to raise awareness, ensure relatives are informed of the process and outcome of the

decision making and documentation completed. The RESPECT audit will be completed by ward managers from May/June 2023.

- The business case for Learning Disability and Autism team within WHT was developed in Q3 and has now submitted in Q4 for approval.

- During Q4 the Oliver McGowan eLearning training package was launched across the Trust. Compliance will be monitored monthly at TSG.

- Flagging has started within the Trust for people with learning Disability and/or Autism. These flags are being added to people who have attended the hospital and are known to have a diagnosis.

- During Q4 work has started to establish a sharing of information agreement between the ICB and WHT for the GPs to share their learning disability registers to enable the flagging on the electronic patient records.

- The Trust can flag autistic people who use WHT services. Flags are being added by the paediatric consultants as part of the diagnostic pathway.

- A Neurodiversity Working Group has been established with Human Resources, Occupational Health and Health and Wellbeing to review the support that may be needed by neurodiverse staff across WHT and RWT.

7. Health providers are required to provide evidence of incremental improvement of processes over time through; regular evaluation through audit, leading to required improvements in the light of their efficiency, effectiveness and flexibility.

Q4 Update:

- Throughout Q4, the safeguarding development plan has been presented at the TSG for monitoring and oversight. (**Appendix 4**). The work is progressing positively in relation to previous concerns raised during 2021. The safeguarding development plan now forms part of the normal reporting process through the Safeguarding Group and continues to provide assurance to the ICB and Local Authority.

- The safeguarding team leads attend all WHT Divisional Governance meetings to support and provide oversight of risks that are discussed.

- During Q4, the safeguarding team continued to undertake the Trust audit around RESPECT and MCA completion for those adults deemed to lack capacity in relation decision-making. Results are disseminated to the Divisional teams for review and reported corporately through PBI reports.

Following a review of the RESPECT audit this will be completed by ward managers from May/June 2023.

- In Q4, in preparation for the planned transition to Liberty Protection Safeguards (LPS) the safeguarding adult team have worked collaboratively with RWT and ICB. Following the delay in implementing LPS the adult safeguarding team will now focus on MCA and DoLS during 2023. The team will also continue to attend local and regional collaborative meetings to ensure the Trust is sighted on progressing with the LPS implementation plan when it becomes an active process again.
- WHT have drafted an action plan following the recent publication of 'Changing our Lives' report for LD and Autism service which looked at what health providers offer against a set of measures. (Appendix 5). The action plan will be reviewed and progressed during 2023.

Actions:

- To ensure actions are concluded, and learning is disseminated across the Trust.

8. Health providers are required to provide evidence and assurance that they are responding to National Reports and Inquiries.

Q4 Update:

- During Q4, there was a planned external review of WHT ED by the ICB which included an interest in the oversight of safeguarding processes. Key lines of enquiry included safeguarding training compliance; incident management; vulnerable case escalation (in particular those who presented with potential mental health or behaviour and the support offered to patients entering the Trust with a LD/Autism diagnosis. Information was provided accordingly and as a result no actions required. The LD business case was discussed and provided an opportunity to provide some assurance that the Trust was working with RWT to address gaps in provision (as part of the collaboration across both organisations.

- WHT were advised in March (by NHSE) that the plans to implement LPS in 2023/24 were on hold (until the next parliament). As a result, the Trust will continue to focus on the MCA/DoLS agenda until further information is available and will be attending local meetings with ICB/LA and other providers to ensure there is a consistent focus on the intended work around LPS should it be presented back for a response.

- During Q4, WHT Head of Safeguarding attended the regional Named Nurse professionals network meeting in Telford. Feedback at this event from other

health providers was in regard to themes from CQC inspections which described a particular focus on LD/Autism provision, the management of mental health patients in unscheduled care and how health Trusts manage patients who go 'missing' from ED.

- There is a forthcoming CQC inspection of adult social care planned in Walsall. WHT will be requested to participate in relevant focus groups in support of this programme. The date for this is unclear, but likely to be 2024.

- There is a Walsall Youth Justice Inspection planned for Q2. WHT will be requested to participate in relevant focus groups and to provide health information in regard to cases identified for thematic review.

Action:

- To continue to develop and manage the LD Business case.
- To attend and support partnership meetings in response to meetings and inspections.

9	a. Health providers are required to demonstrate they have effective arrangements for engaging and working in partnership with other agencies. b. Health providers are required to demonstrate that they actively engage with all aspects of the work of the local safeguarding partnerships, strategic groups and sub groups (including Channel, MAPPA, MARAC, CSP, CJB and Modern Slavery Partnerships)

Q4 update.

- During Q4 WHT reviewed attendance at all key Walsall Partnership meetings and present actions to the TSG, WSP and ICB.
- During Q4 the Safeguarding team have attended all requested partnership and safeguarding meetings with Walsall Local Authority (LA), ICB and all care planning operational meetings. This includes MARAC and Practice Review Group (PRG)
- A combined Walsall Safeguarding Partnership feedback form is now presented to the TSG monthly (from December 2022).
- WHT have submitted the completed ICB Dashboard monthly. All exceptions are discussed at the TSG (attendance from ICB noted)
- WHT do not attend Multi Agency Public Protection Arrangement (MAPPA) meetings, however the safeguarding adult lead is liaising with MAPPA service leads to manage any potential risks from offenders who may attend WHT.
- The safeguarding adult lead is liaising the Community Safety Partnership Prevent lead to support attendance at Channel Panel meetings.

Actions:

- To report on partnership meetings at the TSG.

- To ensure information is provided to the Partnership for key groups as discussed within the meetings.

Walsall Healthcare NHS
NHS Trust

Safeguarding Dashboard

Achieving target	Populated by P&I
Within 1% of achieving targe	Populated by Service
> 1% of target	

Rag rating tolerances internally set

Reference	Metric Name	Target	Frequency	Comments / data source / date available	Oct-22			Nov-22			Dec-22			Jan-23			Feb-23			Mar-23			Narrative
					N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	
LQSG01	Level 1 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence (YTD per month)	95%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	1129	1166	96.83%	1113	1157	96.20%	1114	1151	96.79%	1134	1191	95.21%	1145	1221	93.78%	1176	1241	94.76%	
LQSG02	Level 2 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 2 Safeguarding Children competence (YTD per month)	85%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	2018	2166	93.17%	1996	2144	93.10%	1990	2121	93.82%	2086	2228	93.63%	2102	2258	93.09%	2162	2296	94.16%	
LQSG03	Level 3 training for Safeguarding Children. As set out in Safeguarding Children & Young. People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date. Level 3 Safeguarding Children competence. (YTD per month)	85%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	1024	1249	81.99%	1049	1254	83.65%	1072	1225	87.51%	1091	1277	85.43%	1123	1307	85.92%	1110	1313	84.54%	This will be raised at the Trust Safeguarding Group in May this may have been attributed to the strikes.
LQSG04	Level 4 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 4 Safeguarding Children competence	100%	Recorded Monthly Reported Quarterly	Check with workforce.	6	8	75.00%						90.00%	4	5	80.00%	4	5	80.00%	4	5	80.00%	Training booked for June.
LQSG05	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members. As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document.	100%	Reported Annually	ok	100%						100%			97.00%						100%			100% compliant next due training Q4
LQSG06	Level 1 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence (YTD per month)	95%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	1103	1154	95.58%	1089	1135	95.95%	1089	1131	96.29%	1118	1177	94.99%	1133	1194	94.89%	1161	1216	95.48%	
LQSG07	Level 2 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence (YTD per month)	85%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	1054	1097	96.08%	1044	1084	96.31%	1021	1065	95.87%	1065	1119	95.17%	1058	1169	90.50%	1080	1167	92.54%	
LQSG08	Level 3 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence (YTD per month)	85%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	1774	2260	78.50%	1770	2259	78.35%	1790	2228	80.34%	1833	2364	77.54%	1909	2389	79.91%	2016	2441	82.59%	To note adult safeguarding training has increased by 5%. Additional dates and advertising have supported the increase.

Walsall Healthcare NHS

NHS Trust

Reference	Metric Name	Target	Frequency	Comments / data source / date available	Oct-22			Nov-22			Dec-22			Jan-23			Feb-23			Mar-23			Narrative
					N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	
LQSG09	Level 4 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 4 Safeguarding Adults competence	100%	Recorded Monthly Reported Quarterly	ok	2	2	100.00%				1	2	50.00%	1	2	50.00%	1	2	50.00%	Z			
LQSG10	Safeguarding Adults training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document.	100%	Reported Annually	ok	100%						100%			97.00%						100%			
LQSG11	Basic Prevent Awareness Training (level 1&2) as defined in NHS England – Prevent Training and Competencies Framework (2015). Percentage of staff with up to date PREVENT competence. (YTD per month)	95%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	2042	2104	97.05%	2001	2070	96.67%	1984	2045	97.02%	2059	2140	96.21%	2107	2213	95.21%	2131	2224	95.82%	
LQSG12	Prevent Awareness Training (level 3,4 & 5) WRAP training as defined in NHS England – Prevent Training and Competencies Framework (2015). Percentage of staff with up to date competencies. (YTD per month)	85%	Recorded Monthly Reported Quarterly	Provided by workforce team from ESR system, by the 7th w.d	2214	2404	92.10%	2217	2404	92.22%	2196	2375	92.46%	2342	2518	93.01%	2340	2521	92.82%	2402	2585	92.92%	
LQSG13	Statutory Organisational Prevent Leads to demonstrate criteria met to achieve competency levels as defined in NHS England – Prevent Training and Competencies Framework (2015).. • Attendance at a minimum of 2 NHSE regional Prevent forums each financial year (4 take place). • Evidence of face to face meetings with the channel coordinator and	100%	Recorded Monthly Reported Quarterly	JR Checking with WCCG Verbal assurance ? agree with CCG how to demonstrate										1	1	100.00%	1	1	100.00%	1	1	100.00%	Safeguarding Adult Lead met with Prevent coordinator for Walsall Safer partnerships in January 2023. Prevent training session arranged for safeguarding adult Team for 09.02.23. Invitations to Channel meetings to be forwarded. Contact also made with Adrian Spanswick, NHSE re: Regional Prevent Forums
LQSG14	Learning Disabilities Awareness Training	95% (Trajectory to be agreed)	Recorded Monthly Reported Quarterly		1774	2260	78.50%	1770	2259	78.35%	1790	2228	80.34%	1833	2364	77.54%	1909	2389	79.91%	2016	2441	82.59%	New Oliver McGowan training is being rolled out for staff to complete and compliance to be monitored. April data to commence. This will be reported from May onwards.
LQSG15	Domestic Abuse Awareness Training	95% (Trajectory to be agreed)	Recorded Monthly Reported Quarterly		1774	2260	78.50%	1770	2259	78.35%	1790	2228	80.34%	1833	2364	77.54%	1909	2389	79.91%	2016	2441	82.59%	To note small increase in March 2023.
LQSG16	Mental Capacity Act (Previously Mental Capacity Act/DoLS (LPS) Training - split April 2022)	95%	Recorded Monthly Reported Quarterly	Provided by BI report from ESR system, on the 1st w.d (Snapshot)	2894	3126	92.58%	2917	3138	92.96%	2861	3077	92.98%	2944	3181	92.55%	3045	3346	91.00%	3151	3380	93.22%	To note small increase in March 2023.
LQSG16	DoLS (LPS) Training	95%	Recorded Monthly Reported Quarterly		2901	3137	92.48%	2925	3149	92.89%	2866	3080	93.05%	2995	3251	92.13%	3032	3337	90.86%	3140	3374	93.06%	To note small increase in March 2023.

Reference	Metric Name	Target	Frequency	Comments / data source / date available	Oct-22			Nov-22			Dec-22			Jan-23			Feb-23			Mar-23			Narrative
					N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	
LQSG17	DBS Compliance – new staff (within the last 3 months)	100%	Recorded Monthly Reported 6 monthly	Fiona to progress	227	256	88.67%	221	258	85.66%	178	209	85.17%	207	227	91.19%	186	201	92.54%	172	186	92.47%	
LQSG18	DBS Compliance – existing staff	100%	Recorded Monthly Reported 6 monthly	All staff - provided by Bi report from ESR system, on the 1st working day	4421	4790	92.30%	4589	4963	92.46%	4601	4963	92.71%	4716	5082	92.80%	4727	5082	93.01%	4771	5123	93.13%	
IRSG01	Percentage compliance with provider protocol for child protection supervision for frontline staff (individual or group) (Health Visiting)		Reported Quarterly		74.00%									Q4 73% for HV Service 70% for SN service									
IRSG03	Percentage compliance for safeguarding supervision for Named Professionals/Specialist roles within Safeguarding		Reported Quarterly	tbc							87.50%			1	2	50.00%	1	2	50.00%	6	7	86%	One practitioner outstanding due to change of supervisor.
IRSG04	Number of referrals made for PREVENT		Monthly	JR – on submission unify OK	0			0			0			0			0			0			No referrals were made this month – Jan 2023
IRSG05	Compliance with quarterly CCG/provider meetings, either 1:1 or Safeguarding Forum -		Monthly – Reported Quarterly	On CQR agenda Safeguarding forum – not established yet	Yes			Yes			Yes			Yes			Yes			Yes			
IRSG06	100% Compliance with Submitting Safeguarding Reporting Framework to CCG	Yes	Monthly	This document ok	Yes			Yes			Yes			Yes			Yes			Yes			
IRSG07	100% Compliance with Prevent Returns (NHS Digital – Strategic Data Collection Service)	Yes	Quarterly	ok already done	Yes									Yes									

Reference	Metric Name	Target	Frequency	Comments / data source / date available	Oct-22			Nov-22			Dec-22			Jan-23			Feb-23			Mar-23			Narrative
					N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	
IRSG07	Numbers of DoL's/LPS referrals.		Monthly – Reported Quarterly	DoLs being replaced by LPS. OK JR has data.	35						48			23			33			23			Across hospital
IRSG07	Number of DoL's/LPS authorised. Number of LPS completed under the Vital Act. Number of DoL's/LPS which have objections		Monthly – Reported Quarterly	DoLs being replaced by LPS. OK JR has data.	NA						1			0			0			0			No DoLS were authorised for this month

Appendix 2 - Safeguarding Service
Safeguarding Policy Document – updated May 2023

Walsall Healthcare NHS
NHS Trust

No.	Name of Policy	Approval Date	Review Date	Commence Review (3 months prior to review date)	Lead Practitioner	Notes/Progress
1	Prevent Policy - OP110	26.04.22	April 2025	January 2024	JL	26.04.22 – Policy is now on the intranet.
2	Female Genital Mutilation Policy (FGM) V2 April 2022	June 2023 TBC	December 2023	September 2023	TT	**03.05.23 Policy on target to be completed for 11th May Trust committee for feedback before presenting to the policy panel.** 07.04.23 planned to be completed before May 2023 to be presented at trust group.
3	Domestic Abuse Policy V2 Under review: October 2022	May 2023 TBC			SS	**03.05.23 Policy presented at Trust safeguarding committee on 12.04.23 for final feedback. Feedback incorporated into final document for Policy group May 2023.** 07.04.23 completed to policy to be presented in April 2023.
4	Safeguarding Supervision Policy (Children and Adults). (Safeguarding Children and adults' policy are being combined). Policy will be	Sept 2023 TBC	October 2022		DF/JJ	**03.05.23 Policy under review in line with ICB safeguarding supervision policy. To be presented at Trust safeguarding committee July 2023.** 07.04.23 – policy continuing to be reviewed in line with ICB safeguarding supervision policy.

	referred to as one policy.					
5	Safeguarding Adults at Risk Policy Policy will no longer be combined with Childrens policy to ensure policy can be completed.	Sept 2023 TBC	April 2023	January 2023	JL/LR	**03.05.23 Policy commenced review decision made to complete adults' policy separately from children's policy to prevent further delay of policy being completed to be presented to Sept.** 07.04.23 – request to extend submission due to staff shortages.
6	Safeguarding Children Policy Policy will no longer be combined with adults' policy to ensure policy can be completed.	Sept 2023 TBC	April 2023	January 2023	DR	**03.05.23 Policy under review decision made to complete children's policy separately from adult's policy to prevent further delay of policy being completed.** 07.04.23 – request to extend submission due to staff shortages.
7	Managing Allegations Against Staff (new policy)	July 2023 TBC	December 2022	September 2022	JL	**03.05.23 Joint policy with RWT transferring policy onto WHT policy proforma to be presented at Trust safeguarding committee June 2023.** 07.04.23 – under review planned to submit to policy group in June.
8	Deprivation of Liberty Safeguards (DoLS) Policy	June 2023 TBC			ML/JL	**03.05.23 final amendments to policy being completed with the aim to present to the Trust committee in June 2023.** 07.04.23 – policy continuing to be reviewed and amended.
9	Mental Capacity Act Policy For ratification Jan 2023	20.12.22	November 2026	September 26	JL	06.01.23 – Policy approved at policy group panel 20.12.22.

Appendix 3 – Summary Report for PRG Group

Walsall Healthcare NHS Trust	
Trust Safeguarding Group	
Meeting Date:	10.05.2023
Title:	Summary Report for PRG Group.
Executive Summary:	This report provides an update to the group regarding the activity and input by WHT into the Walsall Safeguarding Partnership, Practice Review Group held on the 21.04.2023
Action Requested:	For the group to receive the summary report for information.
Report of:	Mak Inayat Deputy Head of Safeguarding.
Author: **Contact Details:**	Mak Inayat Tel 01902 602318 Mak.inayat@nhs.net
Links to Trust Strategic Objectives	Safeguarding is linked to all Trust Strategic Objectives
Resource Implications:	N/A
Equality and Diversity Assessment	Overarching safeguarding agenda is considered in relation to age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion and belief, sex, and sexual orientation.
Risks: BAF/ TRR (describe risk and current risk score)	NA
Public or Private: (with reasons if private)	Private the information has not been published therefore not available in the public domain.
References: (e.g. from/to other committees)	To be presented at the Trust Safeguarding Committee
Appendices/ References/ Background Reading	

NHS Constitution: (How it impacts on any decision-making)	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details	
1	This meeting continues to be held virtually using Microsoft Team and was chaired by Maria Kilcoyne.
2	**Action Log** Outstanding action: Further assurance requested that WHT midwifery review section 6 and safeguarding lead for SAR 9 review recommendations and feedback back to PRG MI to follow up with midwifery and safeguarding lead.
3	**Development session.** **Changes to local arrangements.** Discussion was had regarding local arrangements for screening of notifications/referrals of a Serious Safeguarding Incident and requests for Rapid Reviews. An additional step responding to serious child safeguarding practice incidents is being introduced to the local arrangements. • The Screening Panel represented by the three statutory partners have the responsibility to determine if a Rapid Review is required once a case has been referred. • Once a referral has been screened by the three statutory partners a range of different responses will be triggered supported by Working Together (2018) guidance. • The panel will agree it meets criteria for consideration of a Rapid Review 'serious harm' has occurred the national panel are notified, and the case is scoped to consider if it meets criteria for further in-depth analysis to learning lessons in respect of partners safeguarding practice. • If the case does not meet threshold for a Rapid Preview alternative audit assurances can be considered. If single agency, then that agency will be required to undertake and audit and present findings and learning to the Practice Learning and Development Group. • Where single agency involvement leads to serious incident and an internal review, WSP will request notification of learning which may have an implication on multi-agency safeguarding systems. • See embedded flowcharts.  2023.03.27 Case Review and Decision **Scheme of Delegation.** • Discussion re the purpose of this 'Scheme of Delegation' was discussed setting out how members of the Walsall Safeguarding Partnership (WSP) will operate, responsibilities to ensure WSP strategic plans and core functions are progressed and that the shared responsibility to safeguard children, young people and adults at risk is carried out effectively. **West Midlands Regional Adult Review (SAR) Guidance.** • Rapid Review guidance discussed. • Purpose of SARs is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. • This is to ensure lessons can be learned from the case and those lessonsare learned in practice to prevent similar harm occurring again. **Local Child Safeguarding Practice Reviews (LCSPR) toolkit.**

	• The purpose of a child safeguarding practice review is to explore how practice can be improved through changes to the system. • This toolkit provides professionals with a guide to follow when undertaking or participating in a Rapid Review and / or Local Child Safeguarding Practice Review. • It highlights the statutory elements outlined in *Working Together to Safeguard Children 2018,* Children and Social Work Act 2017 and outlines responsibilities for key people at each stage of the process. **Concern** Discussed at the last WSP PRG in January was concerns regarding a 4th rapid review involving neglect of children. An in-depth thematic analysis was requested by WSP through MASG arrangements the first meeting involving practitioners is due to take place on 03.05.23.
4	**WMAS Audit.** • This audit report (March 2022) was presented by author – Deb Ward (Sandwell Safeguarding Adults Board Operations Manager). • Purpose of the audit was to gain further insight of referrals by WMAS. • Key themes identified were inappropriate referrals, use of incorrect safeguarding concern form, retention of safeguarding forms, outcomes of safeguarding concerns/screening, Mental Capacity Act, making safeguarding personal and information sharing. • Please see report below for further information. WMAS AUDIT REPORT.docx
5	**Partnership Case Updates** There is a total of 16 reviews in the WSP system. i. 4 Child reviews (SCR/LCSPR) ii. 5 Adult reviews (SAR) iii. 2 DHR's iv. 1 Child CSA tabletop review v. 1 Child Neglect Thematic Review vi. 1 Adult Learning Review vii. 2 Adult referral pending decision making scoping meeting. **Adults Reviews: -** Derek Benson, WSP Adult Safeguarding Chair, will be chairing SAR scoping meetings and SARs in Rapid Time. viii. **SAR5** – completed with outstanding actions and are ready for publication, now delayed due to entering the pre-election period. ix. **SAR6** - completed with outstanding actions and are ready for publication, now delayed due to entering the pre-election period. x. **SAR7** – reports and recommendations were approved at Executive Group 15/02/23. Action plans will now be compiled meeting arranged. xi. **SAR8** – reports and recommendations were approved at Executive Group 15/02/23. Action plans will now be compiled meeting arranged. xii. **SAR9** – former proposed LCSPR (baby who died with congenital abnormalities), of which the mother was a victim of intra-familial abuse. The SAR panel is progressing the report and is on track.

xiii. **SAR10** – adult with complex health issues, bi-lateral amputation below the knee and visually impairment. Outcome of Coroner's inquest, the cause of death was established as: Cardiorespiratory Depression, Central Nervous system depression and excess intake of Morphine, Gabapentin and Paracetamol.
Concerns of domestic abuse with partner. There was professional involvement prior to death, missed opportunities by a number of key agencies to intervene to provide care or support and protect.

xiv. **SAR 11 (in rapid time)** – adult known to mental health services and had learning difficulties. Adult suffered cardiac arrest and died from choking. It was agreed partners could have worked more collaboratively together. There was limited information within scoping in respect of adult's cultural background which may have been contributing factors to access services.

This was the first Rapid Review in time held in Walsall where the case was discussed, and all learning established with no further learning required to progress to a "traditional SAR". A report and action plan will be compiled. The SAR in rapid time draft guidance is in the process of seeking approval and will be presented to Operations & Scrutiny in due course.

2 SAR referrals awaiting decisions: -

xv. **Review 1** – death of young adult following stabbing, young adult had care and support needs and known to MH services and WHT. Discussed on 28.04.2023 panel felt did not meet criteria for SAR or Rapid in Time Review.

xvi. **Review 2** – death of an elderly person in a house fire who had care and support needs. Meeting to be held 02.05.2023.

Childrens Reviews.

xvii. **SCR W6** – Court proceedings concluded outcome not shared. Media restrictions have been lifted 05.04.2023. WSP are reviewing how to mitigate impact of harm to children who are victims of this case.

xviii. **SCR W10** – On-going criminal proceedings subject to CPS decision making.
The report cannot be finalised or published until ongoing police proceedings concluded.

xix. **SCR W12** - Review author met with mother on 06.03.2023. No contact with father.
Author to update report for circulation to Joint Case Review Group.

xx. **LCSPR W14** – A redacted version of the report will be written and requested to be uploaded to the NSPCC website to protect family anonymity. Contact made with father 23.03.2023 report will be updated to reflect father's views.

xxi. **LCSPR W15 New** – Rapid review held in respect of the death of a 5-year-old child, whilst in a foster care. The cause of death is as yet unexplained; however, the initial findings are significant dehydration and severe constipation. The case is subject to criminal proceedings. A review author has been commissioned and Terms of Reference are being compiled. Scoping discussion meeting held 18.04.2023.

xxii. **Neglect Thematic Review** has been commissioned with 4 recent rapid review cases which did not meet threshold for LCSPR, 2 of the reviews included large sibling groups. The aims of the review are to identify barriers to the identification and response to neglect and ensure learning is available for consideration. These reviews will implications and learning for WHT as well covid.

DHR Reviews: -

xxiii. **DHR10** – requires minor changes and will be submitted to with Home Office in April 2023. This will be presented to the Panel in October 2023.

	xxiv. **DHR11** - Is currently still on hold, following receipt of further information. Awaiting CSP to confirm how to progress due to limited information available and no conclusion findings.
6	**WSP focus work and concerns.** i. **Operation Satchell** - the criminal trial/press release which is also linked to SCR W6 has generated media interest for agencies and their involvement with the family. This has implications for WHT. ii. **Impending numerous SAR publications** - Delay in publication of SAR5 & SAR6 to be closely followed by publication of SAR7 & SAR8 in the coming months.
7	**WHT focus work and concerns.** • There are themes learning emerging form the reviews which will be discussed at the next Trust safeguarding committee. • The safeguarding team through the internal CSPR/SAR group will complete outstanding actions.
8	**Next Meeting** Walsall Partnership Practice Review Group – 21st July 13.30-16.30 Walsall Internal CSPR, DHR, SAR Group – 24th May 15.00 -16.30

Appendix 4 - Safeguarding Assurance Development Plan – May 2023

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
1	**Safeguarding Service & Team Resource**	To carry out a review of the current resources within the Safeguarding Team (Adults, Children and LAC) to ensure there is the capacity to promote good professional practice, support the local safeguarding system and processes, provide advice and expertise for fellow professionals, and ensure safeguarding supervision and training is in place.	~~**January 2023**~~ **July 2023** (To conclude recruitment process) Head of Safeguarding	**01.05.23** **Business Support Manager (Band 5) post interim post conducted March 23. Awaiting commencement date.** **Admin Band 3 posts x 2 out to advert.** **NNSC Band 7 x 2 posts: Recruited. Start date tbc.** **Office space found at Town Wharf Block 3. No date confirmed to move in. Escalated and awaiting outcome.** 05.01.23 The Business Support Manager Band 5 post to be readvertised. NNSC Band 7 posts x 2wte currently in recruitment progress. 08.11.22 Deputy Head of Safeguarding has commenced in post on Monday 3rd October. Band 5 Business Support manager post now in recruitment stage (November 2022). Date for interview tbc. 2 Band 7 posts in Safeguarding Children Team out for advert/recruitment. Team office space at WMH escalated to COO. Awaiting confirmed allocated area by November.	**In process** Staff in post
2	**Safeguarding Supervision Process (Adults & Children)**	**a)** Safeguarding Team to develop a Specific Safeguarding Supervision Policy (Children and Adult Policy)	~~**January 2023**~~ **July 2023** Head of Safeguarding and Team Leads	**01.05.23** **Initial findings of safeguarding supervision survey are to raise awareness of safeguarding supervision, so staff understand the benefits. Challenges for staff is balancing acuity and patient care and having protective time to access**	**In process** Evidence: (*Copy of Supervision Policy*)

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				safeguarding supervision. Deputy Head of Safeguarding to continue focusing on one pilot site in ED to work with staff to find a model which incorporates the demands of the service, so staff feel able to access supervision. Staff are receptive to accessing safeguarding supervision which is positive. 03.04.23 Supervision Policy modifications in progress.	
3	**Child Protection Information System (**CPIS) To ensure that this process is embedded across the Trust. • CP-IS Phase 2 roll out for consideration across the Trust (from April 2023)	• Current CP-IS SOP requires improvement • Current SG Children Policy needs to be updated to reflect CP-IS. • Audit to be undertaken to ensure practitioners are using CP-IS during Q3/4. • Phase 2 (NHS England roll out to be considered nationally/locally to include 0-19 service access to CP-IS.	~~**April 23**~~ **July 23** Head of Safeguarding/ Safeguarding Children Team Lead	**03.04.23** **Audit process (ED/Maternity) and review of operating model has commenced during January.** **0-19 Service and safeguarding service to consider roll out into HV/School Nurse service.** 09.12.22 Date to be confirmed. Awaiting dip sampling of records – date cancelled due to sickness within SG Children Team. Plan to complete in Q4 22/23.	**In process** Evidence: *Audit findings & action plan*.
4	**Safeguarding Training Programme to be reviewed. (October 2022)** **Reduced compliance noted in Q2** **The Children and Adult Training Package currently requires reviewing and refreshing.**	• Safeguarding Service to review training delivery options available – meeting to be set up in January 2023 extending remit of work to include all staff groups. • WHT to offer more training dates whilst the review is in place	~~**April 23**~~ **July 23** Head of Safeguarding	**01.05.22** **TNA to be presented to next TSOG.** **RWT and WHT joint safeguarding training group have met monthly (from January 23) to review the staff levels/training programmes available to roll out from July 2023 across both Trusts. Joint training packages have now commenced. Regular communication and targeting of staff outstanding with all training has been highlighted at senior meetings across the Trust.**	**In process**

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
		For WHT to email directly all staff who are outstanding with their training. • TNA for new training programme to be presented to TSOG in June 2023.		**Plan to change WHT staff aligned to Level 3 (Adult) to Band 6 and above.** 09.12.22 Elearning options escalated. Review of overall training programme (with RWT) to commence in Q4. Task and Finish Group to meet to look at the intercollegiate guidance. 06.10.22 Staff have been emailed directly with dates of forthcoming training dates.	
5	**Learning Disability Service Within WHT** confirmation of role of LD service within Trust, and review of LD Strategy/Standards**.** Gap analysis to be undertaken to establish areas for escalation/improvement**.**	To review the current model of service provided by LD team (via BCHT) to include posts, training, autism & LD Strategy. • Additional resource required during scoping of service (from May 2022) • LD Training roll out (Oliver McGowan) L1. • LD Business Case to be written and presented to WHT Finance group	~~**April 23**~~ **June 23** Head of Safeguarding	**01.05.23** **Business Case completed and sent to respective team at WHT.** **Oliver McGowan training has commenced.** **Compliance to be added to the safeguarding Dashboard from May 23** **03.04.23/03.02.23** Business case and financial proposal being finalised February 23 for presentation to Trust Finance/Contract Group. Escalated to Exec team LD Training – Oliver McGowan Level 2 has commenced for reporting on via Dashboard May onwards. Report on progress May TSOG	**In process**
6	**Safeguarding Policy Work from 2022**	Review of all related WHT safeguarding policies to ensure: • Updated • Relevant	**April 23** Head of Safeguarding	**01.05.23/03.04.23** **Policy work in progress. Agenda item at TSOG.** **Policies due for review/amendment to be cited within the quarterly reporting process.**	

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
		• That any outstanding policies are written			
7	**<u>May 2022</u>** **Liberty Protection Safeguards known as LPS (from Oct 2023 tbc)** WHT to be fully prepared for the forthcoming changes within legislation and implications for practice	Review of national (and local) documentation around the intended introduction of LPS and the impact and implications for WHT. • There should be WHT attendance at relevant national and local LPS events. • WHT to attend the Black Country STP LPS Group and feedback to SG Group • Identify a Trust 'Lead' for LPS • Set up a Trust Group with relevant stakeholders to support this work	**April 23** SG Adult Lead	**<u>01.05.22</u>** **WHT advised from NHSE that the plans to implement LPS have now been put on hold (until the next parliament). Ongoing work will still focus on the work aligned to MCA/DoLS. There will be a local group meeting (ICB/Providers) to review processes as interim.** <u>03.04.23</u> WHT attending relevant local/national groups. No update on LPS available. WHT working collaboratively with RWT and ICB to ensure all requirements in place. Contact made with Lincoln and Nottinghamshire Health Providers to seek any learning in regard to work regarding MCA and DoLs applications in readiness too.	**In process**
8	**JANUARY 2023** **Walsall Joint Area Inspection (JTAI)** Inspection undertaken in November 2022. Final feedback received January 2023	Review the final report and ensure any actions for WHT are completed.	**April 23** Head of Safeguarding	**<u>01.05.23/03.04.23</u>** JTAI action plan circulated to respective service areas from Walsall LA. Forthcoming focus on information sharing systems and processes for accessing health data. <u>03.02.23/05.01.23</u> Final report received. Actions to be reviewed with partnership and updated. 4 areas for partnership to address. Action plan in development February 2023	**In process**
9	**February 2023**	For SG Team to review the current process with Walsall Local Authority to	**April 23**	**<u>01.05.23/03.04.23</u>**	

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
	Safeguarding Adult Referral Process WHT Safeguarding team/Walsall Local Authority to work together on communication process to ensure cases resolved	ensure that the information/request for information is being directed to the correct service area	**Adult SG Team**	**The safeguarding team are meeting with Walsall Local Authority to oversee the S42's and to work on referral/communication model going forward. Cited within the Adult SG team monthly report.**	
10	**Completion of Section 11 (Children Act 1989/2004) and Care Act for Adults to be completed by WHT before May 2023.**	For WHT to complete the S11 and Care Act compliance tool (received 27th March 23) and return to Walsall Local Authority by 12th May 2023.	**May 23** Head of Safeguarding	**01.05.23** **Presented to TSOG in May 23 prior to sharing with Walsall LA.** **03.04.23** **Date to be set to complete the self-assessment toolkit process.** **TSOG group to receive the report in May for any comments before responding to Walsall Local Authority.**	**Commenced**

Rag RATE	Description
	Not started yet, or Delayed
	In Process/Progress
	Completed Action

Appendix 5

Changing our Lives- Quality of Health Review- Acute care across the Black Country.

Background

Changing our Lives is a rights-based organisation, there approach rests firmly on the social model of disability. As such, they don't believe people's lives should be limited or defined by labels or diagnoses and are committed to reframing how society views mental health and disability.

The team were commissioned by the ICB to explore health inequalities in relation to people with learning disabilities and autistic people across the Black Country in general hospital settings.

The Standards from the Learning Disability Improvements Standards for Trusts (NHSI) where used as a measured,

- Standard 1 Protecting and respecting rights
- Standard 2 Inclusion and engagement
- Standard 3 Workforce
- Standard 4 Specialist learning disability services (for specialist services only)

Evidence gathering

The team arranged to meet with staff form both WHT and RWT. During the visit to New Cross, they met with the Learning Disability team and received feedback from one family carer. When they visited, they met with the safeguarding lead and a nurse from Black Country Healthcare.

General findings

- Neither RWT or WHT had a consistent approach to supporting autistic patients (this was the same for Sandwell and Dudley). It was identified that both RWT and WHT had a light touch approach to supporting autistic patients.
- There is an inconsistency in the support available for autistic patients and patients with a learning disability.
- Rwt and WHT do not have a changing places toileting facility.
- Tackling health inequalities for people with learning disabilities needs
- to be embedded in the leadership approach in trusts across the Black Country and needs to be a core part of the value base of each trust.
- The scope and depth of the reasonable adjustments that can be offered is inevitability limited due to the lack of learning disability and autism nurses available to support.
- The flagging system is week established within RWT, but work need to be undertaken to establish a flagging system within WHT.
- There was no evidence of sharing good practice between the hospitals.

- RWT and WHT report deaths of patient with learning disabilities to the LeDeR platform.
- RWT nor WHT had systems in place to audit the RESPECT documents for people with learning disabilities or autistic people.

Walsall Manor Hospital

Quality of Health Review- Acute care across the Black Country

Changing our lives February 2022

Position statement 31-1-23

Recommendation	Position statement	Action Required	Target date	RAG
All trusts across the Black Country should work proactively with autistic people who do not have learning disabilities, as well as those who do. If necessary, job descriptions should be reviewed to ensure ALNs are enabled to work with this group of people.	People with Autism who do not have a learning disability are directed to patient experience for support.	A process is required to allow autistic people to access support for trained staff when using WHT services. All new LD specialist nurses JD's to include working with autistic people	Aug 23	
Trusts that have limited ALN input need to review this as a matter of urgency to ensure residents with learning disabilities across the Black Country have equality of access and health outcomes.	The Trust currently has 1 WTE band 6 job shares, employed by BCHC working within Walsall Manor Hospital. This position is commissioned to work with people over that age of 18 and who access the hospital. There is no cover in periods of AL, sickness, bank holidays or weekends.	A business case is being developed and will require funding. The Trust requires a team of staff who can support the additional needs of people of all ages with LD and or autism. If the Trust is not able to achieve a 7 day a week service, an Intranet page needs to be established with information and guidance for staff outside of office hours.	Aug 23	
Trusts should share their good practice with each other with the aim of providing consistent care for people with learning disabilities and autistic people across the Black Country. A mechanism for regular sharing should be built into the way that trusts work.	There is no formal arrangement for sharing of information across the Black Country. WHT and RWT plan to provide an equitable service across both sites. The	A business case is being developed and will require funding. The Trust requires a team of staff who can support the additional needs of people of all ages with LD and or autism.	Aug 23	

	service will include support for the community-based staff.	A regular meeting needs to be established across the Black Country to share good practice		
All trusts across the Black Country need to use one agreed hospital passport as this would improve recognition and continuity of use. Where other paperwork or Easy Read materials are improved recognition and continuity of use. Where other paperwork or Easy Read materials are shown to improve outcomes for people with learning disabilities and autistic people, these should be shared between trusts.	The Trust currently uses very limited amount of easy read materials and relies on the LD nurses to provide this. The leaflets that are being used do not carry the Trust logo and use Photosymbols pictures. The Trust does not have a licence to use Photosymbols	The Trust needs to establish a process to be able to provide easy read information when it is required.	April 23	
Trusts should have Easy Read complaints procedures easily accessible to people with learning disabilities and family carers and people should be routinely informed about these.	As above	As above	April 23	
All hospitals that do not already have Changing Places toilets should install them. These will be mandatory in any new hospital built after January 2022. Temporary modular facilities are available to address this shortfall while awaiting installation of a permanent facility.	The Trust dose not have a changing places toileting facility.	The Trust need to explore options for a changing places toileting facility.	Aug 23	
The four trusts would benefit from a shared flagging system that alerts the ALN team when people with learning disabilities and autistic people are admitted to hospital. As far as possible, flagging systems should also be shared with other relevant partners such as GP surgeries, community health teams or community social care teams.	The Trust has a flagging system for both LD and autism.	This action would require an ICB approach		

Walsall Manor operates differently to the other trusts as its ALNs are employed by Black Country Healthcare Foundation Trust. Information should be gathered about how these impacts on the delivery of care for people with learning disabilities and autistic people and any relevant learning should be used to improve practice and shared with the other three trusts.	The Trust provide a very limited services for people with LD.	A business case is being developed and will require funding. The Trust requires a team of staff who are able to support the additional needs of people of all ages with LD and or autism.	Aug 23	
Hospitals should have clear policies in place to ensure that the quality-of-care people get outside of ALN teams' core hours is consistent with the care they get when ALNs are present.	Currently the Trust does not have policies for the care of people with LD and or autism	Clear policies for the additional support needs for people with LD and or autism are required If the Trust is not able to achieve a 7 day a week service, an Intranet page needs to be established with information and guidance for staff outside of office hours.	Aug 23	
All staff in all hospitals should have regular training that addresses health inequalities for people with learning disabilities, reasonable adjustments and people's rights including knowledge of the Mental Capacity Act. Evidence should be captured about whether this training has improved understanding and practice, and future training adjusted accordingly.	The Trust currently deliver LD awareness during the safeguarding training package. There is no stand-alone package for LD and or autism.	The Oliver McGowan LD and autism training became a statutory requirement for all health and social care staff in Nov 2022. The ICB are currently reviewing how this can be delivered with BCHC.	Aug 23	
Trusts that have not undertaken an audit of their DNACPRs for autistic people and people with learning disabilities should do so and inappropriate DNACPRs should be removed or amended as necessary.	The Trust do not currently undertake an audit for DNACPR's for people with LD and or autism.	An audit programme needs to be established for the care of people with LD and or autism.	April 23	
All trusts should demonstrate efforts to improve people and families' understanding of their rights. They should ensure that key pieces of work are coproduced with people		The Trust needs to identify people with LD and or autism who can support in the recruitment process.	Aug 23	

and family carers and that recruitment processes for specialist learning disability roles and for all senior leadership roles include people with learning disabilities, autistic people and family carers.				
All trusts should include people with learning disabilities, autistic people and family carers in learning from complaints, investigations and mortality reviews.		The Trust needs to identify people with LD and or autism who can support in the complaints, investigations and mortality review process.	Aug 23	

Item 14.13

Walsall Healthcare NHS Trust

Meeting of the Trust Board held in Public	
Meeting Date:	7th June 2023
Title of Report:	Infection Prevention and Control Annual Report
Action Requested:	To inform
For the attention of the Board	
Assure	The NHS Standard Contract requires the Trust to publish an annual report detailing the infection prevention and control activities for the year.
Advise	The report provides detail on the Trust performance with regard to organisms that are subject to mandatory reporting. The Trust has achieved the planned infection prevention and control activities outlined in the annual programme 2022/23
Alert	Nil
Author and Responsible Director Contact Details:	Amy Boden, Deputy Director Infection Prevention and Control Tel 01922 721172 ext 5822 Email amy.boden@nhs.net Lisa Carroll Director of Nursing & Director of Infection Prevention and Control
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Safe and responsive urgent and emergency care
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Progress joint working across Wolverhampton and Walsall
Resource Implications:	None
Report Data Caveats	This is a standard annual report.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	N/A
Risks: BAF/ TRR	Findings and gaps in assurance are included on the IPC BAF assurance tool.
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	
References	None
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Care Colleagues Collaboration Communities

NHS
Walsall Healthcare
NHS Trust

Infection Prevention & Control Annual Report 2022/23

Lisa Carroll
Director of Infection Prevention & Control

Amy Boden
Head of Infection Prevention and Control
Deputy Director of Infection Prevention & Control

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Lead Nurse, Infection Prevention and Control

Dr Aiden Plant
Consultant Microbiologist and Infection Control Doctor

To deliver exceptional care together to improve the health and wellbeing of our communities

Respect Compassion Professionalism Teamwork

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1.0. Executive Summary

- The Annual Infection Prevention and Control (IPC) Report reports on infection prevention and control activities within Walsall Healthcare NHS Trust for April 2022 to March 2023. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability.
- The following organisms are subject to mandatory reporting. These are MRSA, MSSA, Clostridioides difficile and Gram-negative bloodstream infections (Escherichia coli, Klebsiella species, Pseudomonas aeruginosa).
- The Trust has achieved the planned infection prevention and control activities outlined in the annual programme 2022/23 including planned audits, education sessions and undertook additional duties to support the Trust in response to the COVID-19 pandemic and other outbreaks.
- The Trust experienced 1 case of MRSA bacteraemia during 2022-23 against a target of zero.
- There were 50 Toxin positive reportable cases of Clostridium Difficile (C. diff) against a trajectory of no more than 27 cases.
- Mandatory surgical site surveillance was completed in elective orthopaedic hip and knee replacements for 1 quarter; no infections were identified.
- During 2022/23 the COVID-19 pandemic continued to challenge the IPC team and Trust wide services, posing additional demand in the prevention and control of infection within healthcare premises.
- Compared to 2021/22 endemic organism rates increased such as Norovirus, Influenza A and B; outbreaks and closures due to these impacted Trust wide services.
- The Trust is currently rated Green by NHS England and Improvement for Infection Prevention and Control. The Trust received very positive feedback for progress in standards of IPC which granted the green score from previous amber in 2021/2022.

2.0. Introduction

Healthcare Associated Infections (HCAIs) can cause harm to patients, compromising their safety and leading to a suboptimal patient experience and increased length of stay in hospital. Maintaining low rates of HCAIs remains a cornerstone of the Trust's approach to providing safe, high-quality care across all the services. The Trust has been working hard to improve infection prevention and to raise the rating by NHSE to green. This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving quality of patient experience as well as helping to reduce the risk of acquiring an infection. Additionally, the Trust continues to work collaboratively with a number of external partners as part of its IPC and governance arrangements.

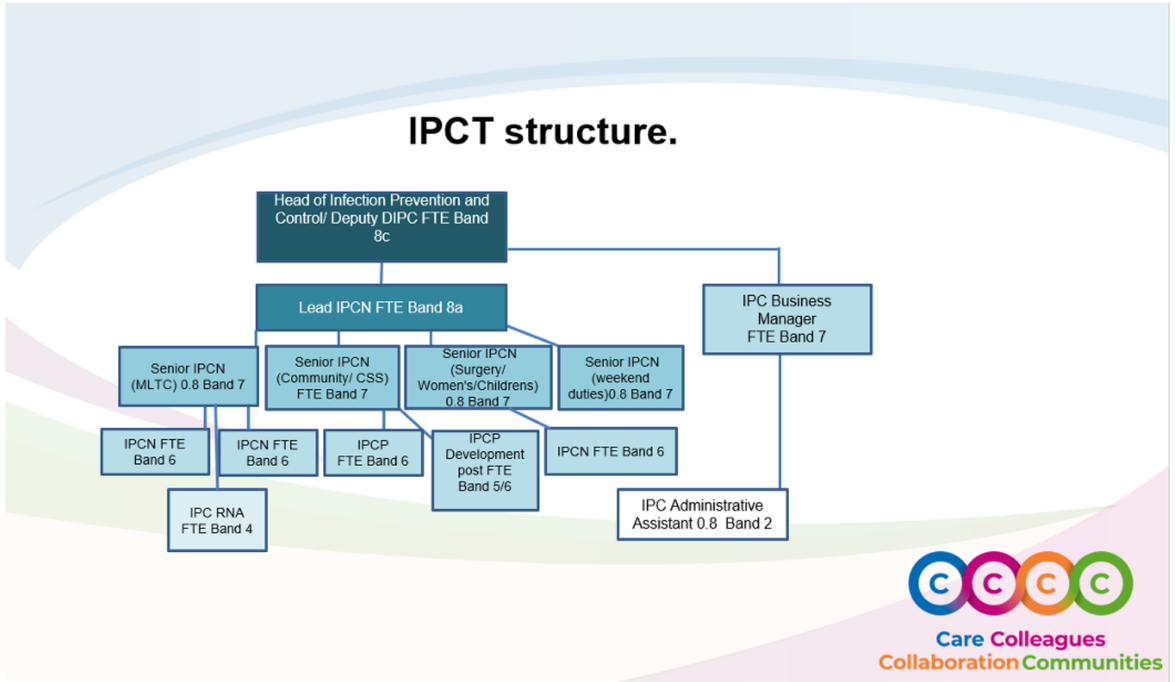
3.0. Reporting arrangements

The Infection Prevention & Control Team (IPCT) is based at the Manor Court.

The team works closely with all Trust colleagues and external contractors to support a vision of no person being harmed by a preventable infection. The service provides IPC support to Walsall Healthcare NHS Trust. In addition, they work closely with Walsall Council's Health Protection team and the ICB Health Protection Team to deliver a health economy approach to infection prevention strategies.

The role of Director of Infection Prevention and Control (DIPC) is undertaken by the Trust's Director of Nursing who reports directly to the Deputy Chief Executive and Chief Executive on matters pertaining to infection prevention and control in line with the requirements of the Health and Social Care Act 2008. The role of Deputy DIPC is undertaken by the Head of Infection Prevention and Control.

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC or Deputy DIPC and met monthly during 2022-2023.



4.0. IPC team structure

The IPC team structure for 2023 is detailed below. 2022-23 has focused on introducing a wider range of roles into the team structure to reflect that infection prevention is everyone's responsibility. This has led to expanding recruitment opportunities for Infection Prevention Practitioners (Nursing and Midwifery Council Registrants/ HCPC registration or General Dental Council registration). In 2022, a dental nurse commenced in the IPCT structure, expanding the education portfolio for the team, particularly with a focus on preventing pneumonia. At the end of 2022, a clinical nurse fellow commenced in the team, leading to working closely to champion IPC education for CFNs. In March 2023, a novel role into IPC commenced at Walsall Healthcare; a Nursing Associate, focusing on infection prevention at the front door. As recruitment opportunities arise, the Infection Prevention Practitioner position will continue to be advertised for 2023-24.

2022-23 observed great development for the IPCT and a good example of "growing our own." The newly appointed Lead Nurse in 2022 had initially commenced in the team as a Band 5 Infection Prevention Nurse, developing as a Band 6 IPCN and Senior IPCN during the COVID-19 pandemic. Two IPCNs during the financial year were also successful in appointments to Senior IPCN positions. The team provide a robust development programme for Infection Prevention Practitioners, following the Infection Prevention Society competency framework and contributing to regional development programmes. The team also lead a CPD event for Infection Prevention Practitioners in Walsall and Wolverhampton with a "Thinking Thursdays" programme.

5.0. Links to Clinical Governance/Risk Management/Patient Safety

The DIPC is a member of the Quality, Patient Experience and Safety Committee and Infection Prevention and Control specialists attend the Health and Safety Committee and Divisional Quality Boards.

Monthly reports are prepared by the IPCT and presented to the IPCC, the Quality, Patient Experience and Safety Committee and the Board. Ad hoc reports and audit requests are also undertaken to meet service requirements.

6.0. Infection Prevention and Control Committee (IPCC)

The role of the IPCC is to provide strategic direction for the prevention and control of Healthcare Associated Infections (HCA

I) in Walsall Healthcare Trust. The committee members ensure a confirm and challenge approach and assurance that the Trust meets the requirements and mandates of the National Infection Prevention and Control Standards and the Trust's own policies and procedures. It ensures that there is a strategic response to new legislation and national guidelines. In addition, the committee seeks assurance from the divisions and ensures compliance with the Health and Social Care Act 2008. Terms of reference (ToR) for the IPCC can be found in Appendix 1.

Compliance with The Health and Social Care Act is measured using the hygiene code. This is routinely assessed at Infection Prevention and Control Committee via the IPC Board Assurance Framework (BAF) updates. The Deputy DIPC at Walsall Healthcare has been working as part of a National IPC group in the development of a new "business as usual" infection prevention BAF. This is being launched in financial year 2023-24.

6.1. Decontamination Group

The Hospital Sterilisation Disinfection Unit (HSDU) is a purpose-built building that is situated opposite the main hospital. The HSDU is ISO 13485:2016 accredited and provides a service to Walsall Healthcare and the Community. The HSDU is audited on a yearly basis by our external auditors, who provide an inspection, verification, testing and certification company. In addition, the Trust conducts monthly internal audits undertaken by our own trained internal auditors. This assurance process includes yearly management review meetings to address non-conformances, supplier failures, quality performance, education & training, customer feedback, Medicines Health Products and Regulatory Authority (MHRA) alerts, water safety and any new legislation. Discussions also take place regarding any departmental changes and improvements that can be made to the service. This review is reported to the external auditors and quarterly to IPCC.

The HSDU provides decontamination services (over 7 days) throughout the Trust with the main customers being Theatres.

The HSDU also provides an endoscope decontamination service for Endoscopy, ENT, Urology and Theatres (over 6 days) which was Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited in April 2019.

Decontamination group meetings take place quarterly and cover all aspects of decontamination throughout the Trust and reports to IPCC.

6.2. Antimicrobial Stewardship

Antimicrobial resistance (AMR) arises when the organisms that cause infection evolve ways to survive treatments. The term antimicrobial includes antibiotic, antiprotozoal, antiviral, and antifungal medicines.

Resistance is a natural biological phenomenon but is increased and accelerated by various factors such as misuse of medicines, poor infection control practices and global trade and travel.

This is a particular concern with antibiotics. Many of the medical advances in recent years, for example, organ transplantation and cancer chemotherapy need antibiotics to prevent and treat the bacterial infections that can be caused by the treatment. Without effective antibiotics, even minor surgery and routine operations could become high risk procedures if serious infections can't be treated.

The UK's 20-year vision and 5-year national action plan on AMR 2019-2024 were co-developed across government, its agencies, the health family and administrations in Scotland, Wales and Northern Ireland with support from a range of stakeholders. The national action plan builds upon the UK 5-year AMR strategy (2013 to 2018) and sets out the first step towards the UK's vision for AMR in 2040. It focuses on three key ways of tackling antimicrobial resistance:

- Reducing need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials; and
- Investing in innovation, supply and access

The plan also sets out key measures of success to ensure progress towards the 20-year vision which include:

- Halve healthcare associated Gram-negative blood stream infections
- Reduce the number of specific drug-resistant infections in people by 10% by 2025
- Reduce UK antimicrobial use in humans by 15% by 2024

Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

Antimicrobial Stewardship Team (AMST); governance and reporting

The Antimicrobial Stewardship Team consists of Dr Plant (Antimicrobial Clinical Lead) and 2 x 0.5WTE Lead Antimicrobial Pharmacists.

Governance and Reporting:

The AMST meet weekly and report monthly to the Medicines Management Group which is chaired by the Chief Medical Officer. The AMST also provides clinical governance support to the Outpatient Parenteral Antimicrobial Treatment (OPAT) team in the form of virtual ward-rounds and critical review of OPAT referrals from in-patients.

The Antimicrobial Pharmacists participates in a regional antimicrobial pharmacist forum and monthly meetings which feed into a national group.

A written report is provided to the Medicines Management Group, IPCC and to the Medicine and Surgical Divisional Quality Boards.

Clinical ward rounds:

There is a daily consultant microbiologist ward round Monday-Friday, and a weekly Clostridioides difficile ward round.

There are 3 antimicrobial stewardship time out ward rounds a week on ward 11, 1 and 4 as well as OPAT MDT described above.

Antimicrobial Stewardship Strategy 2023/2024:

The Trust has an Antimicrobial Strategy which provides a framework to support appropriate antimicrobial use across the organisation.

The Trusts Antimicrobial priorities into 2023/2024 include:

- A new Trustwide drug chart will be rolled out Spring 2023, the AMS team have completed a substantial revision that will enable the drug chart to be used as a tool to ensure appropriate antimicrobial review. A key priority of the team will be to ensure effective use of this drug chart
- The 2023/24 CQUIN for IV to PO switch is a key priority for the AMS team and IPC, data collection will be commencing in May 23
- Completing regular review of MicroGuide continues to be a key priority of the AMS team
- The team conduct bi-monthly point prevalence studies to assess the documentation of allergy, nature of allergy, documentation and indication of antibiotics on the drug chart
- The team continue to monitor, feedback and investigate the consumption of watch and reserve antibiotics.

AMST activity feedback 2022/23

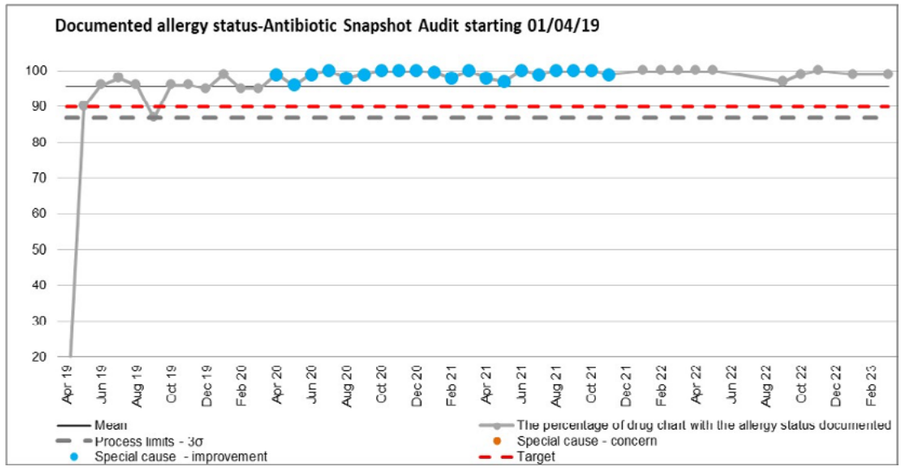
OPAT patients reviewed and associated cost savings 2022:

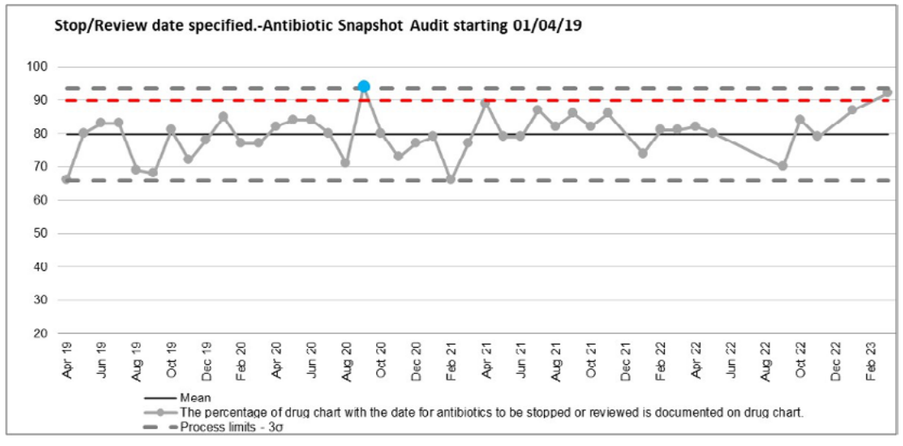
Month	SPA	CIT self	Allied	Acute	Acute	GP	Front D	A&E U	Days sa	Money	Total	new re	Curren
January	2	3	2	5	6	2		0	222	99,900	27	20	7
February	4	0	0	2	3	5		0	134	60,300	15	14	1
March	2	2	4	1	2	4		3	212	95,400	21	18	3
April	4	0	0	6	2	1		3	140	63,000	21	16	5
May	5	0	2	3	2	2		0	193	86,850	20	14	6
June	5	0	0	8	0	0		0	96	43,200	15	13	2
July	9	0	1	4	1	1		0	140	63,000	18	16	2
August	1	0	0	7	0	2		0	99	44,550	13	10	3
Septembe	1	1	1	8	6	1		2	131	58,950	22	20	2
October	4	1	0	4	3	4		0	184	82,800	18	16	2
Novembe	4	0	1	4	2	3		0	200	90,000	19	14	5
Decembe	0	1	0	6	1	3	2	1	214	96,300	20	14	6
Total	**41**	**8**	**11**	**0**	**28**	**28**	**2**	**9**	**1965**	**884,250**	**229**	**185**	**44**

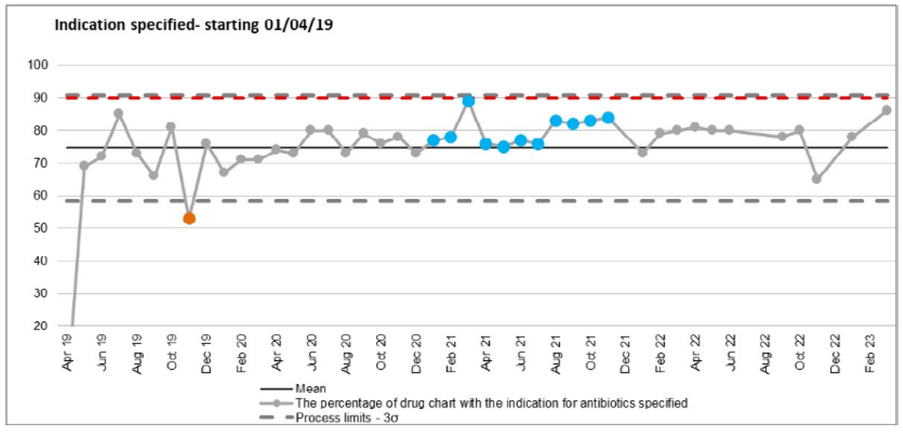
Results from 2022/23 Point Prevalence Audit

The AMST have 3 KPI's with regards to appropriate antimicrobial prescribing:

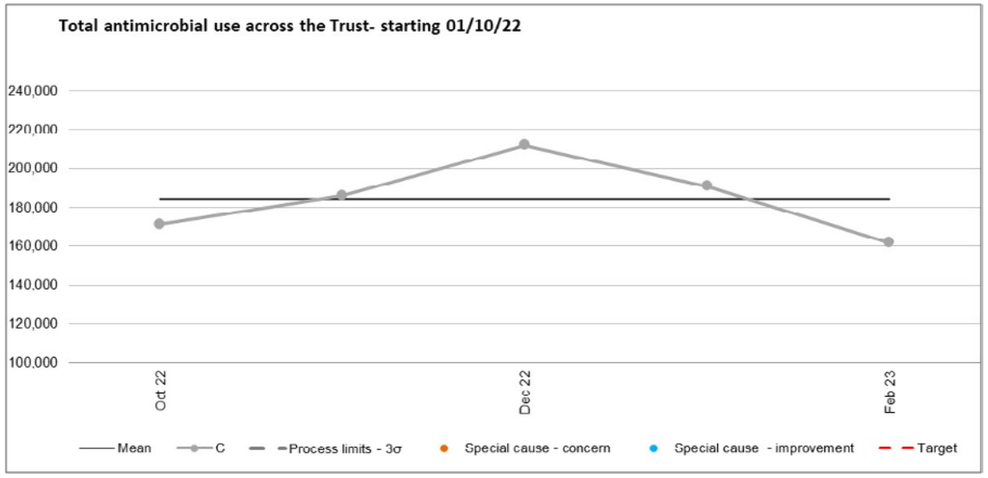
1. 100% of drug charts to have an allergy status
2. 90% of antibiotic prescriptions to have documented indication on the drug chart
3. 90% of antibiotic prescriptions to have a documented duration on the drug chart

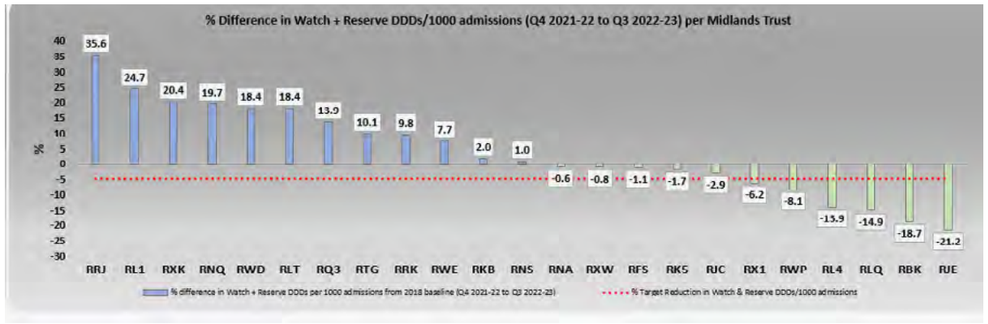




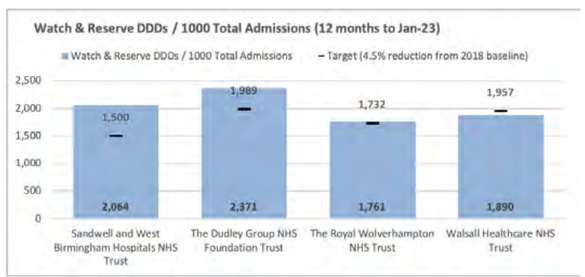


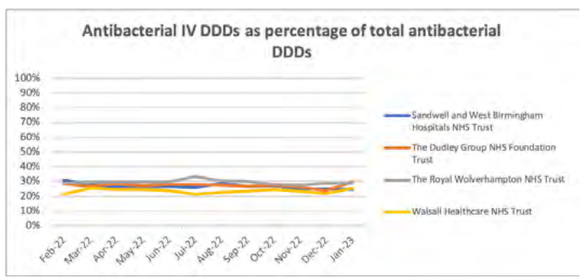
Antimicrobial consumption data:





Walsall's target to reduce Watch and Reserve is -4.5% from baseline, we are achieving -18.66%





Regional comparisons of consumption show high performance at Walsall for meeting the Watch and Reserve targets and favourable IV to PO switch ratios.

Quality Improvement Projects

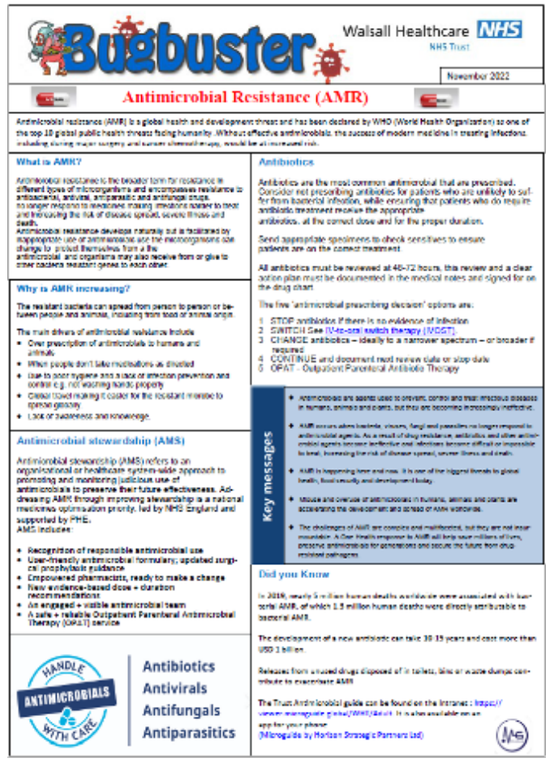
AMST have set up the following QI projects which are ongoing at the Trust:

UTI QI project: Multidisciplinary project involving junior doctors, AMS pharmacists, IPC nurse, consultant microbiologist, IPC nursing associate to improve the diagnosis and management of UTI at the Trust

CAP QI project: Multidisciplinary project involving junior doctors, ward pharmacists, AMS pharmacist, consultant microbiologist, IPC nursing associate to improve diagnosis and management of CAP on acute ward areas

In addition to the above mentioned workstreams a formalised program of teaching is in place for AMS for junior doctors, pharmacists, grand round , NMPs and community nurses, as well as teaching sessions on request for clinical teams.

The Infection Prevention Team and AMS team delivered bespoke education on Antimicrobial Stewardship in November to coincide with the international stewardship campaign. This included a promotional stand at the Trust and delivering direct 1:1 education with 70 members of clinical staff.



6.3. Water Safety group

The Water Safety Group provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring water related hazards are assessed and monitoring/control measures developed and instigated.

The aim of the Water Safety Group is to ensure the safety of all water used by patients, visitors, relatives and staff, to minimise the risk of infection associated with waterborne pathogens across WHT estate.

The Group meet on a monthly basis and work closely with the Infection Prevention & Control Team. The group's remit is to:

- Ensure the Water Safety Plan is reviewed.
- Review and action risk assessments and other associated documentation.
- Review new builds, refurbishments, modifications and equipment and ensure they are designed, installed, commissioned and maintained to the required standards.
- Ensure maintenance and monitoring procedures are in place.
- Surveillance of environmental monitoring, specifically in respect of determining water sampling requirements and agreeing location of augmented areas.
- Ensure augmented units within the Trust are tested monthly and results are reviewed and actioned as required.

The remit will include all elements as per Section 6.9 of Health Technical Memorandum 04-01 Part B 2016.

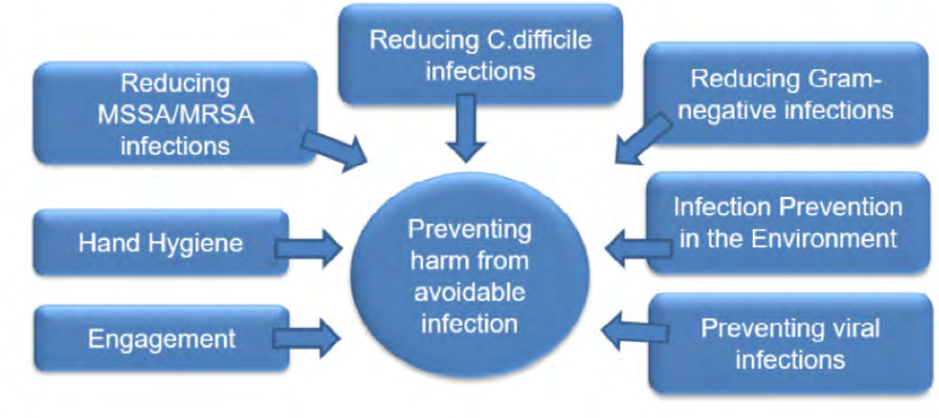
6.4. Assurance Framework for Infection Prevention and Control

The framework can be found in Appendix 3 and demonstrates the reporting structure for the IPCC.

7.0 Annual work plan 2022-23

An annual work plan runs throughout the financial year; it is prepared by the IPCT, agreed each year by the IPCC and approved by the Board. The programme for 2023-24 can be found in appendix 4.

The annual programme for 2022-23 had a set of strategic objectives which linked to the Hygiene Code:



Each strategic objective and actions have been reviewed to assess progress and objectives for the 2022-23 programme.

7.1 2022-23 Strategic Objective: Hand Hygiene

Most health care associated infections are preventable through good hand hygiene practices. The IPCT continues to promote hand hygiene standards throughout their programme of work and delivered an updated hand hygiene campaign during May 2022 to coincide with the World Health Organisation Hand Hygiene Day. This was combined with promotion of personal protective equipment with a particular focus on the Glove Aware campaign. This was delivered in collaboration with the Occupational Health Team to ensure the messages promoting reduction of glove use included the importance of skin health in health care workers in addition to messages of sustainability in preventing transmission of infection.

Hand hygiene audits are completed by the IPC team every quarter and reported to the IPCC. The observations last between 5 and 20 minutes and ward staff are not made aware the observations are being completed.

These observations are a snapshot of practice and may vary depending on workload, staffing levels, staff present in the department and number of staff observed. It can be difficult in some areas to observe whether hand hygiene takes place prior to or during some procedures and therefore observations are based on easily observed practice.

Audits throughout the financial year demonstrated sustained standards of hand hygiene amongst staff groups following educational campaigns from the IPC team and departmental level support provided. March 22 to December 22 showed sustained practice, however March 23 showed a decrease in performance.

The audit is based around the World Health Organisation (WHO) five moments of hand hygiene.

Comparison of Compliance scores from IPCT audits.

February 2023 released a revitalised campaign in collaboration with NHSE regional "Take your gloves off" strategy, preventing inappropriate use of gloves in clinical settings. The IPCT launched "reasons to fall out with gloves" which has expanded in to a wider supportive piece, where education has been provided during Sustainability Lunch Hour, Trust nursing and AHP forums, Grand Round and CDs meetings.

	Mar 22	June 22	Sept 22	Dec 22	Mar 2023
All Doctors	93%	97%	91%	90%	89%
Registered nurses	91%	97%	97%	95%	86%
Clinical support workers	95%	98%	99%	96%	86%
Students and cadets	93%	98%	96%	93%	85%
Other Staff	97%	99%	96%	96%	84%
Trust score	**94%**	**98%**	**96%**	**94%**	**86%**

7.2 2021-22 Strategic Objective: MSSA/MRSA Reduction

The IPC team provided education across clinical areas to prevent infections associated with indwelling devices. This included developing newsletters to teach staff on aseptic technique and best practice with indwelling devices and promoting educating with an up-to-date visual resource on visual infusion phlebitis (VIP) scoring. Face to face education on VIP scoring was provided to 202 clinical staff during the year with additional education provided during local audit cycles.

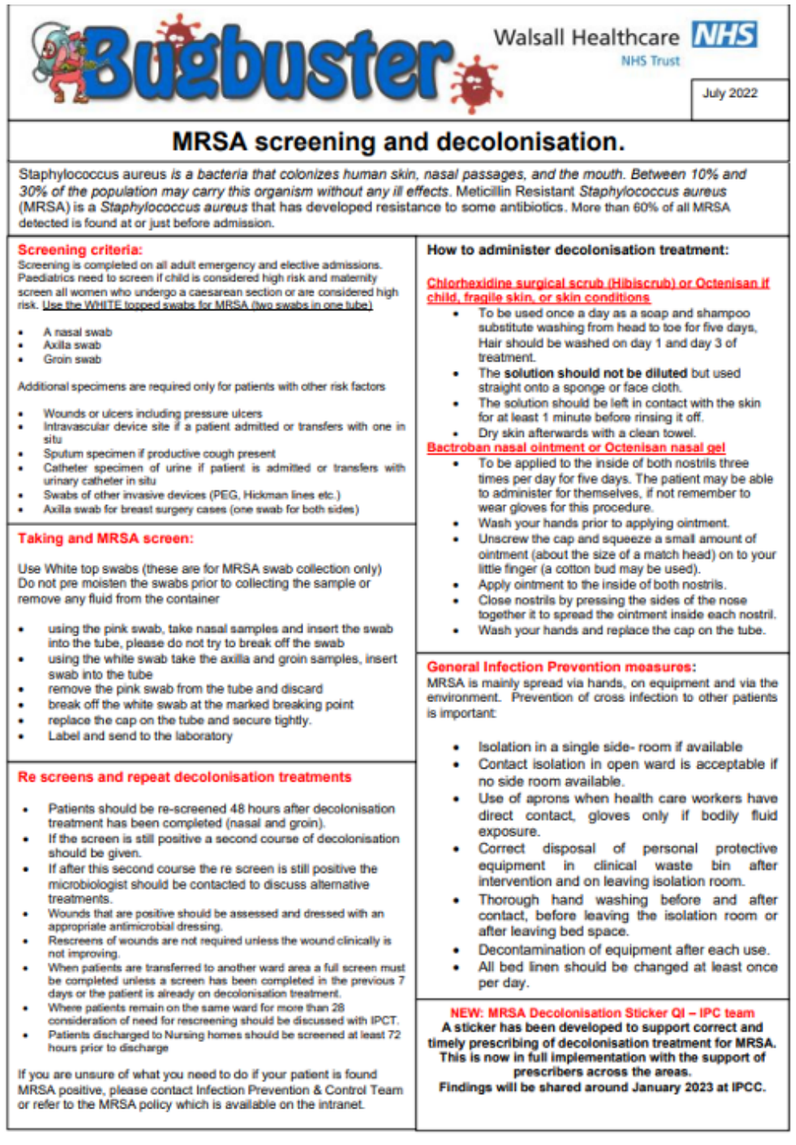
The IPCT incorporated MRSA screening and decolonisation education in the focus of the month theme. Face to face education on this topic was provided to 103 clinical staff during July 2022 with additional ad-hoc educational sessions provided as part of audit cycles.

7.3 2021-22 Strategic Objective: Surgical Site Infection (SSI) Surveillance

Members of the IPCT contribute with their expertise to the Trust SSI group, focusing on interventions based on NICE guidance and the One Together Framework. Outcomes of the group are presented to the IPCC. The surgical division also introduced a surgical site infection surveillance nurse to support with their improvement projects, supported by the IPC team.

The Trust Deputy DIPC is the chair of the Clinical Product Evaluation Group (CPEG); this group has commenced a variety of projects including introduction of products to improve elements to prevent the incidence of SSI, including antimicrobial sutures, patient temperature monitoring and patient perioperative warming strategies.

Further details on surgical site infection can be found in section 8 of the report.



Bugbuster — Walsall Healthcare NHS Trust — July 2022

MRSA screening and decolonisation.

Staphylococcus aureus *is a bacteria that colonizes human skin, nasal passages, and the mouth. Between 10% and 30% of the population may carry this organism without any ill effects.* Meticillin Resistant *Staphylococcus aureus* (MRSA) is a *Staphylococcus aureus* that has developed resistance to some antibiotics. More than 60% of all MRSA detected is found at or just before admission.

Screening criteria:

Screening is completed on all adult emergency and elective admissions. Paediatrics need to screen if child is considered high risk and maternity screen all women who undergo a caesarean section or are considered high risk. Use the WHITE topped swabs for MRSA (two swabs in one tube)

- A nasal swab
- Axilla swab
- Groin swab

Additional specimens are required only for patients with other risk factors

- Wounds or ulcers including pressure ulcers
- Intravascular device site if a patient admitted or transfers with one in situ
- Sputum specimen if productive cough present
- Catheter specimen of urine if patient is admitted or transfers with urinary catheter in situ
- Swabs of other invasive devices (PEG, Hickman lines etc.)
- Axilla swab for breast surgery cases (one swab for both sides)

Taking and MRSA screen:

Use White top swabs (these are for MRSA swab collection only) Do not pre moisten the swabs prior to collecting the sample or remove any fluid from the container

- using the pink swab, take nasal samples and insert the swab into the tube, please do not try to break off the swab
- using the white swab take the axilla and groin samples, insert swab into the tube
- remove the pink swab from the tube and discard
- break off the white swab at the marked breaking point
- replace the cap on the tube and secure tightly.
- Label and send to the laboratory

Re screens and repeat decolonisation treatments

- Patients should be re-screened 48 hours after decolonisation treatment has been completed (nasal and groin).
- If the screen is still positive a second course of decolonisation should be given.
- If after this second course the re screen is still positive the microbiologist should be contacted to discuss alternative treatments.
- Wounds that are positive should be assessed and dressed with an appropriate antimicrobial dressing.
- Rescreens of wounds are not required unless the wound clinically is not improving.
- When patients are transferred to another ward area a full screen must be completed unless a screen has been completed in the previous 7 days or the patient is already on decolonisation treatment.
- Where patients remain on the same ward for more than 28 consideration of need for rescreening should be discussed with IPCT.
- Patients discharged to Nursing homes should be screened at least 72 hours prior to discharge

If you are unsure of what you need to do if your patient is found MRSA positive, please contact Infection Prevention & Control Team or refer to the MRSA policy which is available on the intranet.

How to administer decolonisation treatment:

Chlorhexidine surgical scrub (Hibiscrub) or Octenisan if child, fragile skin, or skin conditions

- To be used once a day as a soap and shampoo substitute washing from head to toe for five days, Hair should be washed on day 1 and day 3 of treatment.
- The **solution should not be diluted** but used straight onto a sponge or face cloth.
- The solution should be left in contact with the skin for at least 1 minute before rinsing it off.
- Dry skin afterwards with a clean towel.

Bactroban nasal ointment or Octenisan nasal gel

- To be applied to the inside of both nostrils three times per day for five days. The patient may be able to administer for themselves, if not remember to wear gloves for this procedure.
- Wash your hands prior to applying ointment.
- Unscrew the cap and squeeze a small amount of ointment (about the size of a match head) on to your little finger (a cotton bud may be used).
- Apply ointment to the inside of both nostrils.
- Close nostrils by pressing the sides of the nose together it to spread the ointment inside each nostril.
- Wash your hands and replace the cap on the tube.

General Infection Prevention measures:

MRSA is mainly spread via hands, on equipment and via the environment. Prevention of cross infection to other patients is important:

- Isolation in a single side- room if available
- Contact isolation in open ward is acceptable if no side room available.
- Use of aprons when health care workers have direct contact, gloves only if bodily fluid exposure.
- Correct disposal of personal protective equipment in clinical waste bin after intervention and on leaving isolation room.
- Thorough hand washing before and after contact, before leaving the isolation room or after leaving bed space.
- Decontamination of equipment after each use.
- All bed linen should be changed at least once per day.

NEW: MRSA Decolonisation Sticker QI – IPC team

A sticker has been developed to support correct and timely prescribing of decolonisation treatment for MRSA. This is now in full implementation with the support of prescribers across the areas.

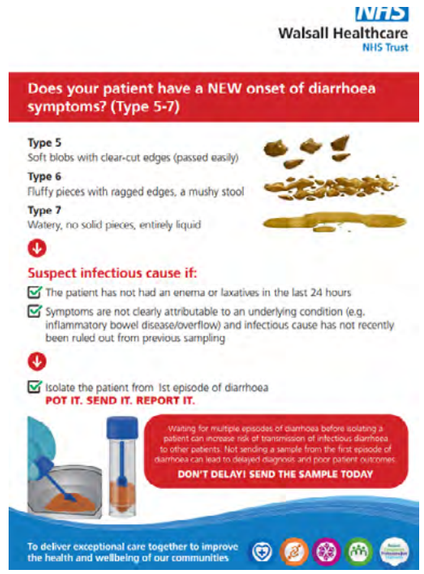
Findings will be shared around January 2023 at IPCC.

7.4 2021-22 Strategic Objective: C.difficile reduction

Themes from C.difficile post infection reviews are articulated from divisions at IPCC to share learning. Antimicrobial stewardship reports are shared monthly at IPCC, with AMS actions highlighted earlier in the report.

The IPCT deliver focused C.difficile education sessions across the acute hospital and community services on request and in response to C.difficile audit cycle following on from the initial focus campaign in quarter one.

Following a thematic analysis of C.difficile cases in January 2023, a C.diff event was organised and delivered by the IPCT to 63 clinical staff. The sessions focused on themes identified for learning across the organization. Excellent feedback was received and plans made for financial year 23-24 for further events. The thematic analysis also triggered an updated campaign on stool sampling, promoting to test on the first episode of type 5-7, to ensure patients with infectious diarrhoea are clinically managed as soon as possible for the best outcomes.



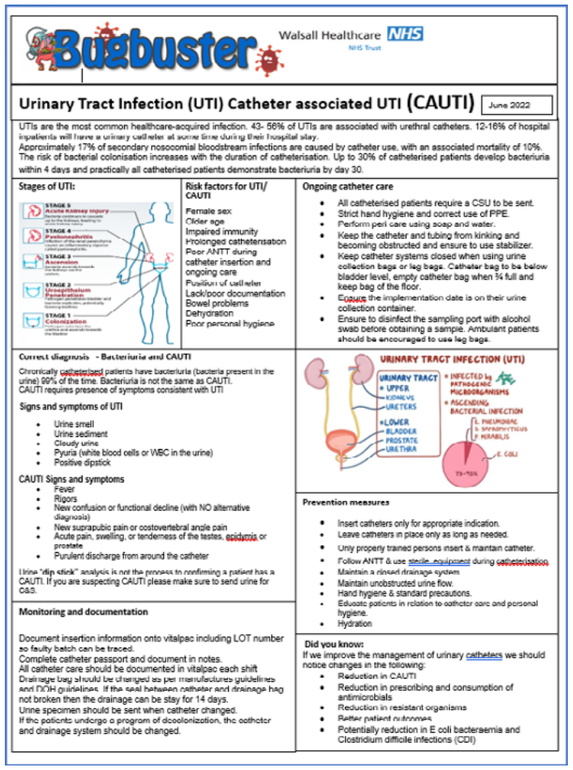
An MDT review is undertaken on a weekly basis between IPC, ward clinician, consultant microbiologist and antimicrobial pharmacist for current inpatients with C.difficile, to ensure the patient is receiving optimum treatment and correct measures are in place.

Further details of C.difficile cases throughout the financial year can be found in section 8 of the report.

7.5 2021-22 Strategic Objective: Gram-negative infection reduction

Different members of the IPCT are project leads focusing on reduction of Gram-negative infections, including urinary tract infections and healthcare acquired pneumonia. A procurement project has commenced on the use of new catheterisation packs, aiming to maintain asepsis and prevent breaches in asepsis through contamination of key parts.

In January 2023, bespoke education on mouth care was provided directly to 52 clinical members of staff, with additional education provided at a local level. A business case has been submitted for a mouth care team at the Trust, with an aim to reduce the incidence of hospital acquired pneumonia through an education delivery plan and dental expertise to support care planning.



Bugbuster — Walsall Healthcare NHS

Urinary Tract Infection (UTI) Catheter associated UTI (CAUTI) June 2022

UTIs are the most common healthcare-acquired infection. 43- 56% of UTIs are associated with urethral catheters. 12-16% of hospital inpatients will have a urinary catheter at some time during their hospital stay.
Approximately 17% of secondary nosocomial bloodstream infections are caused by catheter use, with an associated mortality of 10%.
The risk of bacterial colonisation increases with the duration of catheterisation. Up to 30% of catheterised patients develop bacteriuria within 4 days and practically all catheterised patients demonstrate bacteriuria by day 30.

Stages of UTI:

STAGE 5 Acute Kidney Injury
STAGE 4 Pyelonephritis
STAGE 3 Anaemia
STAGE 2 Cystitis/Urethritis/Prostatitis
STAGE 1 Colonization

Risk factors for UTI/ CAUTI

Female sex
Older age
Impaired immunity
Prolonged catheterisation
Poor ANTT during catheter insertion and ongoing care
Position of catheter
Lack/poor documentation
Bowel problems
Dehydration
Poor personal hygiene

Ongoing catheter care

- All catheterised patients require a CSU to be sent.
- Strict hand hygiene and correct use of PPE.
- Perform peri care using soap and water.
- Keep the catheter and tubing from kinking and becoming obstructed and ensure to use stabilizer.
- Keep catheter systems closed when using urine collection bags or leg bags. Catheter bag to be below bladder level, empty catheter bag when ¾ full and keep bag of the floor.
- Ensure the implementation date is on their urine collection container.
- Ensure to disinfect the sampling port with alcohol swab before obtaining a sample. Ambulant patients should be encouraged to use leg bags.

Current diagnosis - Bacteriuria and CAUTI

Chronically catheterised patients have bacteriuria (bacteria present in the urine) 99% of the time. Bacteriuria is not the same as CAUTI.
CAUTI requires presence of symptoms consistent with UTI

Signs and symptoms of UTI

- Urine smell
- Urine sediment
- Cloudy urine
- Pyuria (white blood cells or WBC in the urine)
- Positive dipstick

CAUTI Signs and symptoms

- Fever
- Rigors
- New confusion or functional decline (with NO alternative diagnosis)
- New suprapubic pain or costovertebral angle pain
- Acute pain, swelling, or tenderness of the testes, epididymis or prostate
- Purulent discharge from around the catheter

Urine "dip stick" analysis is not the process to confirming a patient has a CAUTI. If you are suspecting CAUTI please make sure to send urine for C&S.

URINARY TRACT INFECTION (UTI)

URINARY TRACT + UPPER: KIDNEYS, URETERS + LOWER: BLADDER, PROSTATE, URETHRA — * INFECTED by PATHOGENIC MICROORGANISMS * ASCENDING BACTERIAL INFECTION
1. PNEUMONIAE 2. SAPROPHYTICUS 3. MIRABILIS
E. COLI 75-95%

Prevention measures

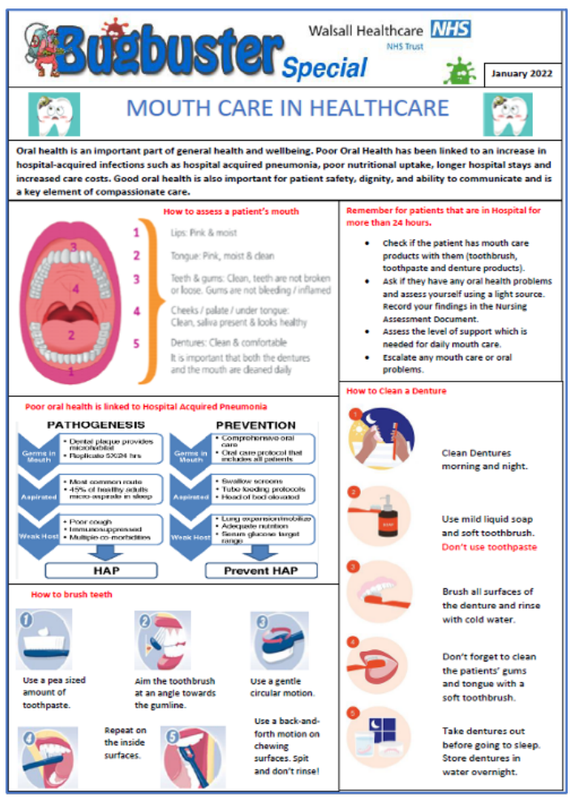
- Insert catheters only for appropriate indication.
- Leave catheters in place only as long as needed.
- Only properly trained persons insert & maintain catheter.
- Follow ANTT & use sterile equipment during catheterisation.
- Maintain a closed drainage system
- Maintain unobstructed urine flow.
- Hand hygiene & standard precautions.
- Educate patients in relation to catheter care and personal hygiene.
- Hydration

Monitoring and documentation

Document insertion information onto vitalpac including LOT number so faulty batch can be traced.
Complete catheter passport and document in notes.
All catheter care should be documented in vitalpac each shift
Drainage bag should be changed as per manufactures guidelines and DOH guidelines. If the seal between catheter and drainage bag not broken then the drainage can be stay for 14 days.
Urine specimen should be sent when catheter changed.
If the patients undergo a program of decolonization, the catheter and drainage system should be changed.

Did you know:
If we improve the management of urinary catheters we should notice changes in the following:

- Reduction in CAUTI
- Reduction in prescribing and consumption of antimicrobials
- Reduction in resistant organisms
- Better patient outcomes
- Potentially reduction in E coli bacteraemia and Clostridium difficile infections (CDI)



Bugbuster Special — Walsall Healthcare NHS — January 2022

MOUTH CARE IN HEALTHCARE

Oral health is an important part of general health and wellbeing. Poor Oral Health has been linked to an increase in hospital-acquired infections such as hospital acquired pneumonia, poor nutritional uptake, longer hospital stays and increased care costs. Good oral health is also important for patient safety, dignity, and ability to communicate and is a key element of compassionate care.

How to assess a patient's mouth

1. Lips: Pink & moist
2. Tongue: Pink, moist & clean
3. Teeth & gums: Clean, teeth are not broken or loose. Gums are not bleeding / inflamed
4. Cheeks / palate / under tongue: Clean, saliva present & looks healthy
5. Dentures: Clean & comfortable

It is important that both the dentures and the mouth are cleaned daily

Remember for patients that are in Hospital for more than 24 hours.

- Check if the patient has mouth care products with them (toothbrush, toothpaste and denture products).
- Ask if they have any oral health problems and assess yourself using a light source. Record your findings in the Nursing Assessment Document.
- Assess the level of support which is needed for daily mouth care.
- Escalate any mouth care or oral problems.

Poor oral health is linked to Hospital Acquired Pneumonia

	PATHOGENESIS	PREVENTION
Germs in Mouth	• Dental plaque provides microhabitat • Replicate 50/24 hrs	• Comprehensive oral care • Oral care protocol that includes all patients
Aspirated	• Most common route • 45% of healthy adults micro-aspirate in sleep	• Swallow screens • Tube feeding protocols • Head of bed elevated
Weak Host	• Poor cough • Immunosuppressed • Multiple co-morbidities	• Lung expansion/mobility • Adequate nutrition • Serum glucose target range
	HAP	Prevent HAP

How to brush teeth

1. Use a pea sized amount of toothpaste.
2. Aim the toothbrush at an angle towards the gumline.
3. Use a gentle circular motion.
4. Repeat on the inside surfaces.
5. Use a back-and-forth motion on chewing surfaces. Spit and don't rinse!

How to Clean a Denture

1. Clean Dentures morning and night.
2. Use mild liquid soap and soft toothbrush. Don't use toothpaste
3. Brush all surfaces of the denture and rinse with cold water.
4. Don't forget to clean the patients' gums and tongue with a soft toothbrush.
5. Take dentures out before going to sleep. Store dentures in water overnight.

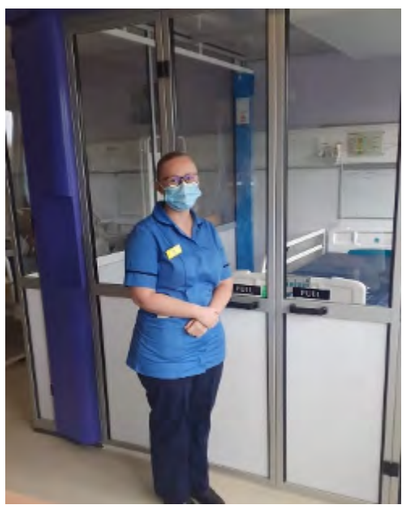
7.6 2021-22 Strategic Objective: Infection Prevention in the Environment

On 14th April 2022, 134 Rediair units were delivered and installed at the Trust.

Rediair is an instant air purification device. Capturing particulates, odours and 99.995% of airborne pathogens. The units have dual HEPA 14 and carbon filters.

Following installation, a qualitative assessment of staff feedback was undertaken with positive results, including staff feeling that the Trust were investing in their safety at work. This encompassed an improvement project led by the Infection Prevention and Control team on "What's your IaQ?- improving indoor air quality". This was a poster presentation at the National Infection Prevention Society conference and with wider invites to present at a National Decontamination conference.

In Quarter 1 of 2022-23, installation of 9 Bioquell segregation pods had taken place across the modular block and acute medical unit. This increased capacity to isolate patients with different infections but continues to enable visibility of patients.



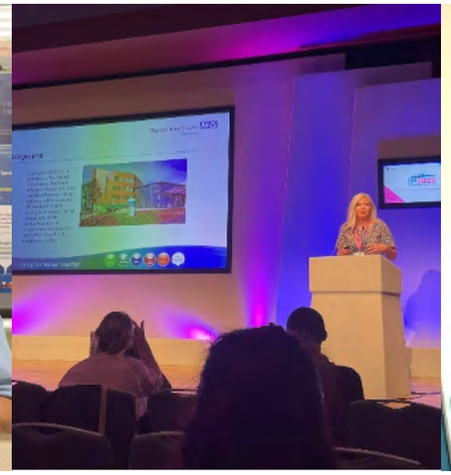
The IPCT have been supporting divisions and estates teams with refurbishment projects across the Trust to improve environmental IPC standards, including for maternity, Wards 16 and 17. IPCT influence for the wards enabled improved spacing between beds to reduce risk associated with droplet/aerosol transmission and bathrooms within bays to reduce risk associated with enteric transmission, in addition to an overall improvement to the fabric of the estate to enhance IPC standards.

Throughout the financial year, members of the IPCT were involved throughout each stage of project work for the new Urgent Emergency Care Centre (UECC). Benefits of the new building for infection prevention include:

- A decontamination suite and isolation facility in the new ED for patients presenting with high consequence diseases (HCID)
- Ability to isolate multiple patients when they first present to hospital whilst still maintaining high visibility of patients
- Optimal mechanical ventilation systems to support isolation for patients presenting with infections and positive pressure rooms for protective isolation
- HTM compliant hand wash basins with minimal splash and Rada sensor taps, enabling frequent flushing of water outlets
- State of the art sampling hatches between bathrooms and dirty utility facilities
- Improved spacing in open bays with contained en-suite facilities and all single rooms in AMU having en-suite bathrooms, improving isolation precautions

An NHSE visit was undertaken at the Trust in July 2022; the overall rating for the Trust has changed from "Amber" to "Green", recognising the significant environmental improvements as part of the refurbishments and engagement and consistent improvements made throughout clinical areas attended during the review.

In October and November 2022, IPCT and GAMA Healthcare provided face to face education on principles of cleaning equipment to clinical areas, directly training 91 clinical staff members. Education was provided at department level on principles of cleaning by the IPCT as part of audit cycles.



7.7 2021-22 Strategic Objective: Engagement

Members of the IPCT fit into the Trust divisional structure to provide support and continuity in improvement cycles, developing key working relationships to support improvement. The IPC nurses were highly praised during the NHSE infection prevention review where the IPC team were spoken highly of for their support and leadership.

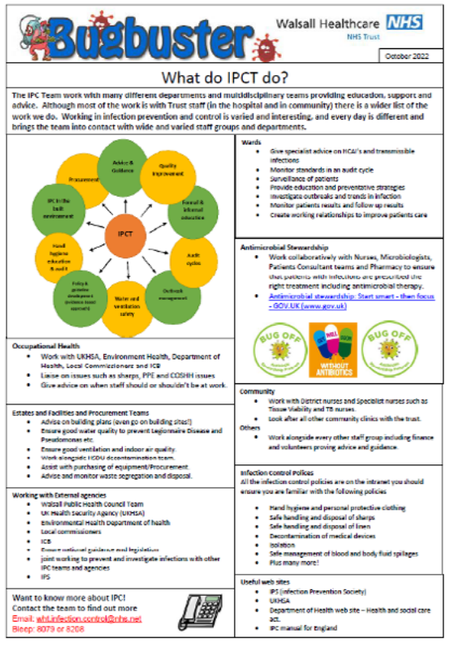
The team provided certificates and positive recognition to individual Trust colleagues as "IPC Hero of the Month" for role modelling high infection prevention standards within their local areas.

A "focus of the month" from the team incorporated a campaign to promote what an Infection Prevention and Control Team does, to increase understanding of the diverse role and the value the expertise provides towards patient safety.

In December 2022, the IPCT launched a weekly IPC update, incorporating 5 key messages for dissemination across the Trust. These are shared via email to senior Trust colleagues and key stakeholders to support cascading key IPC messages and promoting everyone's responsibility in infection prevention and control. Messages are based on key National campaigns, local events, or in response to recent learning identified in HCAI investigations.

The team worked closely with Patient Experience colleagues throughout the COVID-19 pandemic to support a safe process of visiting healthcare settings with a holistic balance of meeting patient and loved ones need for their mental health and wellbeing. This work was presented by the Deputy DIPC at the Infection Prevention Society National conference in October 2022.

Members of the IPCT have all contributed to NHSE regional collaborative groups, including C.difficile, SSIs, Gram-negatives, bare below the elbows, and National education strategies.


Bugbuster
Walsall Healthcare NHS
NHS Trust
October 2022

What do IPCT do?

The IPC Team work with many different departments and multidisciplinary teams providing education, support and advice. Although most of the work is with Trust staff (in the hospital and in community) there is a wider list of the work we do. Working in infection prevention and control is varied and interesting, and every day is different and brings the team into contact with wide and varied staff groups and departments.

IPCT

Wards
- Give specialist advice on HCAI's and transmissible infections
- Monitor standards in an audit cycle
- Surveillance of patients
- Provide education and preventative strategies
- Investigate outbreaks and trends in infection
- Monitor patients results and follow up results
- Create working relationships to improve patients care

Antimicrobial Stewardship
- Work collaboratively with Nurses, Microbiologists, Patients Consultant teams and Pharmacy to ensure that patients with infections are prescribed the right treatment including antimicrobial therapy.
- Antimicrobial stewardship: Start smart – then focus - GOV.UK (www.gov.uk)

BUG OFF
WHO NOW
WITHOUT ANTIBIOTICS
BUG OFF

Occupational Health
- Work with UKHSA, Environment Health, Department of Health, Local Commissioners and ICB
- Liase on issues such as sharps, PPE and COSHH issues
- Give advice on when staff should or shouldn't be at work.

Community
- Work with District nurses and Specialist nurses such as Tissue Viability and TB nurses.
- Look after all other community clinics with the trust.

Others
- Work alongside every other staff group including finance and volunteers proving advice and guidance.

Estates and Facilities and Procurement Teams
- Advise on building plans (even go on building sites!)
- Ensure good water quality to prevent Legionnaire Disease and Pneumonoses etc
- Ensure good ventilation and indoor air quality
- Work alongside HCDU decontamination team.
- Assist with purchasing of equipment/Procurement
- Advise and monitor waste segregation and disposal.

Infection control Policys
All the infection control policies are on the intranet you should ensure you are familiar with the following policies
- Hand hygiene and personal protective clothing
- Safe handling and disposal of sharps
- Safe handling and disposal of linen
- Decontamination of medical devices
- Isolation
- Safe management of blood and body fluid spillages
- Plus many more!

Working with External agencies
- Walsall Public Health Council Team
- UK Health Security Agency (UKHSA)
- Environmental Health Department of Health
- Local commissioners
- ICB
- Ensure national guidance and legislation
- Joint working to prevent and investigate infections with other IPC teams and agencies
- IPS

Useful web sites
- IPS (Infection Prevention Society)
- UKHSA
- Department of Health web site – Health and social care act.
- IPC manual for England

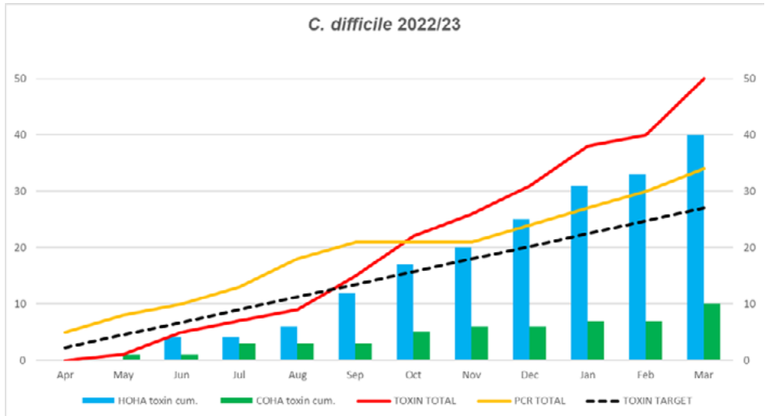
Want to know more about IPC!
Contact the team to find out more
Email: wht.infection.control@nhs.net
Bleep: 8079 or 8268

8.0 Hospital acquired infections

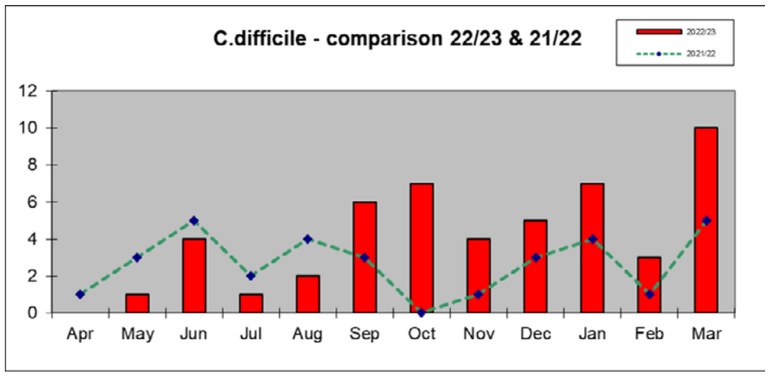
Each year, the Trust is set objectives from NHS England and Improvement for health care associated infections. Below details the Trust performance against the target set and further local surveillance data for HCAIs.

8.1 Clostridioides difficile

The graphs below identify Clostridioides difficile that are Toxigenic producing with a specimen that falls under the Hospital-onset Healthcare-associated (HOHA) or Community-onset Healthcare-associated (COHA) between April 2022 and March 2023 at Walsall Healthcare NHS Trust.



The Trust carries out reviews of all HOHA and COHA C.difficile cases and a multidisciplinary review is undertaken to investigate cases where new lessons can be learnt. These are reported to the divisional meetings and at IPCC.



The graph shows the differences in cases between financial year 2021/22 to 2022/23.

Between April 2022 and March 2023 there have been 50 cases confirmed of HOHA (40) and COHA (10) C.difficile Toxins against annual trajectory of 27.

Total HOHA/COHA CDI cases	50
Avoidable	19
Unavoidable	31

Avoidable cases

- 10 deemed inappropriate acute prescribing of antibiotics
- 13 community onsets with delay in obtaining specimens, which led to meeting the acute acquired criteria
- 4 cases with the same ribotype (002); linked with two separate period of increased incidence report

Common Trends in Risk Factors

- Multiple antibiotics within last 6 weeks
- Over 65
- Proton Pump Inhibitor (PPI)
- Previous history of C. difficile

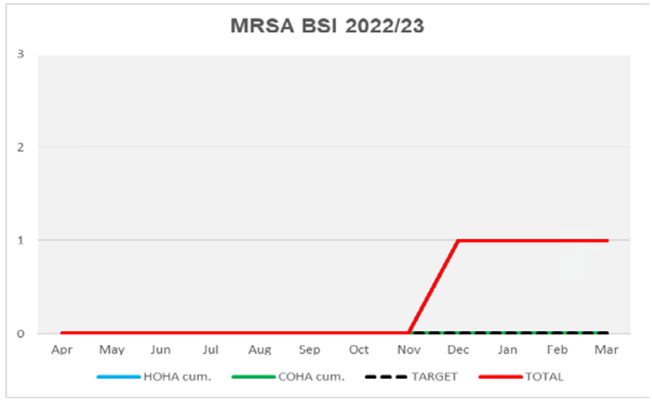
Trend issues and learning in the Trust from avoidable cases

- Delay in sending specimens for C. difficile testing
- Failure to isolate patients when specimens were obtained (due to unavailable isolation facilities, these are captured in incident reports).
- Failure or delay in sending clinical specimens to confirm correct antibiotic therapy / confirmation of infective organism
- Inconsistent review of antibiotic therapy
- Absence of CURB-65 scoring when prescribing for community acquired pneumonia
- Unable to complete a full decant deep clean programme in areas where C.difficile was more endemic

Actions for preventing C.difficile are previously highlighted in the report. Latest learning from cases is incorporated into actions for the 2023-24 annual programme of work.

8.2 Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia

There was one case of MRSA blood stream infection attributed to the Trust during 2022/23 against a National target of 0.



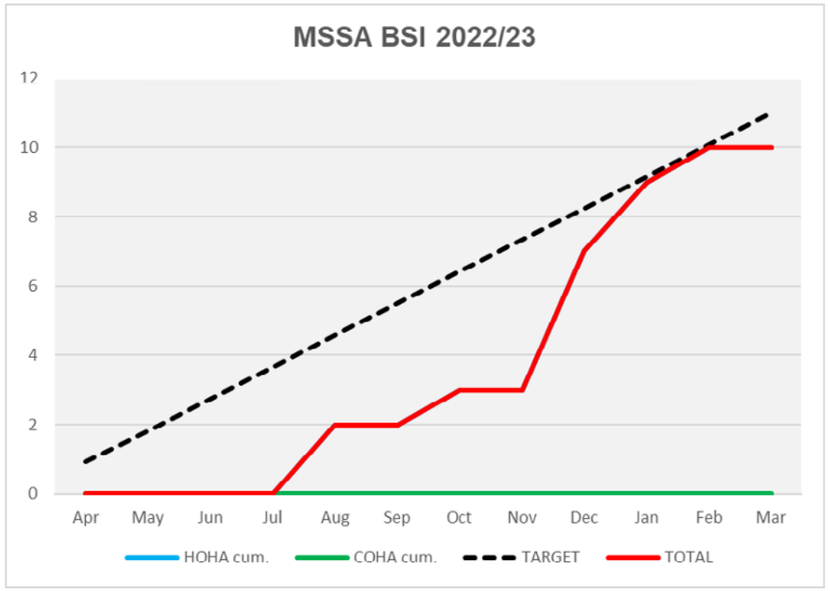
Root cause

Blood culture contaminate.

There has been 1 MRSA bacteraemia this financial year, confirmed in December 2022. This was attributed to maternity services. The patient had been in hospital for 2 days prior to obtaining blood cultures. The post infection review highlighted blood culture contaminate as source of result. This is incorporated into a business case for the implementation of a 24/7 blood culture phlebotomy service in addition to local actions with aseptic technique competencies to prevent the incidence of blood culture contaminates.

8.3 Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia

A total of 10 HOHA and COHA cases were reported in 2022/23 compared to 6 reported 2021/22. There are no set trajectories externally for MSSA bacteraemias.



This represents an increase in cases by 4 in this financial year.

The IPCT aims to maintain low rates of MSSA BSIs and investigate all cases to ascertain if there are further actions that can be taken. Performance of MSSA bacteraemia continues to be monitored at the Infection Prevention and Control Committee.

All cases are reviewed on an individual basis to identify the cause and if there are any lessons to be learnt.

Total HOHA/COHA MSSA	12
Avoidable	1
Unavoidable	11

Root cause of avoidable case:

Source of infection not established.

- VIP scoring not completed 8 hourly
- Not all indwelling devices recorded on vital-pac
- Delay in MRSA admission screen
- Patient with long term catheter poor documentation, urine sample not completed at time of admission.

8.4 E. coli bacteraemia

Reporting of E. coli bacteraemia has been mandatory since June 2011. All cases are reviewed, and a tabletop review completed if the patient dies, and E. coli is indicated as a cause of death or areas of concern are identified during the review.

The national Target for the Trust was 50 for 202/23.

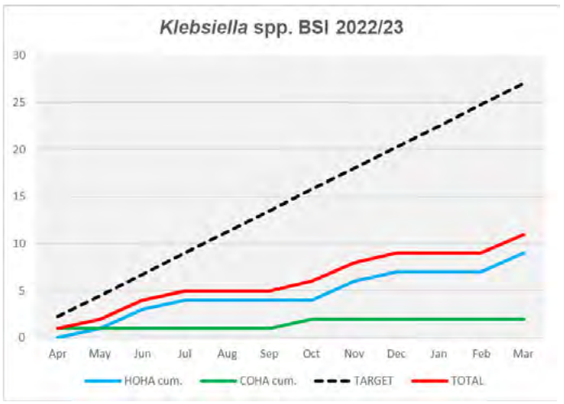
There were a total of 50 cases, 30 HOHA and 23 COHA of E. coli bacteraemia in 2022/23. All cases are reviewed on an individual basis regarding cause. If there are any lessons to be learnt including whether these could have been avoided, these are shared across Walsall Healthcare NHS Trust.

8.5 Klebsiella species

Reporting of Klebsiella Species bacteraemia has been mandatory since April 2017 a national target for the Trust in 2022/23 was 27.

During 2022/23 the Trust reported 11 cases, 9 HOHA and 2 COHA.

All cases are reviewed and a table top review completed if the patient dies and this organism is indicated as a cause of death or areas of concern are identified during the review.

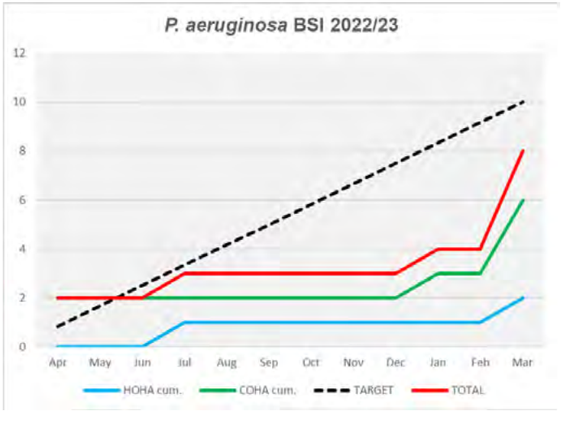


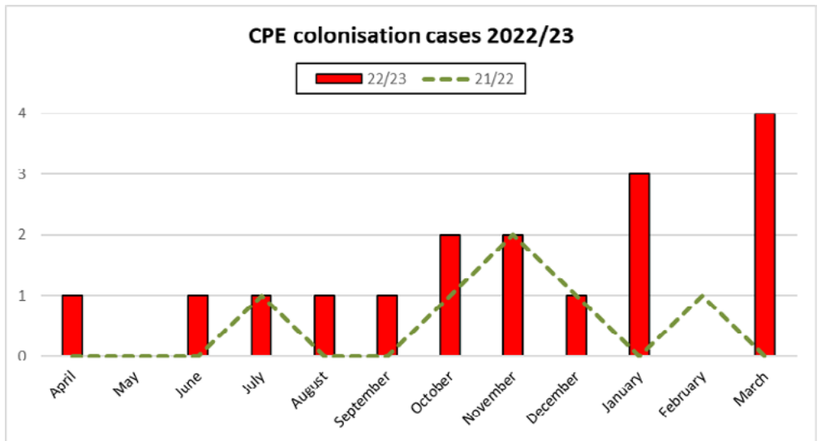
8.6 Pseudomonas

Reporting of Pseudomonas aeruginosa bacteraemia has been mandatory since April 2017 and the national target for 2022/23 was 10.

A total of 8 cases were reported, 2 HOHA and 6 COHA.

The proactive work of the Water Safety Group helps to support prevention of Pseudomonas bacteraemias.





8.7 Carbapenemase-producing Enterobacterales (CPE)

CPE is considered a high-risk transmission hazard and in healthcare settings can lead to poor clinical outcomes due to limited therapeutic options.

Increased incidence of CPE has significant cost and operational implications for healthcare providers. The Trust closely monitor for CPE by undertaking screening based on risk factors to promptly identify and isolate patients who are colonised with the organism. The current screening process is culture-based method. A total of 17 CPE cases were identified compared to 6 in 2021/2022. 4 cases were deemed HCAI colonisation cases.

Bespoke education on CPE was provided by the IPCT following increased prevalence being observed, focusing on admitting areas of the Trust to ensure patients were being screened with risk factors for CPE colonisation.

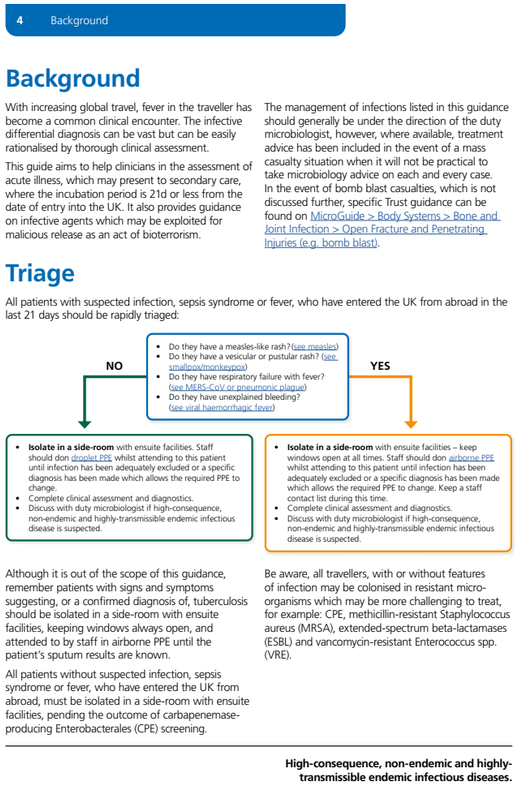
8.8 Other Infectious Diseases

Following changes to COVID-19 restrictions in the wider community, there has been an increase in notifications from UKHSA of other non-endemic infectious diseases, particularly of note Mpox during summer 2022. The IPCT prepared the organisation for the event of caring for a patient with Mpox when initially classed as a HCID and when this was stepped down by UKHSA. The Trust eventually did not manage a patient with Mpox.

Mpox Actions

- Action card prepared and distributed across the Trust.
- IPCT provided face to face briefings with front facing staff to advise on management of suspected cases
- Fit testing support provided to sexual health services and community teams in addition to current provisions at the Trust
- Consultant microbiologist provided education at Grand Round in May 2022
- IPCT attended twice weekly NHSE briefings for update and communicate at Trust level of any updates

Other alerts from UKHSA included a rise in diptheria cases presenting. In the run up to the Commonwealth games in Birmingham and a preparedness piece with the EPRR team, Consultant Microbiologist, Deputy DIPC and Lead Nurse developed an Infectious Disease Manual for Trust staff to use as a quick reference point. This has proven helpful in responsiveness to different alerts and has been shared via the wider regional infection prevention group.


4 Background

Background

With increasing global travel, fever in the traveller has become a common clinical encounter. The infective differential diagnosis can be vast but can be easily rationalised by thorough clinical assessment.

This guide aims to help clinicians in the assessment of acute illness, which may present to secondary care, where the incubation period is 21d or less from the date of entry into the UK. It also provides guidance on infective agents which may be exploited for malicious release as an act of bioterrorism.

The management of infections listed in this guidance should generally be under the direction of the duty microbiologist, however, where available, treatment advice has been included in the event of a mass casualty situation when it will not be practical to take microbiology advice on each and every case. In the event of bomb blast casualties, which is not discussed further, specific Trust guidance can be found on MicroGuide > Body Systems > Bone and Joint Infection > Open Fracture and Penetrating Injuries (e.g. bomb blast).

Triage

All patients with suspected infection, sepsis syndrome or fever, who have entered the UK from abroad in the last 21 days should be rapidly triaged:

- Do they have a measles-like rash? (see measles)
- Do they have a vesicular or pustular rash? (see smallpox/monkeypox)
- Do they have respiratory failure with fever? (see MERS-CoV or pneumonic plague)
- Do they have unexplained bleeding? (see viral haemorrhagic fever)

NO

- **Isolate in a side-room** with ensuite facilities. Staff should don droplet PPE whilst attending to this patient until infection has been adequately excluded or a specific diagnosis has been made which allows the required PPE to change.
- Complete clinical assessment and diagnostics.
- Discuss with duty microbiologist if high-consequence, non-endemic and highly-transmissible endemic infectious disease is suspected.

YES

- **Isolate in a side-room** with ensuite facilities – keep windows open at all times. Staff should don airborne PPE whilst attending to this patient until infection has been adequately excluded or a specific diagnosis has been made which allows the required PPE to change. Keep a staff contact list during this time.
- Complete clinical assessment and diagnostics.
- Discuss with duty microbiologist if high-consequence, non-endemic and highly-transmissible endemic infectious disease is suspected.

Although it is out of the scope of this guidance, remember patients with signs and symptoms suggesting, or a confirmed diagnosis of, tuberculosis should be isolated in a side-room with ensuite facilities, keeping windows always open, and attended to by staff in airborne PPE until the patient's sputum results are known.

All patients without suspected infection, sepsis syndrome or fever, who have entered the UK from abroad, must be isolated in a side-room with ensuite facilities, pending the outcome of carbapenemase-producing Enterobacterales (CPE) screening.

Be aware, all travellers, with or without features of infection may be colonised in resistant micro-organisms which may be more challenging to treat, for example: CPE, methicillin-resistant Staphylococcus aureus (MRSA), extended-spectrum beta-lactamases (ESBL) and vancomycin-resistant Enterococcus spp. (VRE).

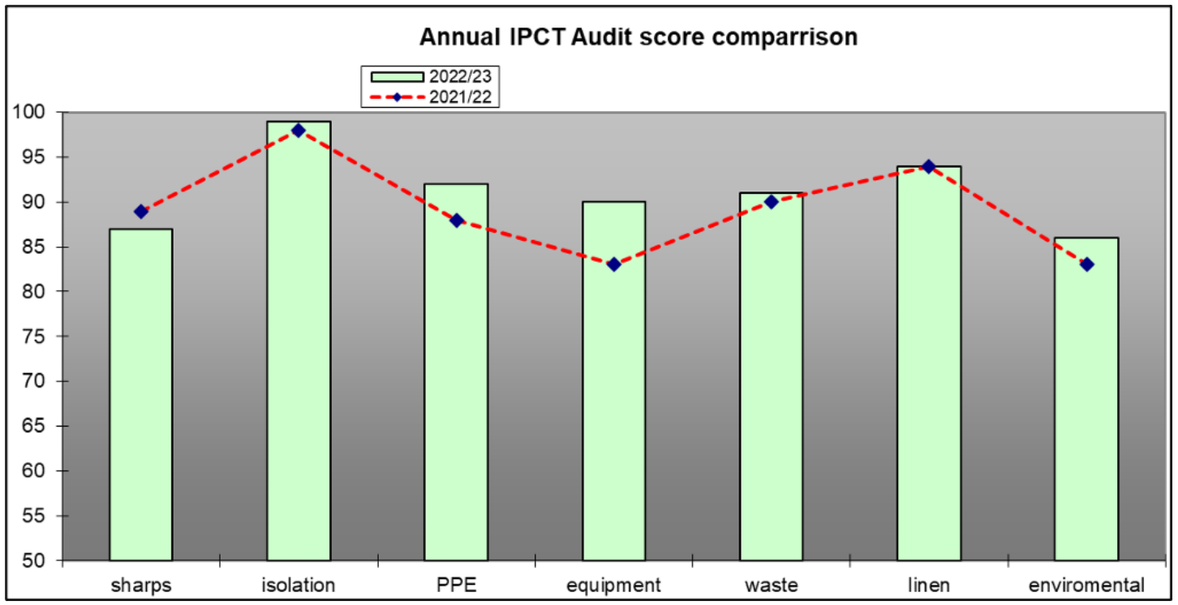
9.0 Acute Services Infection Prevention audits

The following IPC audits were undertaken during quarter one of 2022/2023 covering the acute settings. A comparison to similar audits undertaken during the previous year is provided in the table below.

Audit	2022/2023	2021/2022	Trajectory
Sharps	87	89	⬇
Isolation	99	98	⬆
PPE	92	88	⬆
Equipment	90	83	⬆
Waste	91	90	⬆
Linen	94	94	➡
Environmental	86	83	⬆

Audit results are shared with Divisional Directors of Nursing and are reported to and discussed at Infection Prevention and Control Committee and Divisional Quality and Safety meetings.

Any non-compliance is fed back to the area at the time of audit. These are the planned audits – areas are monitored daily by the IPC team as well as reactive audits completed to support further escalation and improvement.



Since completion of these audits, escalation occurred through IPCC and captured in reports to the Trust board through the IPC BAF to improve environmental issues identified in the audit. Since this, further ward refurbishments have been completed with a plan for further refurbishment in 2023-24 financial year.

The Trust is currently rated Green by NHS England and Improvement for Infection Prevention and Control. The Trust received very positive feedback for progress in standards of IPC which granted the green score from previous amber in 2021/2022.

10 Outbreaks

The IPCT recognises and responds to any significant episode, incident or outbreak of infection. Incidents and outbreaks may be reported in several different ways: by the clinical areas, through microbiology results and IPC visits to the ward. All outbreaks and incidents are included in the IPCT monthly reports and reported via the Infection Prevention and Control Committee.

Outbreaks of Healthcare Associated Infection are reported via the Trust's incident reporting arrangements as serious incidents. An outbreak report is also prepared for the Infection Prevention and Control Committee for significant outbreaks to ensure any relevant lessons are learnt. An outbreak committee is convened to manage and monitor the situation.

Outbreaks of infection, for example Norovirus, influenza, CPEs or periods of increased incidence of Clostridioides difficile are classified as serious incidents and reported on the serious incident reporting system STEIS. A full investigation and 50-day report is subsequently submitted.

The team delivered a variety of winter preparedness webinars and face to face educational sessions in November 2022, to encompass preparedness for COVID-19 outbreaks, Influenza and Norovirus. These were delivered by the Deputy DIPC and Consultant Microbiologist, with accessibility to the resources after the webinars for any staff members.

Norovirus

1 ward closure and 27 bay closures due to Norovirus.

Learning from Norovirus outbreaks included:

- Education to clinical staff to reiterate measures required to prevent transmission of Norovirus and to consider Norovirus testing when a patient presents with symptoms.
- Going back to basics with management of enteric risk.

Influenza

No ward closures and 30 bay closures due to Influenza A/B.

RSV

No ward closures and 2 bay closures within paediatrics.

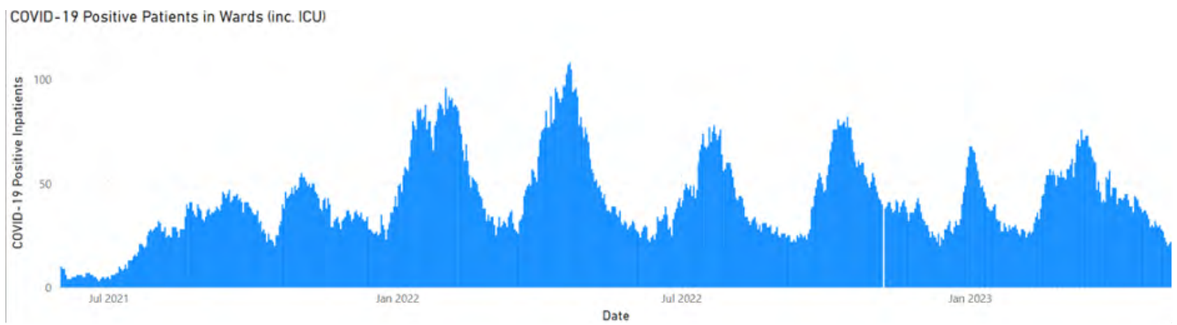
COVID-19

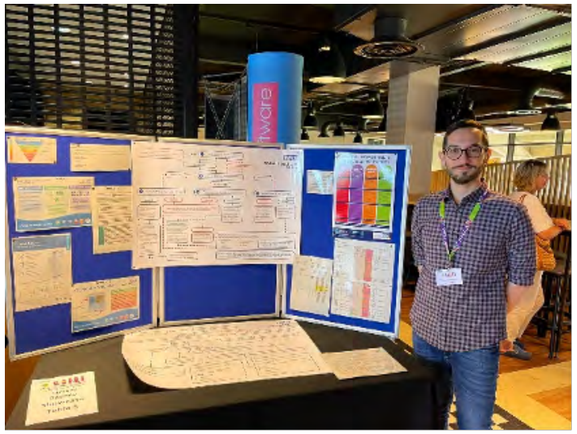
8 ward closures and 305 bay closures due to COVID19 positives in bay and contact monitoring.

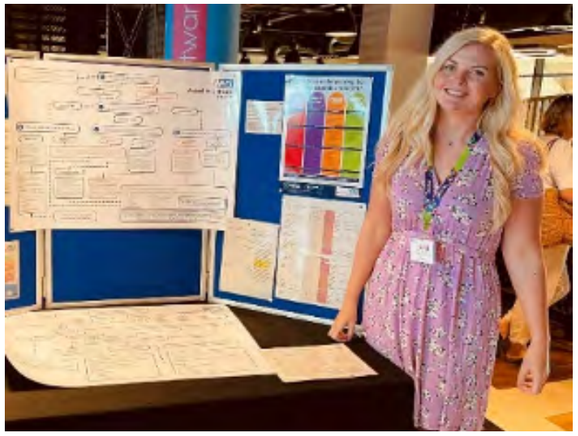
The Trust followed National guidance regarding precautions that needed to be taken to prevent the spread of the virus and updated internal risk assessment and guidance accordingly.

The infection prevention and control team increased the service by providing additional cover over weekends and since July 2022 now provides one Senior IPC Nurse on-site during weekends.

The IPC team supported the Trust and clinical areas with management of patients, providing data required for the National Sitrep and attending tactical meetings (both in the acute and the Community), responding to actions required accordingly.

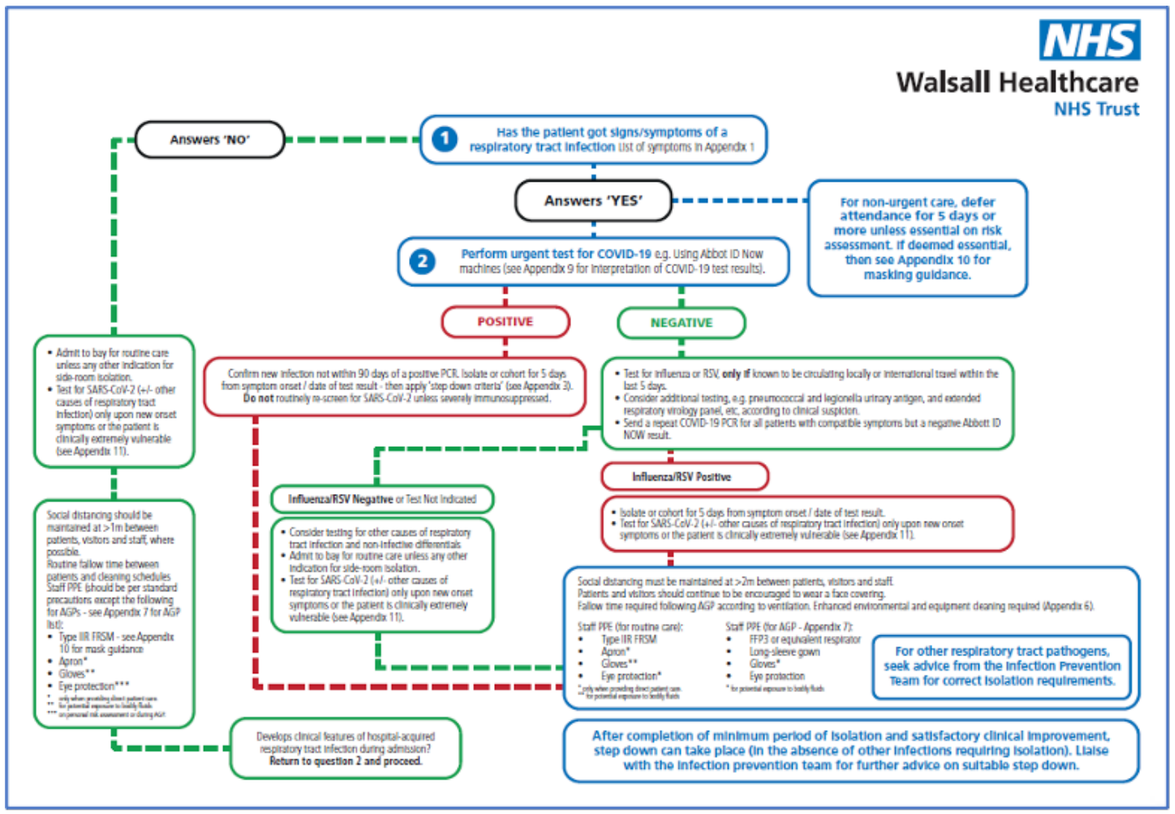






Compliance with standards to prevent transmission of COVID-19 is monitored by the Infection Prevention and Control Team by undertaking assurance audits of practice in different Walsall Healthcare settings based on the standards set out in updated National guidance. A full review of COVID-19 precautions is undertaken through the IPC BAF and this is presented monthly to IPCC. Items for escalation from the BAF are reported to QPES.

The Infection Prevention Team responded to any updates to guidance with a comprehensive multidisciplinary risk assessment with colleagues at Royal Wolverhampton NHS Trust. Updates were made to respiratory pathways which had been recognised regionally as good practice and showcased at regional and National conferences. Other Trusts in the UK have since adopted this pathway to assist in quick decision making.



11.0 Surgical Site Infections (SSI)

In 2004 it became a mandatory requirement for all Trusts undertaking orthopaedic surgery to conduct surveillance of surgical site infections, using the Surgical Site Infection (SSI) Surveillance Service of UKHSA. The data set collected as part of the surveillance is forwarded to UKHSA for analysis and reporting. Surveillance is divided into reporting quarters (Jan-Mar, Apr-Jun, July-Sept and Oct-Dec) and each site is required to participate in at least one surveillance period every 12 Months in at least one orthopaedic category.

In 2022/23 the Trust completed one quarter mandatory surveillance.

Reporting Period: October 2022 – December 2022

Modules completed: Total Hip Replacements and Total Knee Replacements

Operation	Total no of cases	Surgical Site infections
Total knee replacement	28	0
Total hip replacement	26	0
Total	**27**	**0**

12.0 Education

Education remains a core element of the work of the Infection Prevention & Control Team in both hospital and community settings.

The IPCT contribute to the Trust Induction and mandatory updates and a range of planned and bespoke education sessions whenever a specific need arises. These included junior medical staff inductions, sessions for medical and nursing students and intravenous line care.

The IPCT provided bespoke educational sessions through a variety of forums throughout 2022-23, including at Grand Round, Matrons Forums, Ward Managers Forums and at local department level. Sessions focused on contemporary IPC practice and demonstrating current evidence base to rationalise policies and procedures.

The team delivered a "Focus of the month" campaign as part of the annual programme of work which includes educational sessions face to face in clinical departments. The following topics were covered:

- Changes to COVID-19 testing and management
- Glove Awareness
- Hand Hygiene
- Winter preparedness
- Antimicrobial resistance and stewardship
- Sepsis
- MRSA
- Mouthcare
- Urinary Tract Infection prevention
- What the IPCT do
- Aseptic non-touch technique
- Peripheral IV access
- Spring into cleaning

Appendix 1

INFECTION PREVENTION AND CONTROL GROUP

TERMS OF REFERENCE: Version 2 – Reviewed June 2022

RATIFIED BY THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE ON: July 2022

NEXT REVIEW DUE: June 2023

1. CONSTITUTION

1.1 The Quality, Patient Experience and Safety Committee hereby resolve to establish a sub group of the Committee to be known as the Infection Prevention and Control Group (The Group). The Group is an executive group of the Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. PURPOSE

2.1 The purpose of this group is to provide strategic direction for the prevention and control of Healthcare Acquired Infections in Walsall Healthcare Trust. It will performance manage the organisation against the Trust's Infection Prevention and Control Strategy and will ensure that there is a strategic response to new legislation and national guidelines. In addition the committee will seek assurance from the divisions and ensure compliance with the Health and Social Care act.

3. MEMBERSHIP

3.1 The Group will comprise:

- Medical Director / Director of Infection Prevention and Control (DIPC) (Chair)
- Director of Nursing or Deputy
- Head of Infection Prevention (Deputy Director of Infection Prevention)
- Infection Prevention Team Members
- Consultant Microbiologists
- Divisional Directors of Nursing
- Allied Health Professional Representative
- CCG Lead for Quality
- Public Health England representative
- Director of Public Health or Deputy
- One representative from Local Authority
    - o Health Protection Nurse
    - o Public Health Consultant
- Divisional Directors of Nursing & Midwifery (Acute & Community) – Walsall Healthcare NHS Trust
- Antimicrobial Pharmacist
- Occupational Health Service Manager
- Divisional Director Estates & Facilities
- Health and Safety Officer
- Decontamination Lead

4. ATTENDEES

4.1 The Group Chair may extend invitations to attend Group meetings to any individual considered appropriate to progress the work plan of the Group.

5. ATTENDANCE

5.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy must be identified for core members of the Group and must attend when a member is unable to be present. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.

6. QUORUM

6.1 A quorum will be a minimum of seven representatives of which one will be an Executive Director from the Trust, one a member of the Infection Prevention and Control Team and a Consultant Microbiologist.

7. FREQUENCY OF MEETINGS

7.1 The Group will meet formally on monthly basis. Meetings will be expected to last no more than 2 hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Group may be called by any member of the Group, with the consent of the Chair.

8. CHANGES TO TERMS OF REFERENCE

8.1 Changes to the terms of reference including changes to the Chair or membership of the Group are a matter reserved to the Trust board.

9. ESTABLISHMENT OF SUB GROUPS

9.1 The Group may establish sub groups made up wholly or partly of members of the Group to support its work. The terms of reference of such sub group will be approved by the Group and reviewed at least annually. The Group may delegate work to the sub group in accordance with the agreed terms of reference. The Chair of each sub group will be expected to provide a Chairs report to the Group and review its effectiveness on an annual basis.

10. ADMINISTRATIVE ARRANGEMENTS

10.1 The Chair of the Group will agree the agenda for each meeting. The Group shall be supported administratively by the EA to the Director of Nursing who's duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the action notes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Group on pertinent issues / areas
- Enabling the development and training of Group members

All papers presented to the Group should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Group.

11. ANNUAL CYCLE OF BUSINESS

11.1 The Group will develop an annual cycle of business for approval by the Committee meeting at its first meeting of the financial year. The Group work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.

12. REPORTING TO THE COMMITTEE

12.1 The Chair of the Group will provide a highlight report monthly to the Committee outlining key actions taken with regard to the patient safety issues, key risks identified and key levels of assurance given.

13. STATUS OF THE MEETING

13.1 All Groups of the Committee will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Group.

14. MONITORING

14.1 The annual report on assurance will provide a statement that enables the Group to monitor the effectiveness of the Group. This will include levels of attendance, delivery against the forward looking work programme and the management of identified risk.

15. DUTIES

- To develop an Annual Work Plan in the agreed Trust format, denoting the objectives of the Group for approval by the Committee ensuring these are aligned with the Trust's vision, strategy and values and the relevant risks contained in the Board Assurance Framework.
- To identify any risks and issues that may prevent the achievement of the Work Plan and ensure that they are assessed and placed on the Trust's Risk Register and the action plan is monitored and mitigating actions are undertaken to ensure progress is made.
- Strategic responsibilities include the development of a strategic plan for the reduction of healthcare acquired infections and will performance manage the delivery of that strategic plan.
- Approve, review and monitor the Infection Prevention and Control Team's annual programme of work/Code of Practice for Healthcare Associated Infection Action Plan.
- Receive and approve the Infection Prevention and Control Annual Report in the first quarter of the following year prior to submission to the Committee and Trust Board.
- Receive advice from the Infection Prevention and Control Team on new national policy and guidance and its implementation within the organisation, highlighting potential areas of non-compliance.
- Address outstanding areas of non-compliance with national standards and requirements (e.g. CQC/Hygiene Code) and advise the Committee and Trust Board/Executive Team as appropriate.
- Drive improvements through teaching and education to uphold standards in reducing HCAI, monitor SSIs and will have oversight of mandatory reporting
- Review and ensure adequacy of the Trust's Uniform policy.
- Ratify Infection Prevention and Control and Occupational Health policies prior to submission to the TMB.
- Seek assurance from quarterly and annual reports from each division on progress with the Infection Prevention and Control Annual Programme of Work/Code of Practice for Healthcare Associated Infection Action Plan and will monitor progress in implementing these plans.
- Seek assurance from reports from each division on performance against HCAI Key Performance Indicators (KPIs), and will monitor progress in achieving targets and delivering agreed actions.
- Seek assurance from reports from the Director of Infection Prevention and Control (DIPC) on the outcome of discussions following all HCAI Root Cause Analyses (RCAs) including receipt of the RCA Action Plan(s).
- Receive a monthly report from the Antimicrobial pharmacist, regarding antibiotic prescribing audits and performance.
- Receive exception reports on compliance with the National Specifications for Cleanliness (2004, revised in 2014). The Group will also receive the quarterly reports to QPES from the Matrons.
- Seek assurance reports from the Infection Prevention and Control Team against national and local HCAI targets, use of isolation facilities, trends of infectious diseases reported from CCDC and review the work plan of the IPC.
- Receive a highlight report and minutes of the Decontamination Group and reports by exception from the Chair of that Group in order to ensure that decontamination risks are appropriately escalated and managed.
- Receive the minutes of the Accidental Inoculation/Exposure Group and reports by exception from the Chair of that Group in order to ensure that inoculation / exposure incidents and risks are appropriately escalated and managed.

- Receive the minutes of the Water Safety Group and reports by exception from the Chair of that Group in order to ensure that issues are dealt with or escalated as appropriate.
- Receive and review analysis reports on Infection Prevention and Control incidents and make recommendations for further action as necessary and appropriate.

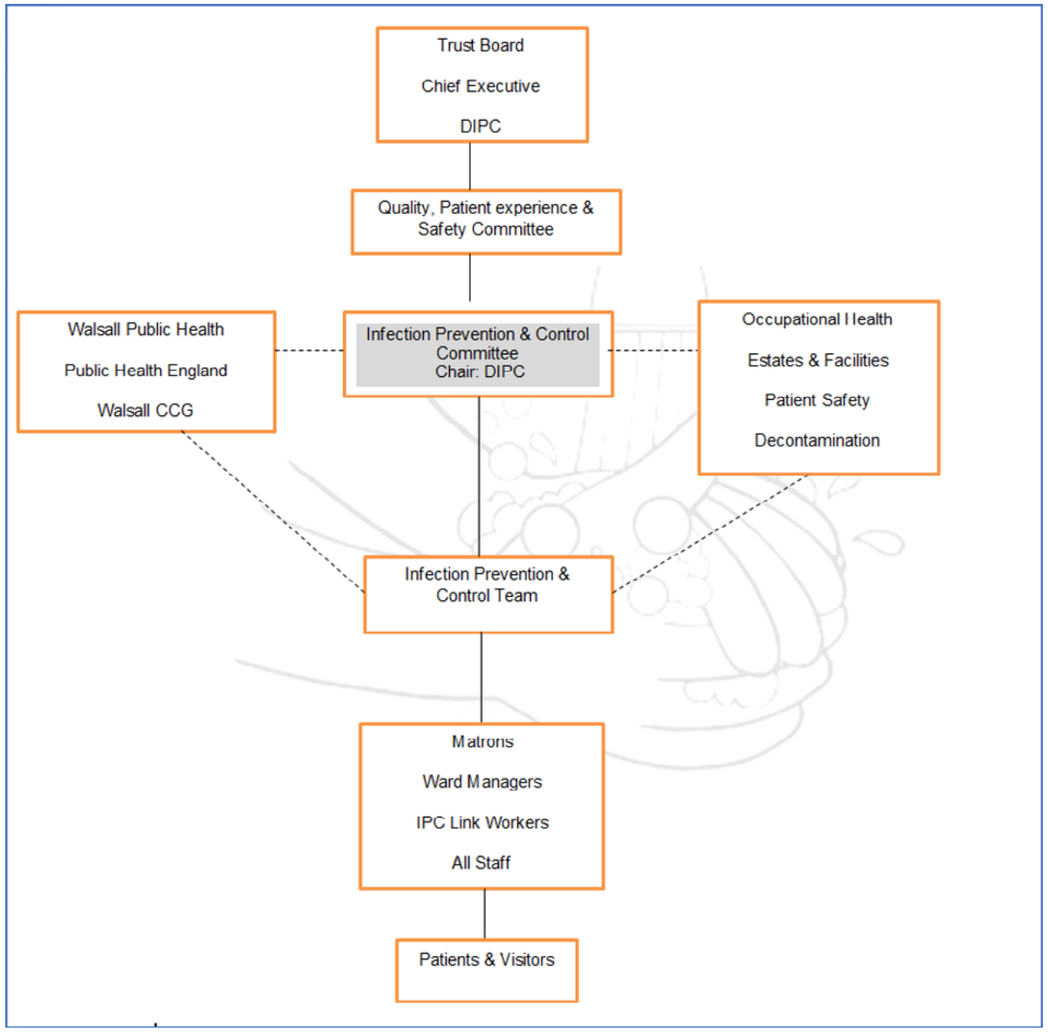
Version Control: Version 2.0

Reviewed by QPES and approved June 2022

Appendix 2

Antimicrobial Stewardship team 2022-23 strategy work plan	
Strategy	**Actions**
Recognition of responsible antimicrobial use	• Certificate of appreciation
Improved audit, feedback and benchmarking of antimicrobial use to clinical team	• Monthly point-prevalence audit
	• Feedback to clinical teams via monthly Medicines Management Group
	• Benchmarking via Antimicrobial Update presented to Infection Control Committee + Medicines Management Group • To achieve successful achievement of the UTI CQUIN
Teaching & training; Public engagement	• Regular rota of teaching to doctors in training
	• Grand Round presentations
	• Public campaign during Antibiotic Awareness Week
User-friendly antimicrobial formulary; Updated surgical prophylaxis guidance	• New revision to current antimicrobial formulary to be published
	• New revision to current surgical antimicrobial prophylaxis guidelines to be published
New evidence-based dose + duration recommendations	• Standard meropenem dosage: 500 mg IV q6h
	• Weight-based dosing instructions to be incorporated into antimicrobial formulary
	• Durations for antimicrobials to be limited to shortest possible duration on antimicrobial formulary
Better antimicrobial dosing for the sickest patients on ITU	• Introduce prolonged infusions of Tazocin, meropenem and temocillin for patients with septic shock on ITU
Quality improvement project: gentamicin use	• Review use of gentamicin dosing calculator
Empowered pharmacists, ready to make a change	• Educational update of pharmacists on improving antimicrobial prescribing, including IV-to-oral switch and avoiding unnecessary dual therapy
	• Resumption of Antimicrobial Pharmacist role following completion of secondment, due to maternity leave
An engaged & visible antimicrobial team	• Daily-to-weekly antimicrobial team ward-rounds for trouble shooting, audit, spot checks, education, etc.
A safe + reliable OPAT service	• Advance the service by launching Complex Outpatient Antibiotic Therapy (COpAT)
	• Maintain a safe OPAT service with adequate governance
New 'discharge enabling' antimicrobials	• Formulary application and laboratory testing of fosfomycin oral salts
Spotlight on 'high risk' antimicrobials: cephalosporins, quinolones, carbapenems, clindamycin, Tazocin	• Audit, feedback and restriction of cephalosporin use

Appendix 3 - Reporting Structure for IPCC



Annual Programme of Work April 2023- March 2024

Introduction

Infection prevention and control is a top priority for Walsall Healthcare NHS Trust. Keeping our patients safe from avoidable harm is everyone's responsibility. In this summary document we set out our programme for the year to keep our patients, staff and the public informed of our planned activity at Walsall Healthcare.

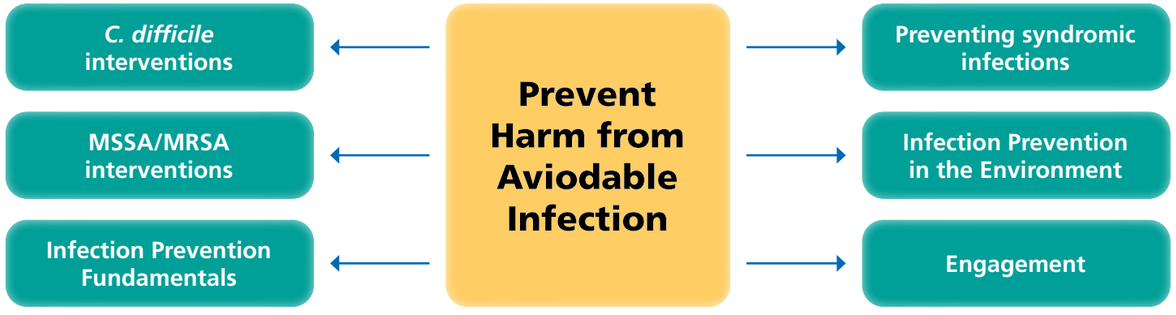
Each year the Infection Prevention & Control Team undertakes a review of the Trust's compliance with the Health & Social Care Act 2008 Code of Practice on the Prevention and Control of Infections (2022). The team's aim is to provide an infection prevention & control service that supports our clinical teams to deliver safe care. This annual plan covers strategic themes we have identified as areas of focus for the financial year 2023/2024. This annual programme of work for the year includes the annual plan, audit plan and our monthly themed focus plan. The programme also takes into consideration flexibility in approach whilst continuing to manage the COVID-19 Pandemic and related local actions required.

Vision

Our vision is to prevent harm from avoidable infection

Strategic themes

Our strategic themes in 2022/2023 focus on improving outcomes for our patients and provide a framework for our operational work plan.



Compliance with the Health and Social Care Act 2008 (updated 2022)

This programme will refer each operational objective to related compliance criterion within the Health and Social Care Act Hygiene Code.

The programme will be reviewed on a monthly basis by the Infection Prevention and Control Team and feedback on progress shared at the monthly Infection Prevention and Control Committee.

Strategic aim	Operational Objective	Action
Infection Prevention Fundamentals	Assurance on compliance with the Infection Prevention BAF	Monthly review of the BAF shared at IPCC, QPES and Trust Board. Gaps in compliance to be highlighted with clear actions in addition to the annual programme of work
		Infection Prevention Policy review schedule to incorporate updates within timeframe/ in response to new evidence/guidance. Objective to standardise materials to the National Infection Prevention and Control Manual
	Implement a multimodal hand hygiene improvement strategy.	Develop a revitalised hand hygiene campaign in line with the World Health Organisation Hand Hygiene day and reduction of glove use in collaboration with the "Take your gloves off" campaign.
		Deliver an educational event on standard precautions with the wider health economy on 5.5.23 to coincide with the WHO Hand Hygiene Day
		Combined audit programme of quarterly hand hygiene and PPE audits undertaken by the IPCT and external audits from the hand hygiene product representative for review at IPCC
		Undertake a review of PPE dispensers across Trust premises to determine appropriate placement, improving ergonomics of the health care environment to influence correct glove use/ hand hygiene prompts
		Involve patients in improving hand hygiene whilst receiving care, utilising patient experience volunteers in encouraging use of hand wipes prior to meal times and encouraging to ask health care workers to clean their hands prior to contact with them.
	Provide a comprehensive educational programme on delivering fundamentals of infection prevention.	Undertake a review of the mandatory training package content with RWT IP Team
		Develop a hybrid training package, consisting of face to face classroom based, virtual delivery by IP practitioners and e-learning packages.

Strategic aim	Operational Objective	Action
MSSA/MRSA interventions	Strong governance processes to embed learning from incidents of MRSA/MSSA bacteraemias	IPCT to lead comprehensive post infection reviews for any MRSA bacteraemia and in the event of an MSSA bacteraemia associated with indwelling devices. Lessons learnt articulated through IPCC, divisional quality meetings and as a snap shot learning please for IPCT to educate clinical areas.
	Gain assurance on decolonisation regimes for patients who screen positive for MRSA during a hospital admission	Trial a change in decolonisation product to a wipe based system to standardise approaches to decolonisation.
		IPCT to review patients who test MRSA positive and ensure decolonisation is prescribed via a standardised prescribing label.
	Prevent the incidece of blood culture contaminants	IPCT to work with FORCE and clinical teams to provide education on aseptic technique to standardise approaches to obtaining blood cultures
		Build a business case for a 24/7 blood culture phlebotomy service as part of the sepsis pathway with an aim to reduce incidence of blood culture contaminants
	Assurance on indwelling device care	Review devices used within the Trust and standardise products based on current evidence base through the Trust's Clinical Product Evaluation Group
		IPCT to undertake audit programme of indwelling device care bi-annually and report through divisional quality meetings and IPCC

Strategic aim	Operational Objective	Action
C.difficile interventions	Antimicrobial Stewardship	Undertake a Qi project to combine with updates to Microguide to improve CURB-65 scoring when prescribing for pneumonia.
		Consultant Microbiologist and AMS pharmacist to deliver "antibiotic time out" sessions to areas of focus identified in AMS audits.
		Monthly reports on antimicrobial stewardship to be reviewed by members of IPCC
		Deliver education to nursing and medical teams on IV to Oral Switch
		Deliver education on appropriate sampling for urinary tract infections and when to undertake urinalysis.
	Environmental cleanliness	Undertake enteric audits in response to a new C.difficile case in an inpatient area. Additional monitoring to include ATP testing of wards in the event of a PII/through request from senior IPCT
		Work with facilities to build a case for a bed decontamination facility, to routinely decontaminate patient beds and bedside equipment
		Work with facilities and clinical teams to plan and deliver a deep clean programme of inpatient wards, with prioritisation to ward areas where C.difficile has been more endemic.
	Education	Provide education at ward and department level as part of the enteric audit cycle on key elements of IPC.
		Deliver bespoke educational event on C.difficile to Trust staff and students, incorporating key themes from incidents.

Strategic aim	Operational Objective	Action
C.difficile interventions	Clinical Management	Weekly C.difficile ward rounds between IPCN, Microbiologist and antimicrobial pharmacist
		Explore options for treatment pathways to incorporate FMT capsules from first episode of C.difficile to prevent relapse
		Nursing Associate role in ED and admitting areas to improve clinical management of patients presenting with diarrhoea symptoms and ensuring samples are obtained.
		IPC Nurse prescriber to support treatment plans of patients admitted with history of C.difficile and on confirmed results.
	Strong governance processes to embed learning from incidents of C.difficile infections	Undertake thematic analysis to indentify any priorities for education/ new interventions to prevent the incidence of C.difficile
		Undertake a data collection for all hospital acquired cases of C.difficile and feedback learning to divisional teams. Follow HCAI governance process as set out in Trust IPC surveillance policy.

Strategic aim	Operational Objective	Action
Preventing Syndromic infections	Preventing Pneumonia	Deliver ward level education on mouth care principles as part of proactive and reactive workstreams.
		Participate in workstreams for the Eat, Drink, Dress, Move intitiative and associated campaigns (Smile Month)
	Preventing Urinary Tract Infections	Participate in Nutrition and Hydration week and other quality agenda items associated with patient hydration
		Undertake point prevelance study six months post implementation of urinary catheter packs
	Preventing Surgical Site Infections	Actively participate and contribute to the surgical site infection group. Link with CPEG for clinical products that demonstrate evidence as an intervention to reduce the incidence of SSIs.
		Develop a business case for the implementation of an SSI team at the Trust
		Undertake a One Together assessment of Trust theatres to identify areas for improvement in the surgical pathway
		Provide support to maternity and surgical divisions in the investigation of surgical site infections and provide expertise to identify learning/divisional actions

Strategic aim	Operational Objective	Action
Infection Prevention in the Environment	Note: some of the elements for this theme are already captured under C.difficile	
	Building Works	Support clinical and estates teams with all stages of planning for ward/department refurbishment programmes utilising infection prevention expertise
	Sustainability	Deliver the "Take your gloves off" campaign in an approach to improve hand hygiene standards and reduce use of single use plastics in healthcare
		Actively participate in Trust projects to improve sustainability with an balance with infection prevention standards
	Cleaning	Actively participate in the Trust Environmental Group, providing infection prevention expertise
		Work with facilities and clinical teams to demonstrate the value of role in preventing nosocomial infections. Incorporate elements of the "Cleaning for Confidence" campaign into promotional materials
	Water	Review clinical areas for risk of splash contamination and work with estates for environmental risk mitigations
		Actively participate in the Trust Water Safety Group, providing infection prevention expertise
	Ventilation	Incorporate indoor air quality with CO2 monitoring and risk mitigations (Rediair) into infection prevention reviews of nosocomial respiratory infections and as part of the airborne/droplet audit cycle

Strategic aim	Operational Objective	Action
Engagement	Patient Voice	Collaborate with the patient experience team to deliver patient education messages in infection prevention
	Promotion	Deliver IP weekly updates with 5 key messages based on campaigns or learning from recent events
		Support delivery of staff vaccination campaigns through education, participation in forums and supporting roving vaccination clinics
		Deliver face to face bespoke sessions based on the focused IP themes with Trust staff
	Infection Prevention Team Development	IP team members to prepare abstracts for submission to upcoming Infection Prevention conferences and contribute as speakers
		Deliver a collaborative educational plan across WHT and RWT to educate infection prevention practitioners and build a strong networking platform
	Staff recognition	Celebrate staff demonstrating high standards of IPC through a staff monthly IPC award programme

Audit	Location	Plan	Related strategic theme
Full Ward Audit	All Inpatient Wards	To be completed by August 2023	Infection Prevention in the Environment, Infection Prevention Fundamentals
Community Audits	Community clinics and units	To be completed by October 2023	Infection Prevention in the Environment, Infection Prevention Fundamentals
Departmental Audits	Acute site departments	To be completed by January 2024	Infection Prevention in the Environment, Infection Prevention Fundamentals
Hand Hygiene and PPE	Acute services and community bed bases, community	Quarterly: June 2023, September 2023, December 2023, March 2024.	Infection Prevention Fundamentals
Hand Hygiene and PPE	Community nursing team	To be completed by October 2023	Infection Prevention Fundamentals
Indwelling device care	All Inpatient Wards	Bi-annually: August 2023 and February 2024	MSSA/MRSA interventions, Infection Prevention Fundamentals, Preventing Syndromic Infections
Enteric Audits	All Inpatient Wards	Reactive audits to new C.difficile cases, Norovirus or acute acquired CPE	C.difficile interventions, Infection Prevention Fundamentals, Infection Prevention in the Environment
Respiratory Audits	All Inpatient Wards	Reactive audits to new HCAI COVID-19 or Influenza cases/ outbreaks	Preventing Syndromic Infections, Infection Prevention Fundamentals, Infection Prevention in the Environment

Month	Theme
April/ May	Fundamentals of Infection Prevention
June/ July	Urinary Tract Infections
	Surgical Site Infections
August/ September	Indwelling device care
	Sepsis
October/ November	Winter Preparedness
	Antimicrobial Stewardship
December/ January	Winter: Reactive IPC work
February/ March	Multi-drug resistant organisms

Care Colleagues
Collaboration Communities

NHS
Walsall Healthcare
NHS Trust

www.walsallhealthcare.nhs.uk

@WalsallHcareNHS

@WalsallHcareNHS

00970 05/23

To deliver exceptional care together to improve the health and wellbeing of our communities

Respect
Compassion
Professionalism
Teamwork

WALSALL HEALTHCARE NHS TRUST BIANNUAL SKILL MIX REVIEW

Data collection January 2023

Author: Lorraine Gardner Corporate Matron for Workforce

Responsible Director: Lisa Carroll Director of Nursing

INTRODUCTION

To deliver safe quality patient care it is essential wards have optimal Nurse staffing levels. It has been acknowledged that one of the contributory factors linking failures in care and patient safety were inadequate staffing levels (Francis 2013). In July 2016 the National Quality Board published 'Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time: Safe, sustainable and productive staffing'. This safe staffing improvement resource provided updated expectations for nursing and midwifery care staffing**.** The Developing Workforce Safeguards published by *NHS Improvement* in October 2018 will assess Trusts compliance with a more triangulated approach to Nurse staffing planning in accordance with the National Quality Board guidance for all clinical staff. This document recommends a combination of evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

To demonstrate the Trust's commitment to the above requirement a twice-yearly Adult Inpatient, Acute Assessment units and Paediatric inpatient skill mix review is completed.

Walsall Healthcare NHS Trust (WHT) uses the 'Safer Nursing Care Tool' (SNCT). The SNCT calculates nurse staffing requirements based on the acuity and dependency of the patients on a ward and it is linked to nurse sensitive outcome indicators.

Acuity and dependency data was collected in January and June 2022 and January 2023 for the recommended 20 days (Mon-Fri) from:

- Fourteen adult inpatient ward areas
- One Community inpatient ward
- One Paediatric Area (June 22 only)

The review does did not include the following areas:

- Ward 14 - Medical Winter Ward (maximum 28 beds)
- Ward 9 - Surgical Winter Ward (maximum 26 beds)
- The Emergency Department – business case recently approved to facilitate the relocation into new UEC. Plan to review again in June 2023
- AMU – business case recently approved to facilitate the relocation into new UEC. Plan to review again in June 2023
- Ward 21 (paediatric ward) – separate business case in progress
- Paediatric Assessment Unit. Separate business case in progress.

RESULTS

OCCUPANCY, ACUITY AND DEPENDENCY

Table 1 below summarises acuity scores from skill mix reviews February 2020 to January 2023.

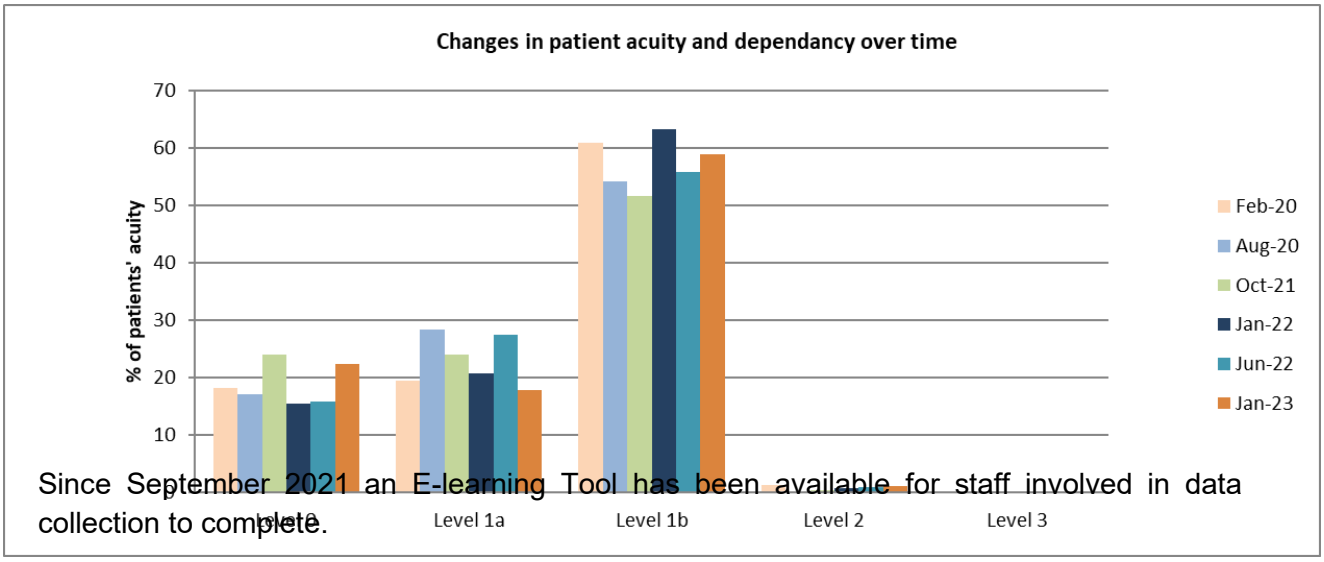
Table 1 Acuity Scores collected by Level

		Feb-20	Aug- 20	Oct-21	Jan-22	Jun-22	Jan - 23
No of Scores	Multiplier	8494	6781	7447	7351	8179	7384
Level 0	0.99	18.1%	17.1%	23.9%	15.3%	15.9%	22.26 %
Level 1a	1.38	19.5%	28.4%	23.9%	20.6%	27.5%	17.86 %
Level 1b	1.72	60.9%	54.2%	51.6%	63.2%	55.8%	58.82 %
Level 2	1.97	1.3%	0.2%	0.3%	0.6%	0.8%	1.06%
Level 3	5.96	0	0	0	0	0	0

Chart 1 demonstrates that acuity score 1b is the most common score consistently in each skill mix review since February 2020.

Data collection for January 2022 and 2023 is within the winter period where typically more patients are in hospital with higher acuity and dependency because of chronic illness.

Chart 1 – changes in patient acuity over time



Since September 2021 an E-learning Tool has been available for staff involved in data collection to complete.

In January 2023 to support the data collection, walk arounds were carried out to gain assurance of the data collection process, challenge acuity grading and support any learning needs identified.

Both of these measures have enhanced staff knowledge around acuity recording, reduced variability and increased confidence in the reliability of the data.

NURSE SENSITIVE INDICATORS (NSI) BY AREA

Table 2 details the number of falls, pressure ulcers, medicine related incidents, complaints and infections during January 2023 compared to June 2022.

Table 2 – Nurse Sensitive Indicators by Area – comparison June 2022 and January 2023

The data for Table 2 was obtained from The Trusts incident management system and PALS, it is noted that medication errors are recorded as a whole and include pharmacy and medical prescribing errors.

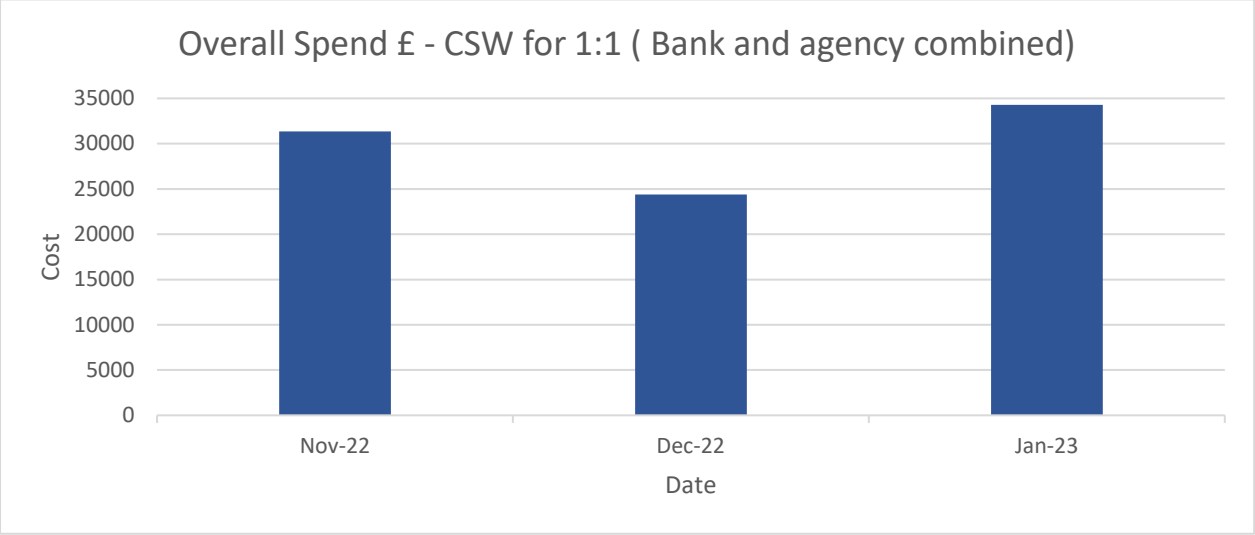
June22 / Jan23 comparison													
		Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23
Jun-22	Ward	Falls per 1000 occupied bed days	Falls per 1000 occupied bed days	Pressure Ulcers	Pressure Ulcers	Medication Errors	Medication Errors	Complaints	Complaints	C-Diff	C-Diff	MRSA	MRSA
MLTC	1	4.79	4.61	1	2	1	2	0	0	0	0	0	0
	2	4.34	0	1	0	1	1	0	0	0	0	0	0
	3	7.73	4	0	1	0	1	0	0	0	0	0	0
	4*	4.02	3.8	4	1	4	5	0	1	0	0	0	0
	7	1.5	5.56	3	1	3	0	0	1	0	0	0	0
	15	2.38	2.33	1	0	1	5	1	1	0	0	0	0
	16	1.34	2.69	2	0	2	2	0	1	0	0	0	0
	17*	0	2.67	3	0	3	3	0	2	0	0	0	0
	29	2.96	7.58	1	2	1	2	2	2	0	0	0	0
SURGERY	10*	6.34	1.22	0	0	0	1	0	0	0	0	0	0
	11*	1.36	2.71	1	0	1	6	1	1	2	0	0	0
	12*	4.02	1.3	3	0	3	4	0	1	0	0	0	0
	20A	8.51	4.72	0	0	0	1	1	0	0	0	0	0
WCCCS	23	0	0	0	0	0	0	0	0	0	1	0	0
COMMUNITY	Hollybank *	8.88	8.55	0	0	0	0	1	0	0	0	0	0

AMBER= falls rate higher than national mean

****= areas where SNCT indicates and uplift of > 10%***

Chart 2 shows the cost of 1:1 care by Bank and Agency CSWs. The total 3-month cost (November 2022 – January 2023) is £90037.

Chart 2- Cost of CSW cover for 1:1's



ESTABLISHMENTS

The Trust has commissioned an external review by NHSE of the skill mix review process and this is currently underway.

In addition to the NHSE review the Trust has commissioned external reviews of paediatrics, Emergency Care and Cancer Services to inform the delivery of safe high-quality care based on best practice and evidence. This includes a review of staffing models.

A review of pathways is also currently being undertaken to ensure flow and length of stay is maximised and to assess overall bed capacity and need within medicine and surgery.

Applying the SNCT multipliers to the data collected, the differential between funded establishments and required establishments are calculated inclusive of 21% uplift. This model is based on establishment and not actual nursing staff in post.

The skill mix review undertaken in January 2022 was at the end stages of the Omicron variant of COVID-19.

In June 2022 the review indicated the need for an increase in RN and CSWs of more than 10% in 6 wards, and 7 wards in January 2023.

Table 3 SNCT establishment calculations January 2023

Division	Ward	WTE- Professional Judgement Jan 23	WTE- SNCT Acuity Tool Jan 23	Current Budget	Areas that breach 10% SNCT threshold	CHPPD	WTE-Total budgeted required post skill mix review	% change from current budget	REG- Difference required from Current to Required budget (%)	CSW- Difference required from Current to Required budget (%)
MLTC	Ward 1	50.28	52.95	47.5		5.9	50.28	5.53	0.00	2.78
	Ward 2	50.28	45.16	47.5		6.7	50.28	5.53	0.00	2.78
	Ward 3	52.95	52.95	47.5		6.8	52.88	10	2.60	2.78
	Ward 4	50.35	45.16	34.43		6.5	50.35	33.60	6.17	10.75
	Ward 7	36.22	32.17	33.43		6.6	36.22	7.70	2.43	0.36
	Ward 15	42.6	39.96	40		6.4	42.60	6.10	1.57	0.00
	Ward 16	39.96	34.77	39.10		7.2	39.96	2.50	0.00	1.00
	Ward 17	43.09	37.36	34.95		7.6	43.09	19.01	2.91	5.28
	Ward 29	52.08	50.35	50.30		6.8	50.30	3.42	0.00	0.00
						Divisional Total	415.96		15.68	25.73
SURGERY	Ward 10	38.81	34.77	33.43		7.3	38.81	13.71	2.35	3.03
	Ward 11	38.81	26.97	34.51		7.1	38.81	11.08	2.42	3.03
	Ward 12 (A)	38.96	37.36	22.01		7.6	38.96	43.53	8.95	8.01
	Ward 20a*	46.44	13.99	47.87		9.9	46.44	1.49	0.00	0.69
						Divisional Total	163.02		13.72	14.76
WOMENS	Ward 23*	20.71	13.99	20.71		9.2	20.71	0.00	0.00	0.00
						Divisional Total	20.71		0.00	0.00
COMMUNITY	Hollybank*	24.38	16.28	21.8			24.38	10.58	2.29	0.29
						Divisional Total	24.38		2.29	0.29
							TOTAL REQUEST		**31.69**	**40.78**

- ***Highlighted in yellow are areas where the SNCT data of January 2023 identifies a change of more than 10% from current budget.***
- ***Highlighted in grey are areas where current budget and SNCT are more than 10% different. In Jan 23s data collection.***
- **** = area with 16 or less beds where SNCT is not considered valid or the preferred tool for this area***

Where the SNCT data of January 2023 identifies a change of more than 10% from current budget these can be explained by the following:

- Ward 4- The data collection is based on 34 beds. Previous SNCT data collection was based on an establishment to 28 beds. In line with the winter plan Ward 4 has increased capacity using winter monies to 34 beds. At the time of writing this report the division have not closed the winter capacity beds and ward 4 remains open to 34.A business case has been agreed at Trust Board and is now being reviewed as part of the internal financial process

- Ward 17- The adjustment to establishment approved by Trust board in June 2022 has not been actioned and the budget needs to be aligned to reflect this. Any further uplift to enable the provision of a Respiratory Support Unit requires a business case, if the non-invasive ventilation pathway is to expand.

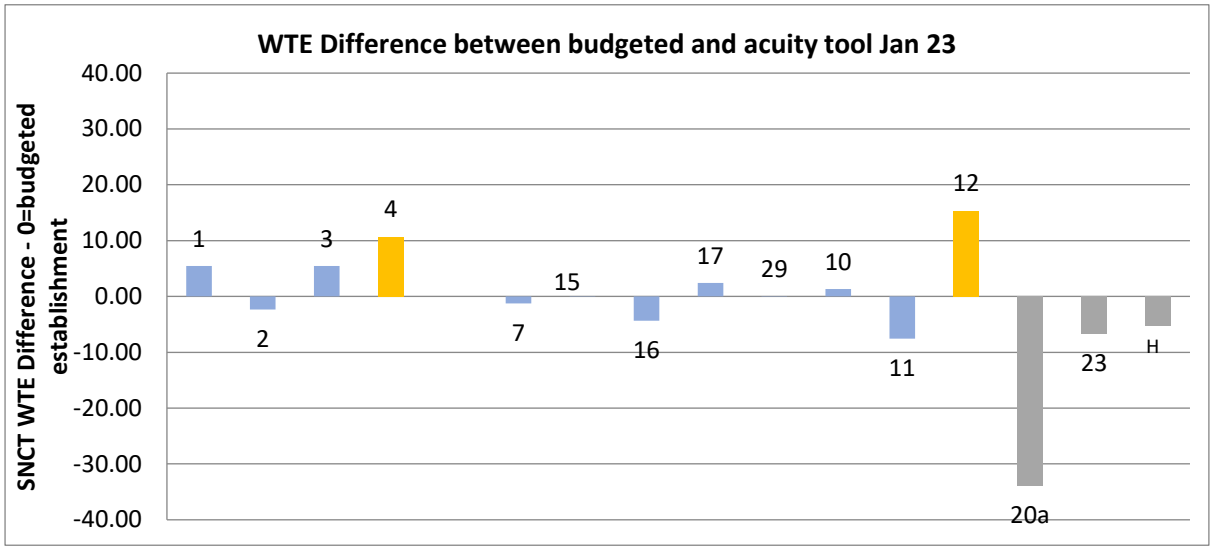
- Ward 10- The adjustment to establishment approved by Trust board in June 2021 has not been actioned and the budget needs to be aligned to reflect this. This was reported following the January 2022 establishment review and remains outstanding in January 2023.

- Ward 11 and 12- These wards were historically managed as one ward (ASU) with a single budget. Following a reconfiguration over 18 months ago ward 11 became a complex surgical ward and ward 12 the emergency surgical ward. At the point of this change being made the budgets and establishments were split. The decision on allocation of the budget between the two wards was not based on the acuity or dependency of patients or any other nurse sensitive indicators. This was highlighted in the January and June 2022 skill mix review and remains outstanding. The configuration is presently being reviewed by the executive team

- Hollybank - The budget for Hollybank was not aligned when the stroke unit was moved from MLTC to the community division and this needs addressing separately.

Chart 3 demonstrates WTE demand from the review.

Chart 3 – WTE Difference between Budgeted Establishment and SNCT -Jan 23

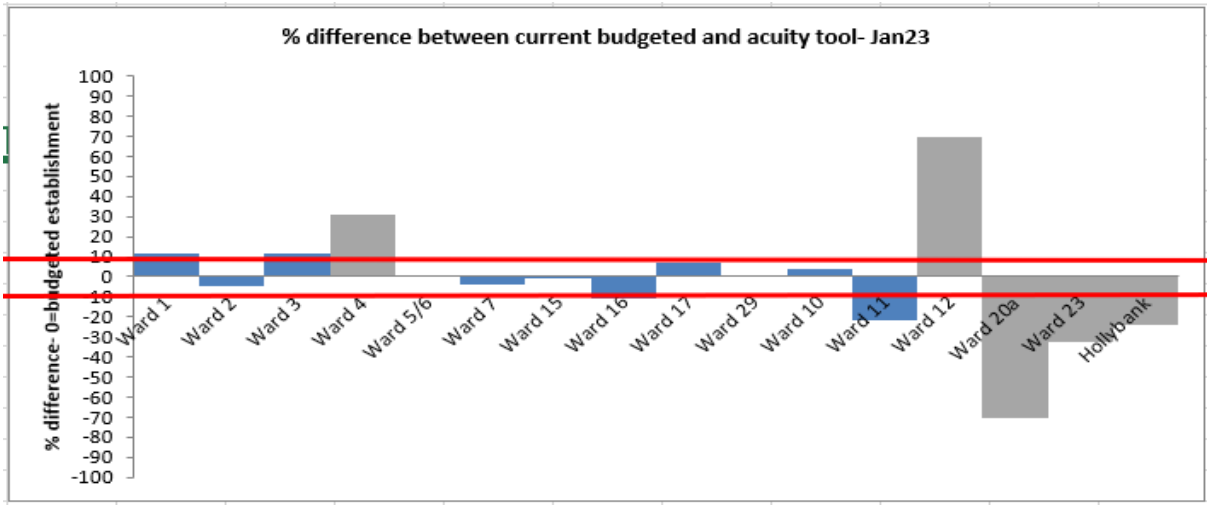


**** Positive figure= SNCT recommends higher than current budget***

**** Wards 20a, 23 and Hollybank are exceptions- SNCT is not accurate or appropriate in departments with 16 beds or less.***

It is accepted that being within 10% of the SNCT multiplier suggested WTE is within limits.

Chart 4-% difference between current budget and acuity tool Jan 23



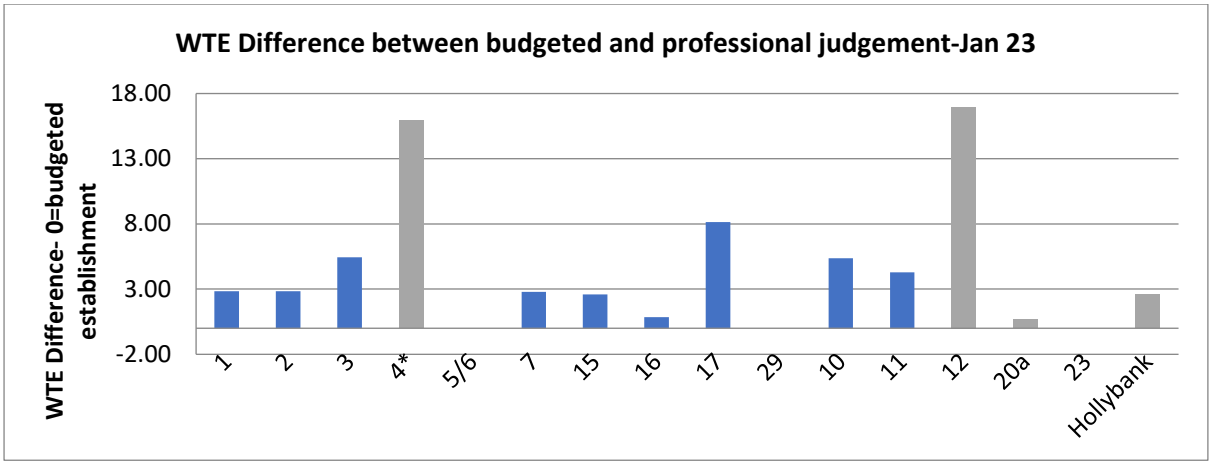
In undertaking a skill mix review it is essential that the acuity/dependency data is triangulated against professional judgement and Nurse Sensitive Indicators.

The application of professional judgement ensures specific local needs are included:

- Ward layout/facilities: the configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, wards with a high proportion of single rooms might make adequate surveillance of vulnerable patients more difficult.
- Escort duties: consideration needs to be given if this role is likely to affect the numbers of staff required. A local data collection and analysis exercise is undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care needs if this is considered to have a significant impact on the ward activity.
- Shift patterns: the type of shift patterns (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These are monitored to understand the impact and effect on staff and patients.

Chart 5 shows the variation between the current budgeted establishment and professional judgement.

Chart 5 – WTE variation from current establishment to professional judgement Jan 23



ANALYSIS

It is essential that decisions to change to staffing requirements are based on a thematic analysis over time rather than a single point measurement unless:

i. One measurement has changed significantly and is support by other triangulated data.
ii. Activity and/or acuity has been altered significantly (change of speciality/bed base change).

DIVISION OF MEDICINE AND LONG-TERM CONDITIONS

WARD 1- Acute Older People

Nurse Sensitive Indicators:

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
4.61	2	2	0	3	64	12	98%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Jan 2022	1.00	4.0	18.9	3.0	0.00	25.97	52.87
June 2022	1.00	4.0	18.9	3.0	0.00	25.97	52.87
Jan 2023	1.00	4.0	18.9	3.0	0.00	23.38	50.28

Recommendation: The Nurse sensitive indicators are good – recommend no change to substantive staffing; continue to use temporary bank workforce for additional 1:1s as required and review approach to management of patients who traditionally require 1:1 care (learning the lessons from ward 2 as requested in June 2022 review) – review in June 2023

WARD 2 –Combined Medically Fit/ Acute Older People

Nurse Sensitive Indicators:

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
0	0	1	0	0	75	9	99%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Jan 2022	1.00	4.0	18.9	3.0	0.00	20.6	47.5
June 2022	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Jan 2023	1.00	4.0	18.9	3.0	0.00	23.38	50.28

Recommendation: The Nurse sensitive indicators are good. No further action review again in June 2023

WARD 3- Combined Medically Fit/ Acute Older People

Nurse Sensitive Indicators:

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
4	1	1	0	0	76	8	95%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Jan 2022	1.00	4.0	1.83	3.0	0.00	23.38	49.21
June 2022	1.00	4.0	18.9	3.0	0.00	23.38	50.28
Jan 2023	1.00	4.0	21.5	3.0	0.00	23.38	52.95

Recommendation: The Nurse sensitive indicators are good. Consideration to be given to the use of Twilight shifts for CSWs, and review of band 4 utilisation within the ward environment. Consider what learning has been taken from Ward 2 since June 2022s review – review in June 2023.

WARD 4- Combined Medically Fit/ Acute Older People

Nurse Sensitive Indicators:

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
3.8	1	5	0	2	67	12	99%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	**Band 7**	**Band 6**	**Band 5**	**Band 4**	**Band 3**	**Band 2**	**Total Budgeted WTE**
Current WTE approved June 2021	1.00	2.52	17.28	0.00	0.00	12.63	33.43 (28 beds)
Jan 2022	1.00	4.0	1.83	3.0	0.00	23.38	49.21
June 2022	1.00	4.0	18.9	3.0	0.00	23.38	50.28
Jan 2023	1.00	4.0	21.5	3.0	0.00	23.38	52.9

Recommendations: The Nurse sensitive indicators are good. Recommend no change to substantive staffing. continue to use temporary bank workforce for additional 1:1s as required and review approach to management of patients who traditionally require 1:1 care (learning the lessons from ward 2). Consideration to be given to the introduction of Nursing Associates at band 4 as recommended in June 2002 – review in June 2023

WARD 7- Cardiology

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
5.56	1	3	0	0	32	8	95%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	**Band 7**	**Band 6**	**Band 5**	**Band 4**	**Band 3**	**Band 2**	**Total Budgeted WTE**
Current WTE approved June 2021	1.00	7.56	12.24	0.00	0.00	12.63	33.43
Jan 2022	1.00	7.56	14.67	0.00	0.00	12.99	36.22
June 2022	1.00	7.56	14.67	0.00	0.00	12.99	36.22
Jan 2023	1.00	7.56	14.67	0.00	0.00	12.99	36.22

Recommendations: Nurse sensitive indicators are good. The uplift in the band 5 RN workforce by 2.43 WTE that was previously agreed by the Trust Board following the June 2022 review needs to be enacted. There is no further change required – review June 2023.

WARD 15-General Medicine/ Diabetes/ Haematology

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy

2.33	0	5	0	0	14	11	95%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	4.0	15.0	2.00	0.00	18.0	40.0
Jan 2022	1.00	4.0	15.0	2.00	0.00	18.0	40.0
June 2022	1.00	4.0	15.0	2.00	0.00	18.0	40.0
Jan 2023	1.00	4.0	17.6	2.00	0.00	18.0	42.6

Recommendation: Nurse sensitive indicators are good. No further action at this time - review June 2023

WARD 16- Gastroenterology

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
2.69	0	2	0	0	22	6	94%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	3.00	15.78	2.00	0.00	17.18	38.96
Jan 2022	1.00	3.00	15.00	3.00	0.00	17.00	39.10
June 2022	1.00	3.00	15.00	2.00	0.00	17.0	38.77
Jan 2023	1.00	3.00	15.78	2.00	0.00	18.18	39.96

Recommendation: Nurse sensitive indicators are good. Recommend no change to current establishment. Division to review band 4 Nursing Associate roles to ensure working within full scope of practice, and a need to understand where the reduction in band 4 WTE budget was used when reduced from 3 to 2 WTE in June 2022. Review June 2023

WARD 17- Respiratory

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
2.67	0	3	0	0	9	5	96%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023:

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	5.20	12.80	3.00	0.00	12.90	34.90
Jan 2022	1.00	5.20	14.03	3.00	0.00	18.18	41.41
June 2022	1.00	5.20	14.03	3.00	0.00	18.18	41.41
Jan 2023	2.68	5.20	14.03	3.00	0.00	18.18	43.09

Recommendation: Nurse sensitive indicators are good. Any proposed increase in band 7 establishment requires a business case from the Division. The budget needs to be aligned to reflect the changes approved by Trust Board in June 2022 – review June 2023.

WARD 29- Acute Medical

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
7.58	2	2	0	0	20	8	99%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	4.0	19.7	5.0	0.00	20.60	50.35
Jan 2022	1.00	4.0	19.7	5.0	0.00	20.6	50.35
June 2022	1.00	4.0	19.7	5.0	0.00	20.6	50.35
Jan 2023	1.00	4.0	19.7	5.0	0.00	20.6	50.35

Recommendation: No further action at this time. Review in June 2023.

DIVISION OF SURGERY

WARD 10- Trauma

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
1.22	0	1	0	6	24	11	100%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE

Current WTE approved June 2021	1.00	2.52	9.82	4.94	0.00	15.15	33.49
Jan 2022	1.00	2.52	12.17	4.94	0.00	18.18	38.81
June2022	1.00	2.52	12.17	4.94	0.00	18.18	38.81
Jan 2023	1.00	2.52	12.17	4.94	0.00	18.18	38.81

Recommendation: Nurse sensitive indicators are good. No change from the establishment agreed in June 2021. Review in June 2023.

WARD 11- Complex Surgery

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
2.71	0	6	0	1	0	5	91%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	2.60	14.76	1.00	0.00	15.15	34.51
Jan 2022	1.00	2.60	16.03	1.00	0.00	18.18	38.81
June2022	1.00	2.60	16.03	1.00	0.00	18.18	38.81
Jan 2023	1.00	2.60	17.18	1.00	0.00	18.18	39.96

Recommendation: Division to submit a business case to substantively increase establishment by 2.42 WTE band 5 RNs and 3.03 WTE CSWs if deemed as required following review of capacity and pathways.

Ward 12-Emergency Surgery

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
1.03	0	4	0	2	9	9	96%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	2.00	10.43	1.00	0.00	7.58	22.01
Jan 2022	1.00	2.00	19.23	1.00	0.00	15.58	38.81
June2022	1.00	2.00	19.23	1.00	0.00	15.58	38.81
Jan 2023	1.00	2.00	19.38	1.00	0.00	15.58	38.96

Recommendation: No change to current staffing levels. Review in June 2023.

Ward 20a-Elective Surgery

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
4.72	0	1	0	1	1	4	81%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	4.32	19.34	1.00	0.00	20.09	45.75
Jan 2022	1.00	4.32	21.34	1.00	0.00	20.21	47.87
June2022	1.00	4.32	21.34	1.00	0.00	20.21	47.87
Jan 2023	1.00	4.32	19.34	1.00	0.00	20.78	46.44

Recommendation: No further action at this time. Review in June 2023

DIVISION OF WOMENS AND CHILDRENS

WARD 23-Gynaecology

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
0	0	0	1	0	0	0	81%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	1.00	11.13	0.00	0.00	7.58	20.71
Jan 2022	1.00	1.00	11.13	0.00	0.00	7.58	20.71
June2022	1.00	1.00	11.13	0.00	0.00	7.58	20.71
Jan 2023	1.00	1.00	11.13	0.00	0.00	7.58	20.71

Recommendation: No further action currently. Review in June 2023.

DIVISION OF COMMUNITY

HOLLYBANK HOUSE-Stroke Rehabilitation

Nurse Sensitive Indicators

Falls per 100 bed days	Pressure ulcers	Medication errors	HCAIs	DoLS applications	Use of cohorted bays	Use of 1:1	Bed occupancy
8.55	0	0	0	0	0	0	95%

WTE as indicated by SNCT data and professional judgment in biannual skill mix review June 2021 – January 2023

SNCT Data collection period	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE approved June 2021	1.00	3.52	7.18	0.00	0.00	10.10	21.80
Jan 2022	1.00	3.52	8.32	0.00	0.00	10.39	23.23
June2022	1.00	3.52	8.32	0.00	0.00	10.39	23.23
Jan 2023	1.00	3.52	9.47	0.00	0.00	10.39	24.38

Recommendation: No further action currently. Review in June 2023.

Recommendations to Trust Board following completion of the skill mix review in January 2023

The Director of Nursing recommends the following:

- The surgical division to develop a business case to increase the establishment on ward 11 by 2.42 WTE band 5 RNs and 3.03 WTE CSWs following review of pathways, capacity and flow

Changes to skill mix that have previously been agreed by Trust Board (June 2022 review) need to be made to the relevant ward budgets.

Skill mix reviews are undertaken every six months and the next review will take place in June 2023.

A timetable will be developed to ensure all clinical areas are reviewed as part of the biannual skill mix review process.

APPENDIX 1

Levels of acuity and dependency

Level 0: Patient requires hospitalisation. Needs met by provision of normal ward cares.

•Elective medical or surgical admission

•May have underlying medical condition requiring on-going treatment

•Patients awaiting discharge

•Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly

•Regular observations 2 - 4 hourly

•**Early Warning Score** is within normal threshold.

•ECG monitoring

•Fluid management

•Oxygen therapy less than 35%

•Patient controlled analgesia

•Nerve block

•Single chest drain

•Confused patients not at risk

•Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence

Level 1a: Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.

Increased level of observations and therapeutic interventions

•Early Warning Score - trigger point reached and requiring escalation.

•Post-operative care following complex surgery

•Emergency admissions requiring immediate therapeutic intervention.

•Instability requiring continual observation / invasive monitoring

•Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly

•Arterial blood gas analysis - intermittent

•Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains

•Severe infection or sepsis

Level 1b: Patients who are in a STABLE condition but are dependent on nursing care to meet most or all the activities of daily living.

•Complex wound management requiring more than one nurse or takes more than one hour to complete.

•VAC therapy where ward-based nurses undertake the treatment

•Patients with Spinal Instability / Spinal Cord Injury

•Mobility or repositioning difficulties requiring the assistance of two people

•Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care)

•Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome

•Patients on End-of-Life Care Pathway

•Confused patients who are at risk or requiring constant supervision

•Requires assistance with most or all activities of daily living

•Potential for self-harm and requires constant observation

•Facilitating a complex discharge where this is the responsibility of the ward-based nurse

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / •Deteriorating / compromised single organ system.

•Post-operative optimisation (pre-op invasive monitoring) / extended post-op care.

•Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure

•First 24 hours following tracheostomy insertion

•Requires a range of therapeutic interventions including:

•Greater than 50% oxygen continuously

•Continuous cardiac monitoring and invasive pressure monitoring

•Drug Infusions requiring more intensive monitoring e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium

•Pain management - intrathecal analgesia

•CNS depression of airway and protective reflexes

•Invasive neurological monitoring unit

Level 3: Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

•Monitoring and supportive therapy for compromised / collapse of two or more organ / systems

•Respiratory or CNS depression / compromise requires mechanical / invasive ventilation

•Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection.

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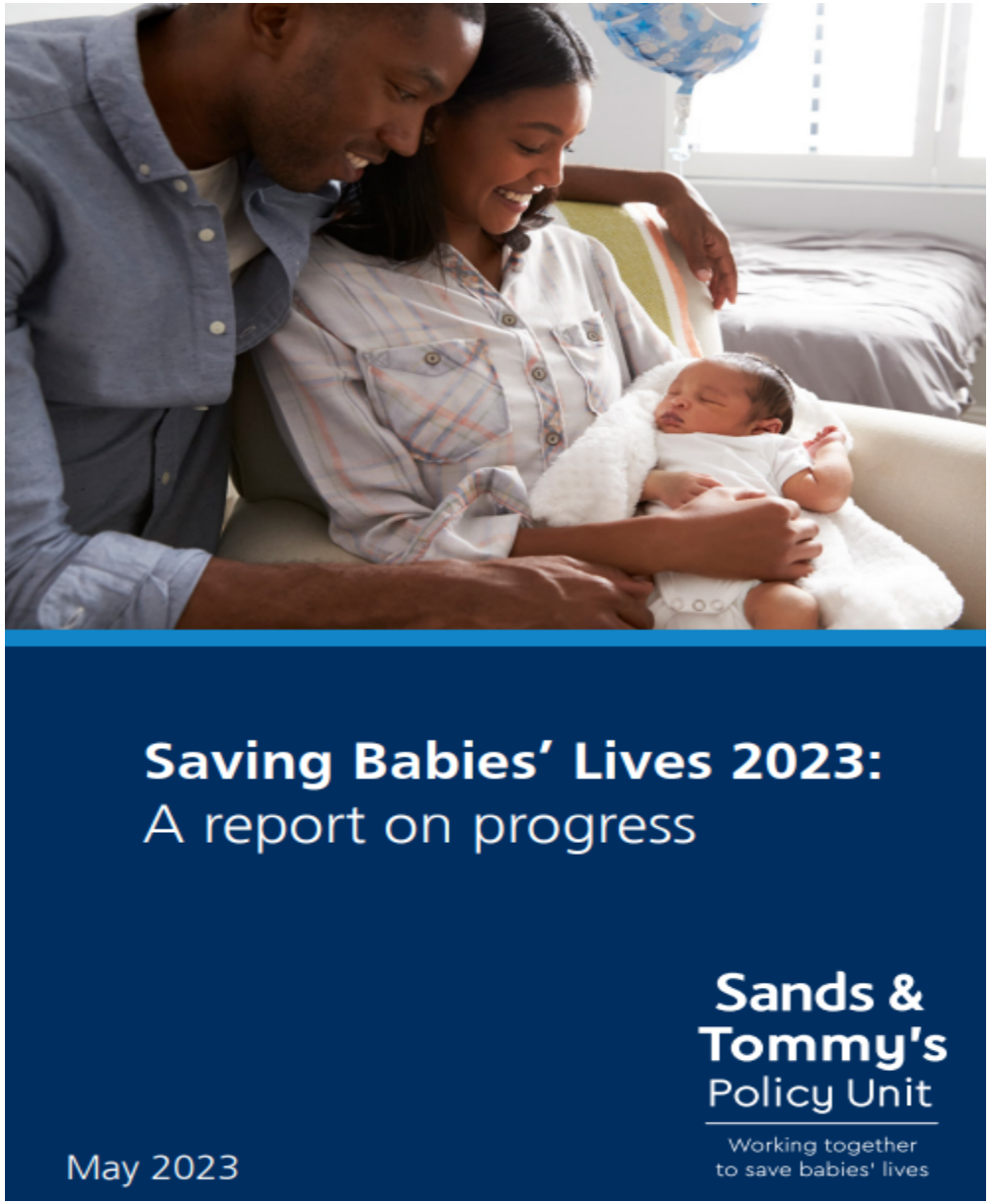
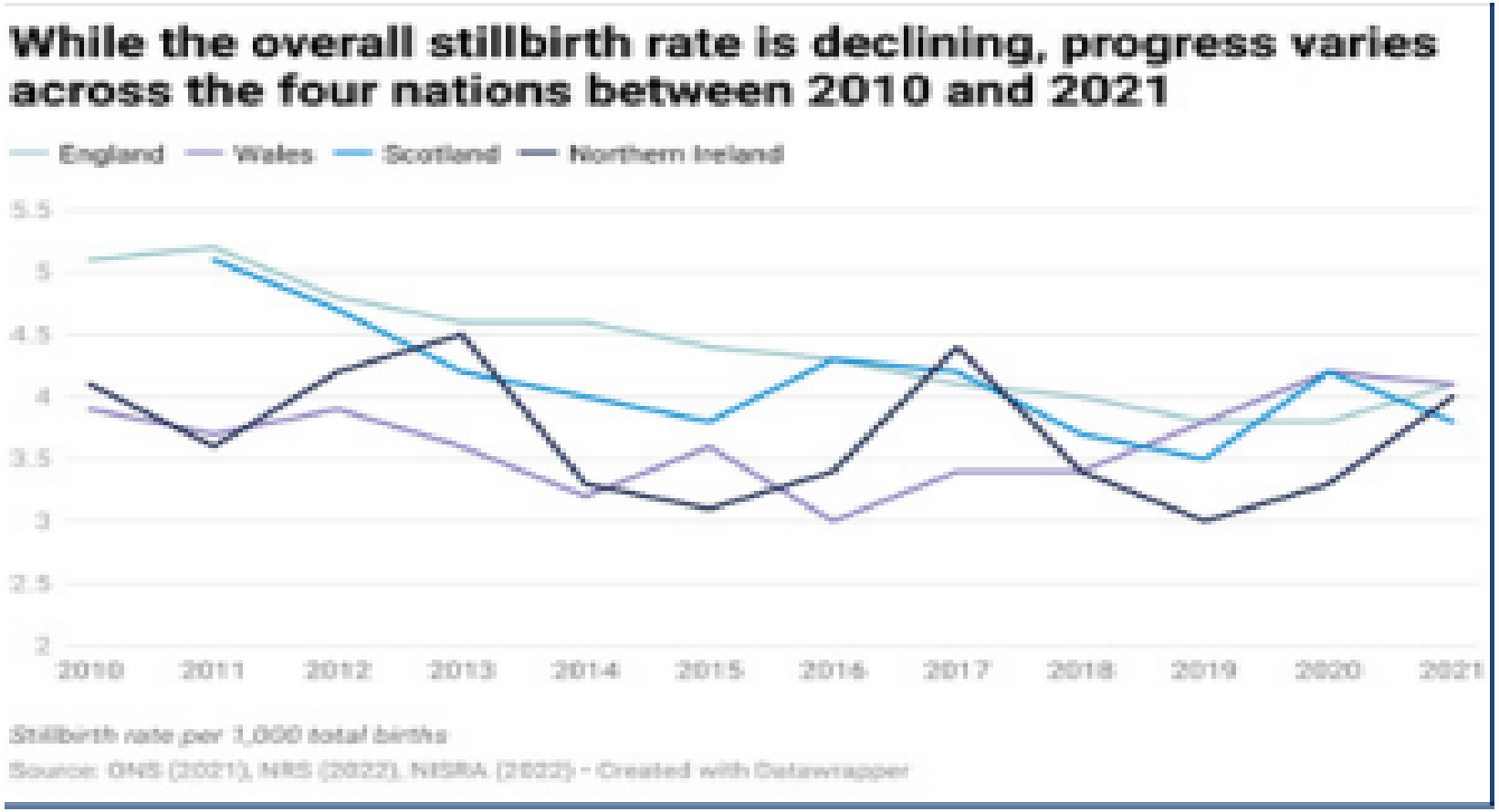
Item 14.15

Presentation of report to the Clinical Audit meeting 17.05.2023



JPU_Saving_Babies_Lives_Report_2023.pdf (sands.org.uk)

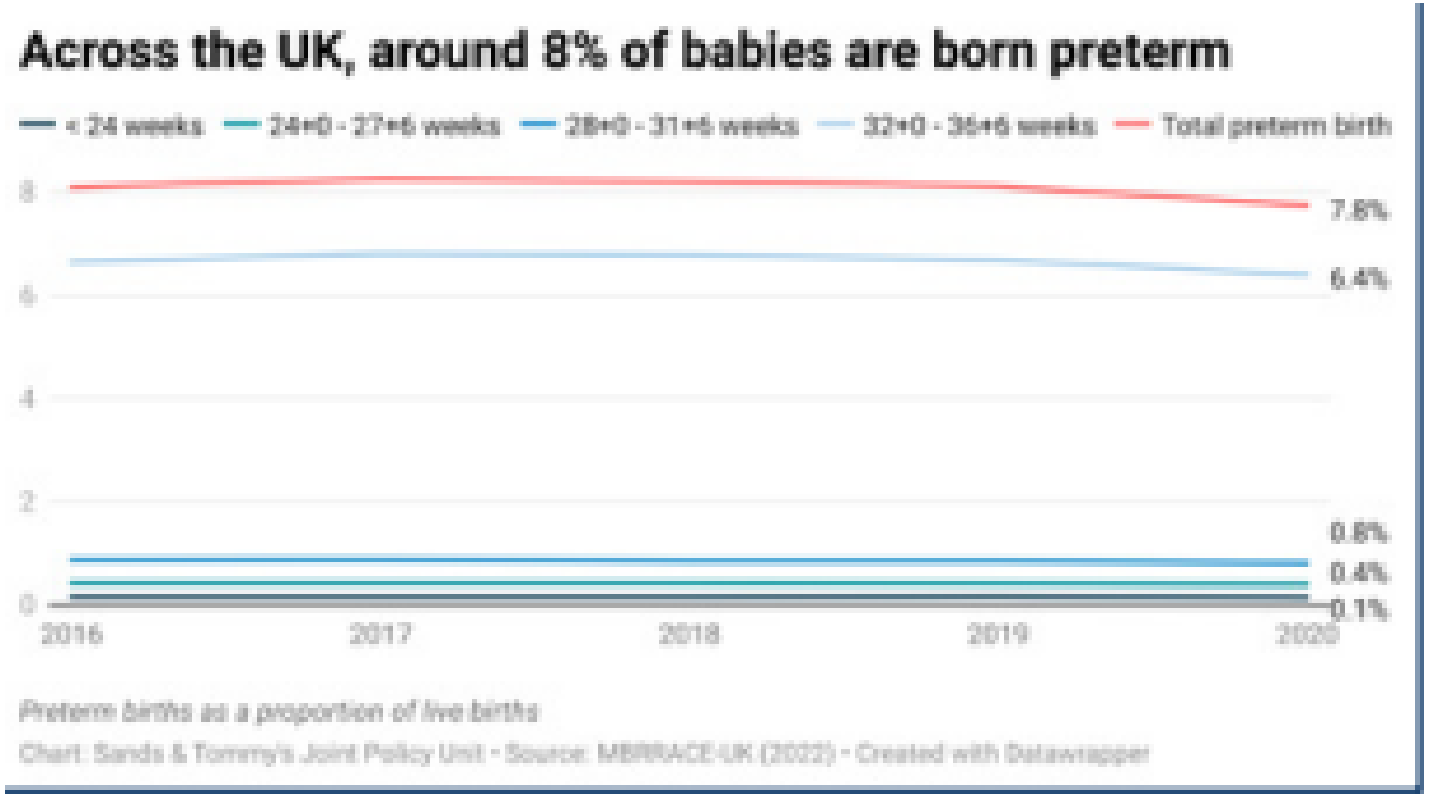
While at the UK-level the rate of stillbirths has declined overall over the last decade, there has been variable progress across the four nations of the UK (see Figure 2). Stillbirths have declined steadily in England since 2010, although there was an increase in the most recent data for 2021.



- In England the government has set an ambition to halve rates of stillbirth by 2025 relative to 2010 rates (see Fig. 3). This equates to 2.6 per 1,000 births. An interim target of a 20% reduction by 2020 (4.1 per 1,000 births) was exceeded with a 25% reduction (3.8 stillbirths per 1,000 births) in 2020. However, stillbirth rates in 2021 increased back up to 4.1 per 1,000 births. This increase could be linked to the impact of the Covid-19 pandemic; however, the data are not clear.
- We know that the pandemic had a significant impact on maternity and neonatal services, and also that Covid-19 can lead to adverse pregnancy outcomes. Covid-19 infection is associated with higher likelihood of preterm birth and may be associated with increased incidence of Small for Gestational Age babies. Covid-19 infection has also been associated with higher risk of stillbirth and neonatal death

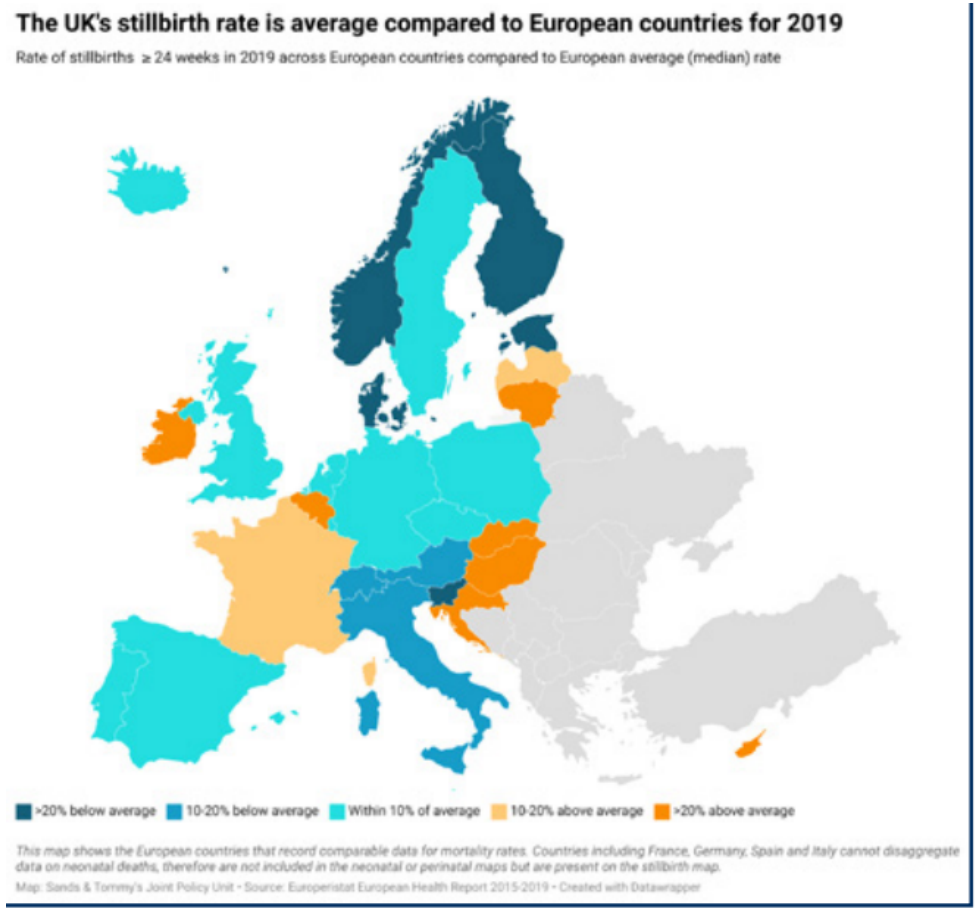
As of March 2023 WMH Still birth rate was 3.01 per 1000
(May data released 17.05.2023 not presented at audit 2.76 per 1000)

- There has been relatively little progress on reducing preterm birth rates across the UK. The total proportion of births that were preterm (born before 37 weeks of pregnancy) was 7.8% in 2020, down from 8.3% in 2017. Preterm birth rates in the UK are higher than the average of 6.9% in Europe .



WMH PRETERM RATE 22-23 6.7%

Rates of stillbirth and neonatal death – comparison with other European countries

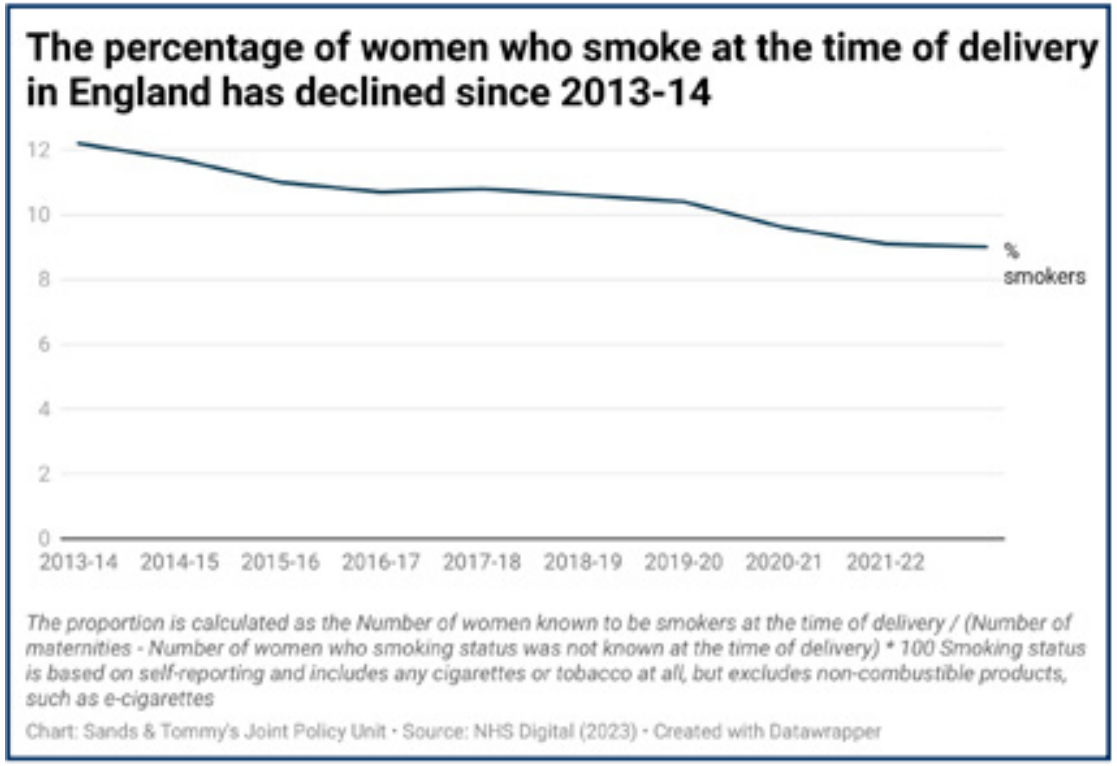


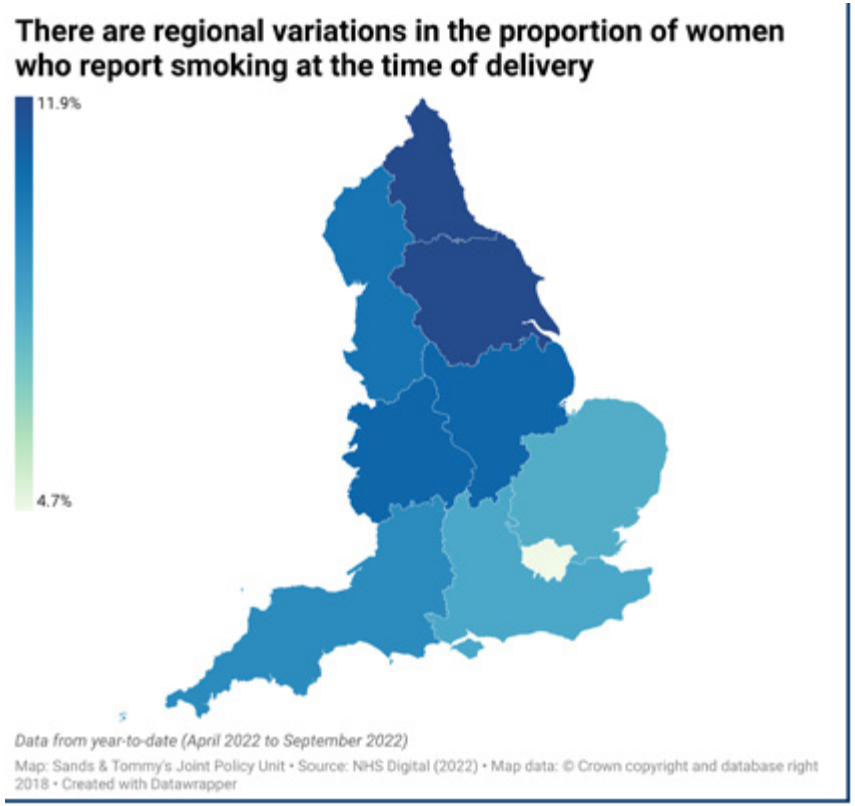
Although international comparisons can be useful to benchmark the UK's progress and to see what is possible elsewhere, comparing progress on reducing stillbirths and neonatal deaths internationally is challenging as we need to recognise the differences in the populations between countries, the health care systems and policies related to pregnancy and maternity care. Countries also vary in the timing of screening for congenital conditions and legislation regarding the gestational age limit for terminations of pregnancy, both of which may affect stillbirth and neonatal mortality rates. Even the indicators themselves vary between countries – which use different thresholds for birth weight and/or gestational age for reporting stillbirths and neonatal deaths. Such national differences in data collection and analysis are a key barrier to meaningful international comparison. Despite these limitations, international comparisons show that it is possible for the UK to continue to reduce perinatal

- Maternal characteristics, including age, diet and obesity, and smoking, drug and alcohol use are associated with higher rates of stillbirth and neonatal death. The profile of the population giving birth has changed over time and, today, is varied across different parts of the UK

- It is important that health services are set up to provide care and support that are tailored to an individual's needs. Maternity services need to have the capacity and resources to understand the complexity of women and birthing people's lives and provide services which meet their needs, effectively assess, and reduce the impact of risk factors. Some of these risk factors are modifiable by health services, meaning they can theoretically be changed through additional support, such as stop smoking services. However, correctly predicting risks can be affected by bias from health care professionals. Risks should be contextualised so that women and birthing people feel supported and not stigmatised by health services

Smoking, drug and alcohol use Smoking is associated with an increased rate of stillbirth, miscarriage and birth defects.





Map 3. Regional variation in the percentage of women who smoke at delivery in England in 2022

- Stillbirths and neonatal deaths are more common among women and birthing people from minoritised ethnic groups and those living in the most deprived areas across the UK. The risk of preterm birth and miscarriage is also higher among minoritised ethnic groups. Inequalities are persistent and have shown little change over time. In fact, the difference in stillbirth rates between those living in the least and most deprived areas has actually increased since 2010

Stillbirth rates were lowest amongst white babies and highest amongst black African babies in the UK between 2016 and 2020

Ethnicity group	Stillbirth rate (2016 - 2020)
White	3.43
Other	3.88
Mixed	4.09
Other Asian	4.53
Indian	4.88
Bangladeshi	5.60
Pakistani	6.21
Other black	6.22
Black Caribbean	6.42
Black African	7.80

Table: Sands & Tommy's Joint Policy Unit • Source: MBRRACE-UK (2022) • Created with Datawrapper

Table 3. Stillbirth rates between 2016 – 2020 across individual ethnic groups in the UK

	Total stillbirths (2020)	Number of stillbirths prevented if rate were equal to stillbirth rate amongst white babies
White	1,486	-
Mixed	160	36
Asian, Asian British	353	128
Black, black British	186	94
Other	96	42
Total	**2,281**	**300**

Based on MBRRACE-UK data for UK and Crown Dependencies

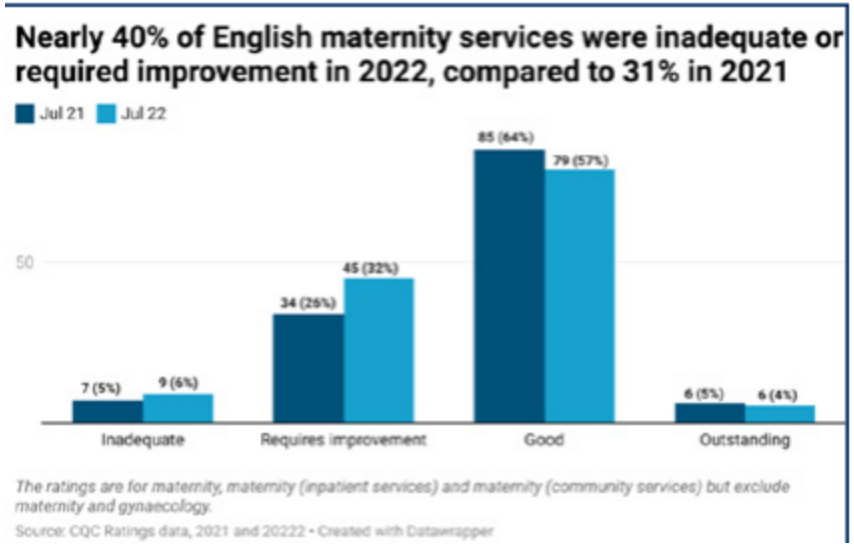
Table: Sands & Tommy's Joint Policy Unit • Source: MBRRACE-UK (2022) • Get the data • Created with Datawrapper

Table 2. Total UK stillbirths in 2020 across ethnic groups and potential number of stillbirths prevented if the rate across all groups were equal to the stillbirth rate amongst white babies

Systemic issues in maternity and neonatal services need to be addressed

- Improving services requires a culture of learning from mistakes, teamwork and collaboration, and ongoing learning and development.

The most recent data from the CQC show a decline in overall maternity service ratings between 2021 and 2022o (see Fig.36). In 2022, 6% of services were rated inadequate and 32% required improvement.



Staffing levels - the current picture Comparing average staffing totals for different health professional roles with the annual number of deliveries for England between 2009-10 and 2021-22140 there were: 2009-10 2021-2

2009-10	2021-22
1 midwife for every 33 births	1 midwife for every 26 births
1 obstetrician or gynaecologist for every 126 births in 2009-10	1 obstetrician or gynaecologist for every 90 births
Not recorded	1 neonatal nurse for every 17 neonatal admissions*
1 maternity nurse for every 108 births	1 maternity nurse** for every 247 births

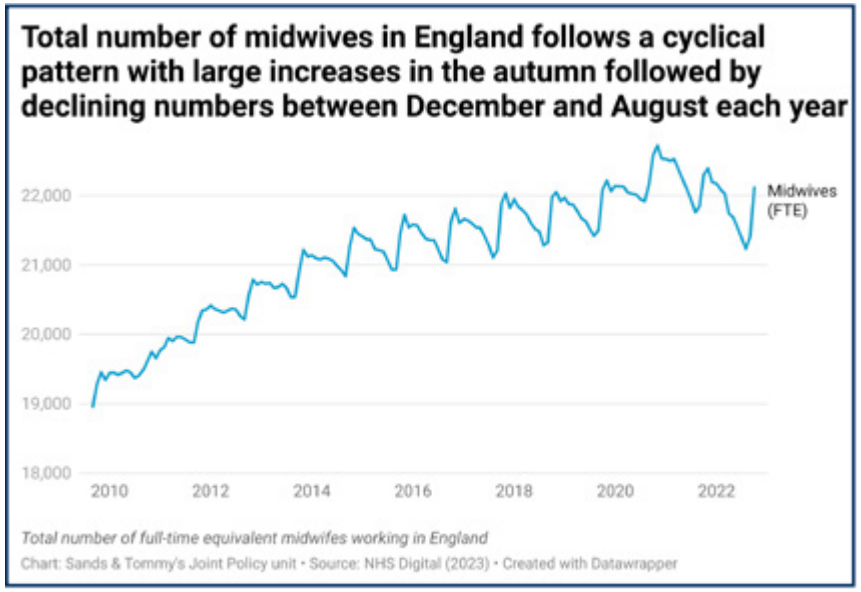
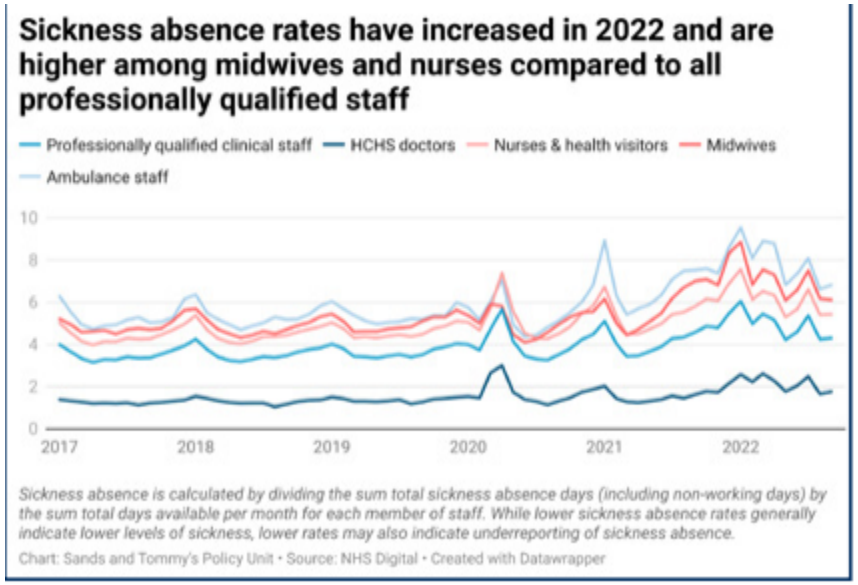
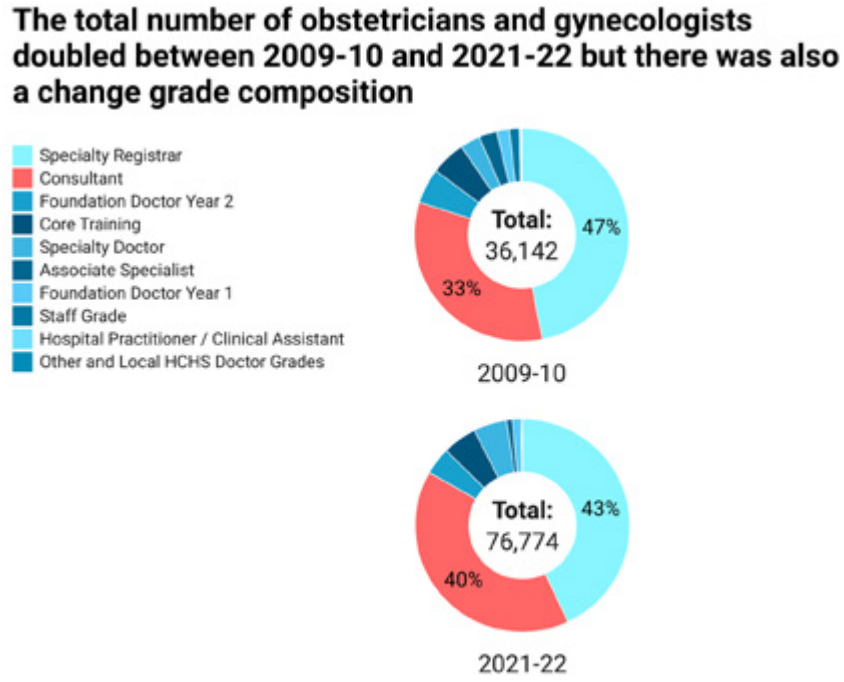


Figure 43. Monthly number of midwives in England between 2010 and 2022



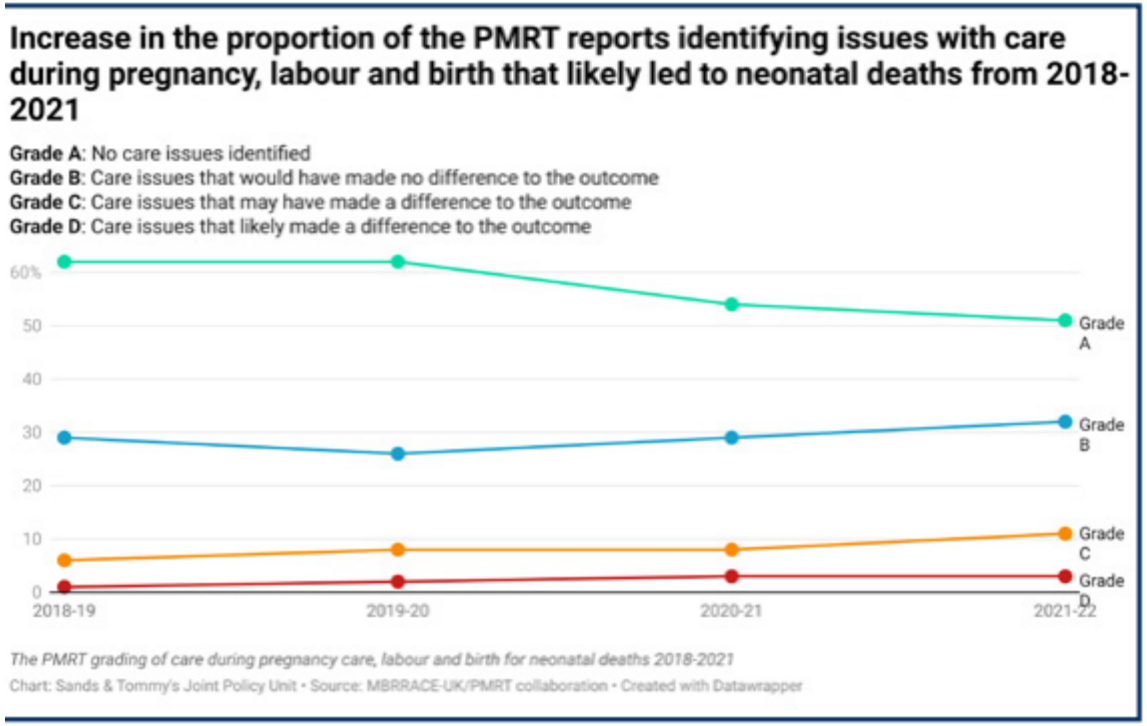


- There is a critical shortage of perinatal pathologists across the UK. The shortage has been building for many years and is leading to long waits for post-mortem reports, as described by parents and healthcare professionals in recent Sands surveys. Providing timely post-mortems is critical for understanding the cause of baby deaths for parents and health services. The workforce of perinatal pathologists is unevenly distributed: in some parts of the UK services remain acceptable, while elsewhere there are too few or no specialist pathologists. Mutual aid between pathology centres has functioned in recent years but has been breaking down as overburdened centres have dwindling capacity to pick up cases beyond their own area. In some areas alternative approaches to service provision have been adopted.

Lessons are still not being learnt when babies die

- Understanding the cause of stillbirths and neonatal deaths is essential to prevent future deaths through research and improvements in care, but there is a lot we still don’t know: in 2021, the causes of 33% of stillbirths and 7% of neonatal deaths were unknown.
- The most common cause of stillbirths in 2020 was placental.
- Standardised hospital reviews following the death of baby are essential to provide answers for parents and families as well providing information for Trusts to know where to improve. In 2021-22, nearly a fifth of stillbirths were found to be potentially avoidable if better care had been provided.

- The PMRT findings for neonatal deaths are presented separately based on care during pregnancy, labour and birth, and care after birth. The number of care issues graded C or D during pregnancy, labour and birth increased from 8% to 13% between 2018-19 and 2021-22 (see Fig. 52). The proportion of issues graded D, where care was likely to have made a difference to neonatal deaths, increased from 1% to 3%, or from 7 to 37 care issues in total.



- The most recent review of spending on pregnancy research in the UK was undertaken by RAND205 in 2020, looking at data from 2013 to 2017. The review found that £51 million is invested each year in pregnancy research in the UK, compared to the £5.8 billion in pregnancy-related care costs which the NHS spends per year. In other words, the NHS spends 1p on pregnancy research for every £1 spent on maternity care, compared to 7p for every £1 on heart disease or 12p for every £1 on cancer.

Item 14.16

NHS England

Three year delivery plan for maternity and neonatal services

March 2023

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Summary

With this plan we aim to make care safer, more personalised, and more equitable, by:

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide “PSIRF” approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new “MEWS” and “NEWTT-2” tools by 2025.
- In 2023, NHS England’s new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Introduction

1. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. We are grateful to the many people and organisations that have shared what needs to be done including NHS staff, Donna Ockenden, Dr Bill Kirkup, and organisations representing families. Most importantly, we would like to thank those using maternity and neonatal services for informing this plan. While the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve.

2. The summary above sets out the benefits we expect to deliver for families through this plan. This will continue to require the dedication of everyone working in NHS maternity and neonatal services in England, who work tirelessly to support families and improve care. Most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved with over 900 more families welcoming a healthy baby each year compared to 2010.

3. But we must acknowledge that there are times when the care we provide is not as good as we want it to be. Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. We know that families from some groups, especially ethnic minorities, have had particularly poor experiences. We must work together to change this, and this plan sets out how we will do this.

4. In preparing this plan we have listened to what you have to say. We know all staff want women and babies to be at the centre of care, and with so many improvement initiatives it can be difficult to know what to prioritise. We know gaps in staffing mean those who provide care do not always have time to learn and improve, and on occasion, struggle to provide care to the highest standards. We have heard that some people feel disempowered by negative team cultures and a lack of strong leadership.

5. For the next three years, we are asking services to concentrate on **four high level themes**. Please take some time to consider these themes, what they mean to you and to the women and babies you care for. Working together, we can make a real difference.

Responsibilities

6. This plan sets out what we need to have in place, and responsibilities for each part of the NHS:

   - Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.
   - Integrated care boards (ICBs) commission most maternity services. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.
   - NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional specialised commissioning teams and operational delivery networks (ODNs).

7. It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. We have sought to improve our approach to quality surveillance at trust, ICS, regional, and national level. This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

What you told us

8. We could not develop this delivery plan without talking to people who use, work in, lead, or have an interest in these services. We want to thank everyone who shared their views to inform this plan. We held 50 meetings reaching over 1,000 attendees, including 191 service users, 419 workforce members, 329 leaders of services, systems, and regions, and 106 stakeholders. We additionally received 2,128 responses to our survey from 782 service users, 1,133 workforce members, 105 leaders, and 108 stakeholders.

9. While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this plan also applies to these individuals; particularly the principles described in Theme 1.

10. While each of the groups who helped inform this plan had different areas they gave greatest importance to, there was clear agreement on what the plan's focus should be. This consensus has shaped the four themes, and the objectives within each of these.

11. The most consistent priority among those using and providing services was safe care. Delivering safe care remains central to this delivery plan.

    "Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right." (Service user)

    "We need to take action and make a pledge to improve the safety of every maternity service in England." (Leader)

12. You told us how important improving equity and equality is. We have a dedicated objective on improving equity.

    "Those that are most vulnerable should be enabled to have a strong voice within maternity care provision." (Stakeholder)

13. You told us that we need to be clear about who is responsible for doing what, and to bring the asks of services and systems into one place. This delivery plan sets out clear responsibilities and measures of success across services and systems.

    “One clear plan that looks to encompasses the recommendations from various reports such as Better Births, Ockenden, Kirkup.” (Workforce member)

Listening to and working with women and families with compassion

14. You told us that personalised care supports safety, makes women feel valued, and avoids families needing to re-tell their story – who they are or what they need. You told us it is important to join up care across maternity and neonatal pathways.

    “To be treated as an individual human being.” (Service user)

    “Consistency! I saw so many different people I had to tell them my 'story' every time.” (Service user)

    “Being fully informed without judgement on pros and cons of all care offered.” (Service user)

    “Listening to the families using the care and embedding their voices along all pathway.” (Leader)

    “Supporting parents to be actively involved in the care of their baby on the neonatal unit (family integrated care).” (Service users)

Growing, retaining, and supporting our workforce

15. You told us that there needs to be enough staff in services, with the time and training to support their effectiveness as well as to protect their wellbeing.

    “Safe staffing that will then provide safe and personalised care.” (Leader)

    “Enough staffing to feel supported, safe and provide care when it is needed.” (Service user)

    “Adequate staff with the appropriate training working in the right environment. Having the time and resources to listen to women and their families.” (Workforce member)

Developing and sustaining a culture of safety, learning, and support

16. You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion.

    “Listening, learning and facing up to failings.” (Stakeholder)

"Confidence in the care provider, trust, integrity and honesty if mistakes occur." (Leader)

"Leadership training to enable managers to better manage teams and support them." (Workforce member)

"Psychological safety at work and teams that work together with a shared vision and a foundation of kindness." (Stakeholder)

Standards and structures that underpin safer, more personalised, and more equitable care

17. You told us that we need to improve our data collection to help oversight and improvement, among other important standards and infrastructure. Our fourth theme focuses on these crucial elements that support the other themes.

"Notes to be available to all staff when required rather than just to one person." (Service user)

"Delivering high quality, evidence-based care in a local environment for service users." (Workforce member)

"Improved data collection and IT systems - joined up maternity and neonatal electronic patient record systems which are user friendly and accessible." (Workforce member)

"Organisational transparency and providing in depth data to provide meaningful data that can be used to prevent as well as respond to trends and themes." (Leader)

Theme 1: Listening to and working with women and families with compassion

1.1 Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Better Births identified that "women wanted to be listened to about what they want for themselves and their baby, and to be taken seriously when they raise concerns". The Ockenden report into maternity services at Shrewsbury and Telford described how families who raised concerns "were brushed aside, ignored and not listened to". This section sets out actions for personalised care, improving equity, and working with service users.

1.2 Key commitments for women and families include:

Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.

Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.

Rolling out perinatal mental health services to improve the availability of this specialist care.

Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.

Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.

Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.

Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Objective 1: Care that is personalised

1.3 Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story. While many women and babies experience excellent personalised care (CQC, 2023), it is clear from independent reports that not all do.

1.4 Our ambition is:

- Women experience care that is always kind and compassionate. They are listened and responded to.
- Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected.
- All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.
- Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.
- Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced.
- All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.
- Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8

weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.

- Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.
- Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.

How we will make this happen

1.5 It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.
- Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

1.6 It is the responsibility of integrated care boards (ICBs) to:

- Commission for and monitor implementation of personalised care for every woman.
- Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.
- Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.

1.7 NHS England will:

- Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.

- Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.
- Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.
- In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.
- Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.
- By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.
- Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.

Objective 2: Improve equity for mothers and babies

1.8 Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022). Though we know NHS staff want to provide the best care to every woman and baby, a National Institute for Health and Care Research funded study found that “multiple structural and other biases exist in UK maternity care”. (Knight, M et al, 2021).

The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

1.9 Our ambition is:

- To reduce inequalities for all in access, experience, and outcomes.
- Targeted support where health inequalities exist in line with the principles of proportionate universalism.
- Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships

ensure all groups are heard, including those most at risk of experiencing health inequalities.

- The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022).

How we will make this happen:

1.10 It is the responsibility of trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.
- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

1.11 It is the responsibility of ICBs to:

- During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.
- Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.

1.12 NHS England will:

- Provide regional and national support for the implementation of LMNS equity and equality action plans.
- Pilot and evaluate new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.
- Continue to work with the Maternity Disparities Taskforce to explore disparities in maternity care and identify how to improve outcomes.

- In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.

Objective 3: Work with service users to improve care

1.18 Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users.

1.19 Our ambition is:

- MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- MNVPs have strategic influence and are embedded in decision-making.
- MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

1.20 In addition, neonatal parental advisory groups represent service user experience as part of operational delivery networks.

How we will make this happen:

1.21 It is the responsibility of trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

1.22 It is the responsibility of ICBs to:

- Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.
- Ensure service user representatives are members of the local maternity and neonatal system board.

1.23 NHS England will:

- Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.
- Through operational delivery networks, support parent representation in the governance of neonatal services.
- Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.

Determining success for Theme 1

1.24 We will determine overall success by listening to women and their families:

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.
- We will use these progress measures:
  - Perinatal pelvic health services and perinatal mental health services are in place.
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
  - The proportion of maternity and neonatal services with UNICEF BFI accreditation.
- Evidence which ICBs can use includes:
  - Feedback on personalised care gathered via MNVPs from a wide range of service users.
  - Local evidence of working with women and families to improve services, including co-production.
- Relevant regulation and incentivisation includes:
  - The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections.
  - The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs.

Case Study: Seeking Sanctuary Clinic - to enhance the maternity care of anyone seeking sanctuary

The Seeking Sanctuary Clinic, hosted in Berkshire West, is a specialist maternity clinic developed in 2021 from co-production between Royal Berkshire NHS Foundation Trust maternity team, and Berkshire West public health team, to enhance the maternity care of anyone seeking sanctuary such as refugees, asylum seekers, those fleeing conflict, undocumented migrants and people who have been trafficked.

This is a 'one stop shop' style clinic held in a children's centre, delivered in two-hour sessions held every two months, aimed specifically for these families, in addition to their usual antenatal and postnatal care. The barriers to access and inequalities that these families may be experiencing are removed where possible. For example, women are able to bring their partners and children with them, there are interpreters booked for every language in attendance, refreshments are provided and transport is available to support people to get to the clinic.

There are many health care professionals and voluntary organisations that come together at the clinic including midwifery and obstetrics. There is also accessible antenatal education with New Directions, sexual health, health visiting, a tuberculosis service, health in pregnancy advisors, Compass Recovery College (mental health and wellbeing support), Reading Refugee Support and Reading Voluntary Action.

The clinic is ever evolving, and additional professionals and organisations are invited to sessions to meet the bespoke needs of the group. Local charity The Cowshed donated to the clinic enabling each family that attends to be provided a ready-made birth bag to assist them on their journey.

The local Maternity Voices Partnership also attends to offer feedback sessions for these groups. While the project is in an initial evaluation phase, feedback so far has been very positive from service users, with more than fifty families supported so far, predominantly from Afghanistan, Syria, and Ukraine.

Theme 2: Growing, retaining, and supporting our workforce

2.1 The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. We need to change that. The plan is informed by the best available evidence, including the QMNC framework which underpins the NMC midwifery standards. This theme sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills.

2.2 Key commitments for women and families include:

NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.

Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.

Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.

Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Objective 4: Grow our workforce

2.3 The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and

psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements.

2.4 Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.

2.5 Our ambition is for:

- Workforce capacity to grow as quickly as possible to meet local needs.
- Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training, absence, and leave.
- Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.

How we will make this happen

2.6 It is the responsibility of trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

2.7 It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

- Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.

2.8 NHS England will:

- Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.
- Boost midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.
- Increase medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services.
- Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.

Objective 5: Value and retain our workforce

2.9 Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services. We need to do more to improve the experience of all our staff, to retain them within the NHS.

2.10 Our ambition is:

- Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.
- All staff are included and have equality of opportunity.

- A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

How we will make this happen

2.11 The NHS Long Term Plan and NHS People Plan set out how improving the experience of our NHS people will encourage them to stay with us for longer.

2.12 It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

2.13 It is the responsibility of ICBs to:

- Share best practice for retention and staff support.
- Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.

2.14 NHS England will:

- Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.
- Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.
- In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.

- In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.
- Continue to address workforce inequalities through the Workforce Race Equality Standard.
- Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.
- By July 2023, develop a safe clinical learning environment charter for trusts; by April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.

Objective 6: Invest in skills

2.15 Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff (for example, Stulberg et al, 2020, McCulloch et al, 2008).

2.16 Our ambition is:

- All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.
- All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards.
- Training is multi-disciplinary wherever practical to optimise teamworking.

How we will make this happen

2.17 It is the responsibility of trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

2.18 NHS England will:

- Refresh the curriculum for maternity support workers (MSWs) by June 2023.
- Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.
- Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.
- Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks.
- Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.
- Through action set out above to grow the workforce, help to address pressures on backfill for training.

Determining success for Theme 2

2.19 We will determine overall success by listening to staff:

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.

  - To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.
- Evidence that ICBs can use includes:
  - Progress against workforce, retention, succession, and training plans.
  - Local staff feedback mechanisms.
  - Progress against the nursing and midwifery high impact retention interventions.
- Relevant regulation and incentivisation includes:
  - The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development.
  - The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place.

Case study: One stop obstetric ambulatory service

The Chelsea and Westminster Hospital NHS Foundation Trust cares for approximately 5,500 maternity patients per year. The maternity team identified common themes in complaints about their service, including delays in receiving care and long waits for obstetric or scan reviews. The team felt they could improve triage management, patient experience and care, through a truly multidisciplinary approach so set up a ‘one stop’ service since January 2021.

The team recognised a key cause of delay within the department was delays in obstetric reviews. They were able to increase consultant presence and recruit a clinical fellow with obstetric ultrasound training to work solely in the triage department for five mornings a week, to deliver a ‘see and treat’ set up, comparable to the way emergency departments are run.

The triage team also includes midwives and maternity support workers, who greet attendees, perform initial observations and a dedicated receptionist who enables clinicians to focus on care rather than administrative tasks. Some midwives have developed professionally to perform tasks that are usually undertaken by obstetricians, such as prescribing and performing presentation scans.

From October 2022 to February 2023 the service has had on average 850 visits per month, with around 100 ultrasound scans performed. The department answers approximately 2,500 phone calls per month, with one midwife allocated to answer phone calls each day to triage and support women.

Improvements in the new obstetric ambulatory service triage system mean the department works more efficiently and safely with staff feeling better supported. Waiting times have been reduced, with 80-95% of women seen within 15 minutes of arrival which exceeds the national KPI (within 30 minutes) for maternity triage services. Feedback from women has also been increasingly positive. The team are exploring future opportunities to expand the service hours and increase the scope of midwifery and maternity support workers, supporting the team’s development and dynamic skillset.

Theme 3: Developing and sustaining a culture of safety, learning, and support

3.1 An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. This theme sets out actions in three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

3.2 Key commitments for women and families include:

> Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.
>
> Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.
>
> Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Objective 7: Develop a positive safety culture

3.3 Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

3.4 Our ambition is:

- All staff working in and overseeing maternity and neonatal services:
  - Are supported to work with professionalism, kindness, compassion, and respect.

  - Are psychologically safe to voice their thoughts and are open to constructive challenge.
  - Receive constructive appraisals and support with their development.
  - Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'.
- Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.
- Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.
- Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

How we will make this happen

3.5 It is the responsibility of trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.
- Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.

3.6 It is the responsibility of ICBs to:

- Monitor the impact of work to improve culture and provide additional support when needed.
- Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.

3.7 NHS England will:

- By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Objective 8: Learning and improving

3.8 Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs.

3.9 Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services.

3.10 The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria. The responsibilities for trusts and ICBs set out below, also apply to these, or any other external investigations.

How we will make this happen

3.11 It is the responsibility of trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.
- Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.

- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.
- Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).

3.12 It is the responsibility of ICBs to:

- Share learning and good practice across all trusts in the ICS.
- Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.

3.13 NHS England will:

- Throughout 2023, support the transition to PSIRF through national learning events.
- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

Objective 9: Support and oversight

3.14 While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

3.15 Our ambition is:

- Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.
- Well led services, with additional resources channelled to where they are most needed.
- Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.

How we will make this happen

3.16 It is the responsibility of trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.

3.17 It is the responsibility of ICBs to:

- Commission services that enable safe, equitable, and personalised maternity care for the local population.
- Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.
- Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.

3.18 NHS England will:

- Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.
- Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.
- Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).
- Work to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.
- During 2023/24, test the extent to which the PQSM has been effectively implemented.

- By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

Determining success for Theme 3

3.19 Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in frontline services.

3.20 Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.

- The evidence ICBs can use across maternity and neonatal services includes:
  - Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.
  - Whether trust boards regularly share and act on learning.
  - Staff feedback on how incidents and issues of concern are managed.
- Relevant regulation includes:
  - The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.

Case study: NFaST - Neonatal Families and Staff Together, supporting neonatal units to become more emotionally supportive environments

In 2021, the North West Neonatal Operational Delivery Network commissioned Spoons, a Greater Manchester-based charity specialising in neonatal family support, to research how their neonatal units could become more emotionally supportive environments for service users and staff.

The project worked with 13 neonatal units and a 28-family focus group, collecting data from more than 260 parents and 250 staff members, exploring their emotional needs. The project identified that the experience of neonatal care has a profound long-term impact on parents and their infants. In turn, the experience of working on a neonatal unit is emotionally challenging and can have significant impact on a staff member's individual wellbeing.

Volunteer peer supporters, who had personal experience of neonatal care, were trained for the units. Psychological training was provided to 100 staff across four neonatal units, including doctors, nurses, and support staff. Reflective practice group sessions were led by a clinical psychologist, to help the teams collaborate and understand each other and the needs of their babies and families better.

The pool of volunteer peer supporters continues to grow, and additional peer support training has been commissioned, with a model of ongoing supervision in development. This project demonstrates the power of true collaboration between the NHS, service users and third sector partners.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

4.1 To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.

4.2 Key commitments for women and families include:

Making care safer by consistently implementing best practice, including:

- By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.

In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.

By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.

Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Objective 10: Standards to ensure best practice

4.3 Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

4.4 Nationally defined best practice already exists, including:

- The Saving Babies Lives Care Bundle, a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- The national maternity early warning score (MEWS)and updated newborn early warning trigger and track (NEWTT-2) tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care.
- NICE guidance, which sets out the evidence based best practice in maternity and neonatal care.

4.5 Our ambition is:

- Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.
- Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice care.
- Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance.
- Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines.
- Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.

How we will make this happen

4.6 It is the responsibility of trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

4.7 It is the responsibility of ICBs to:

- Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.
- Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.
- Monitor and support trusts to implement national standards.
- Commission care with due regard to NICE guidelines.

4.8 NHS England will:

- Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.
- Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.
- Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.
- Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the FutureNHS platform.

Objective 11: Data to inform learning

4.9 The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects.

4.10 Our ambition is:

- Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.
- Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports.
- The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work.

How we will make this happen

4.11 It is the responsibility of trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

4.12 It is the responsibility of ICBs to:

- Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.

4.13 NHS England will:

- At a regional level, understand any variation in outcomes and support local providers to address identified issues.
- Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.

- Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.

Objective 12: Make better use of digital technology in maternity and neonatal services

4.14 Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

4.15 Our ambition is:

- Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.
- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

How we will make this happen

4.16 It is the responsibility of trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.

- Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

4.17 It is the responsibility of ICBs to:

- Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- Support regional digital maternity leadership networks.

4.18 NHS England will:

- Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Determining success for Theme 4

4.19 We will determine overall success by focusing on clinical outcomes:

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.

  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
  - A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
- The evidence that ICBs can use includes:
  - Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.
  - An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
  - Progress against locally planned improvements.
- Relevant regulation and incentivisation includes:
  - The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions.
  - The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.

Case Study: Ask A Midwife - using social media to communicate with service users

Ask A Midwife (AAM) is a social media messaging service managed by midwives, which empowers service users to make timely and informed decisions about their maternity care. AAM is coordinated centrally to ensure consistency of delivery and messaging by the Humber and North Yorkshire local maternity and neonatal system (LMNS), and four acute trusts are now working collaboratively to offer the service via Facebook, Instagram, and email.

The service is staffed by trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. Questions from women and families range from pregnancy, birthing options, appointments, and the care of a new-born baby.

More than 94% of queries can be answered immediately and midwives can refer women to other health professionals and support organisations where required. The service routinely averages 800 queries per month, with more than 8,500 queries answered overall in 2022 and 508 onward referrals to health professionals, maternity units, NHS 111, and pharmacies. Patient confidentiality is conducted in the same way as telephone queries would be in a hospital, but the usual ways of contacting the hospital maternity team, such as by phone, are also available.

The service also allows the LMNS to cascade timely public health updates for pregnant women, including communications around vaccinations, perinatal mental health, postnatal care, and infant feeding. For example, when the AAM team saw an increase in messages around winter viruses they responded by posting self-help information.

AAM is promoted through Maternity Voices Partnership groups, with printed postcards and posters distributed in maternity settings, Children's Centres, through direct referral by midwives, and attendance at community outreach events, such as one in Spring 2023 specifically for people from the Romanian and Polish community.

Support available to staff, trusts, and systems

The maternity hub on the FutureNHS platform has relevant material for each theme.

Theme 1: Listening to and working with women and families with compassion

- Personalised care and support planning guidance and the Personalised Care Institute
- Equity and Equality guidance for Local Maternity and Neonatal Systems
- NHS statutory guidance for working in partnership with people & communities
- National maternity voices partnership toolkit
- Service specification for care of pregnant and post-natal women in detained settings
- Delivering Midwifery Continuity of Carer at full scale
- Maternal medicine network national service specification

Theme 2: Growing, retaining, and supporting our workforce

- Nursing and midwifery retention self-assessment tool
- National preceptorship framework
- Advanced Clinical Practice: capability framework for midwifery
- RCOG advice and guidance on workforce planning and flexibility
- A 'how to' guide and templates to reflect the Core Competency Framework

Theme 3: Developing and sustaining a culture of safety, learning, and support

- Maternity and Neonatal Safety Champions toolkit
- NHS national freedom to speak up policy and guidance

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Support for quality improvement through patient safety collaboratives
- The Maternity self-assessment tool
- The recommendations register
- NICE guidance
- Saving Babies Lives Care Bundle
- An MSDS guidance hub
- For digital health there is Digital Maternity Leaders training course and the Shuri Network brings together women from minority ethnic groups

Acknowledgements

This plan has been developed with contributions from clinical leaders within NHS England and a wide range of partners, including but not limited to:

- The Independent Working Group, chaired by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Members include:
  - British Association of Perinatal Medicine
  - Royal College of Paediatrics and Child Health
  - Royal College of Anaesthetists
  - Obstetric Anaesthetists Association
  - Society of Radiographers
  - Care Quality Commission
  - The Department of Health and Social Care
  - Health Education England
  - Service user voice representatives.

- Hearing from around 3,000 people via events and a survey. This included:
  - People who use maternity and neonatal services
  - National and regional service user voice representatives
  - Frontline professionals, including midwives, obstetricians, and neonatal colleagues
  - Integrated care boards
  - NHS England regional teams
  - Voluntary, community, and social enterprise organisations
  - National Guardian's Office
  - National stakeholders.

We remain committed to working closely with partners as we deliver this plan. Thank you to all the individuals and organisations who have shared their time, expertise, and experience so far.

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This publication can be made available in a number of alternative formats on request.

Walsall Healthcare NHS Trust

April 2023 Workforce Metrics

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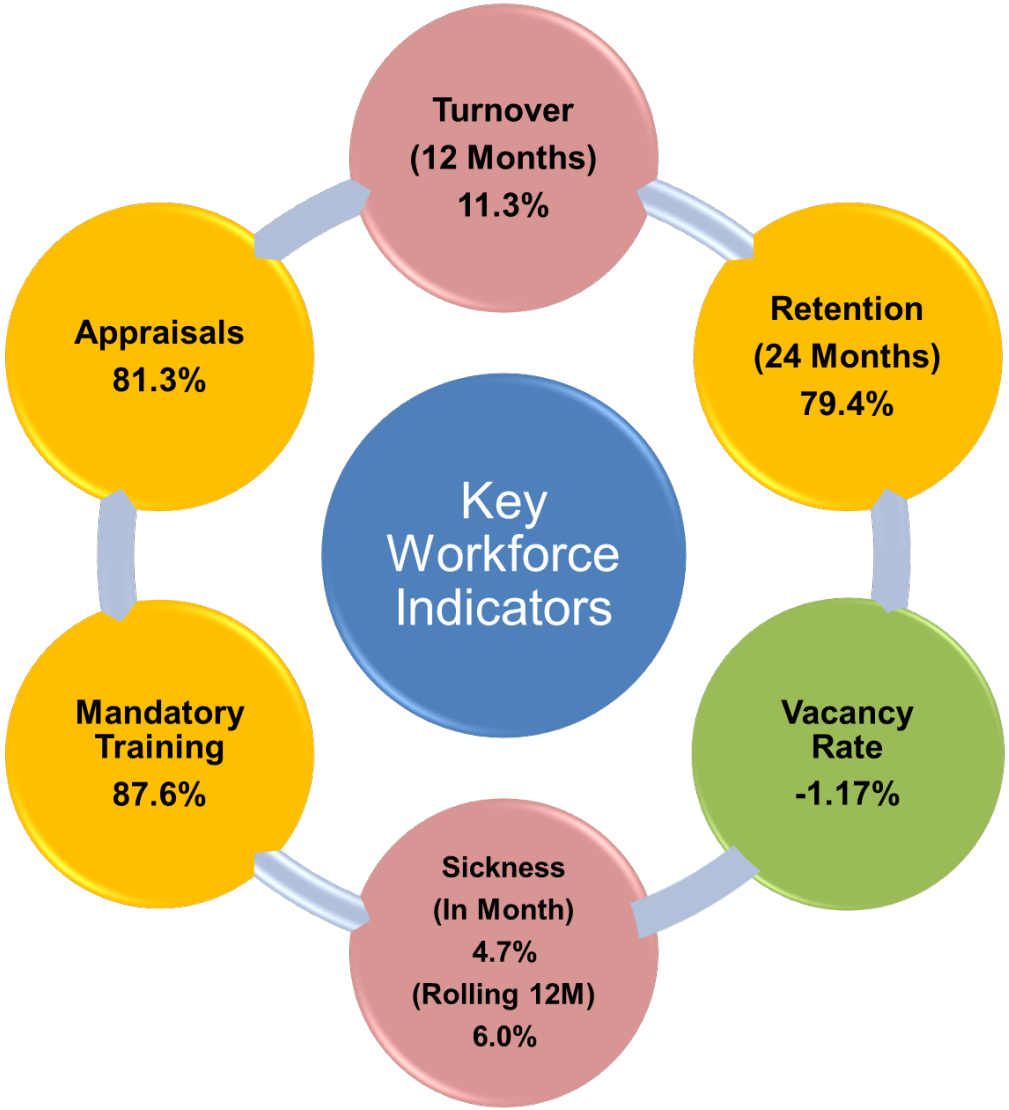
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Key Workforce Metrics

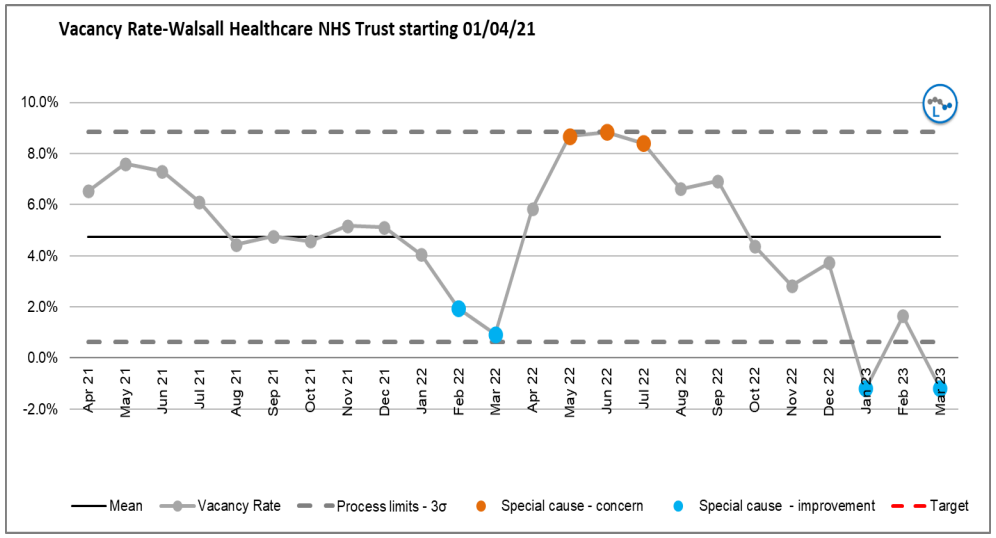


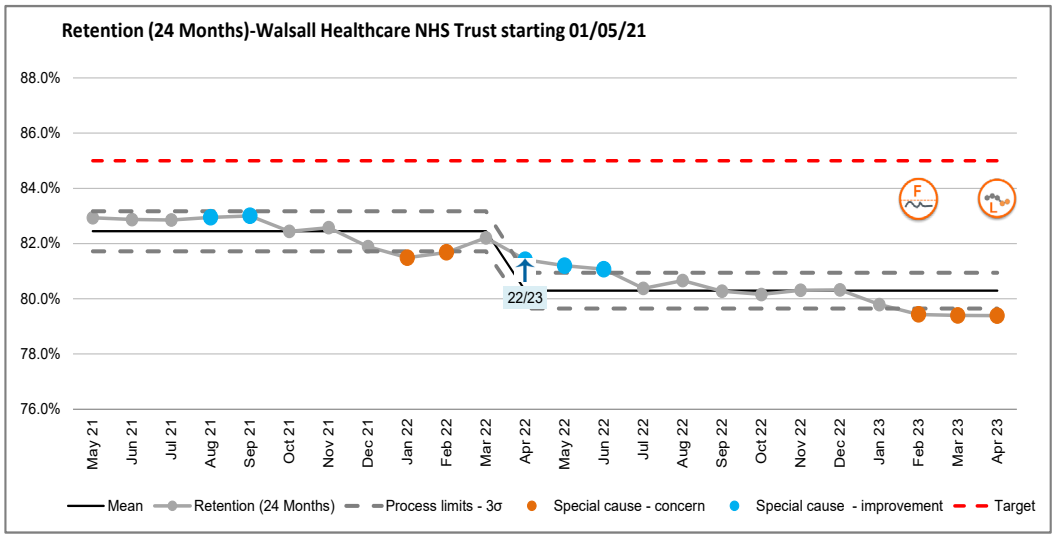
	Target	Will We Meet The Target?	Is Performance Stable?
Sickness Absence	5.0%	Sometimes	Getting Better
Mandatory Training Compliance	90%	No	Getting Worse
Appraisal Compliance	90%	No	Yes
Turnover (12 Months)	10%	No	Getting Better
Retention (24 Months)	82%	No	Getting Worse
Vacancy Rate**	10%	Yes	Yes

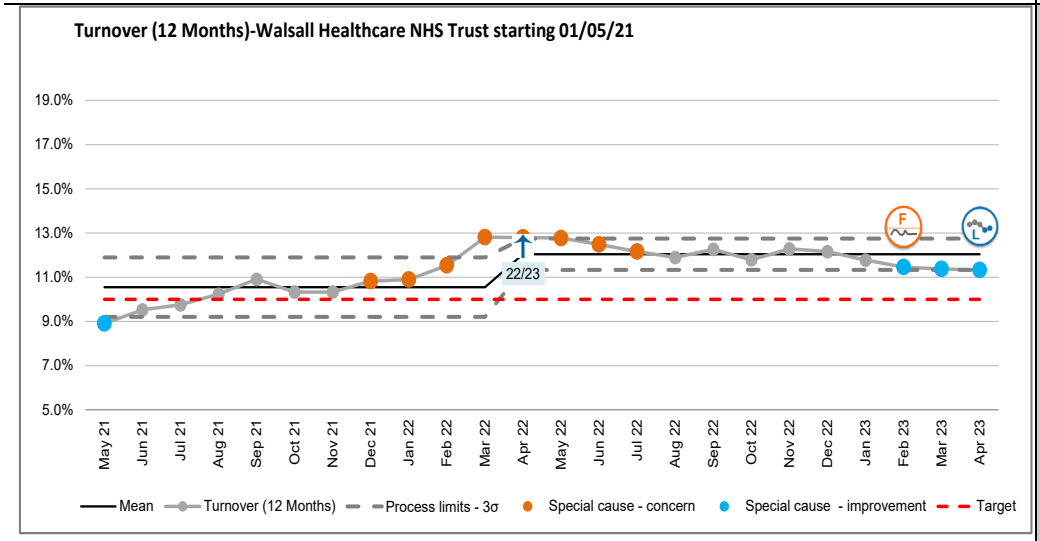
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







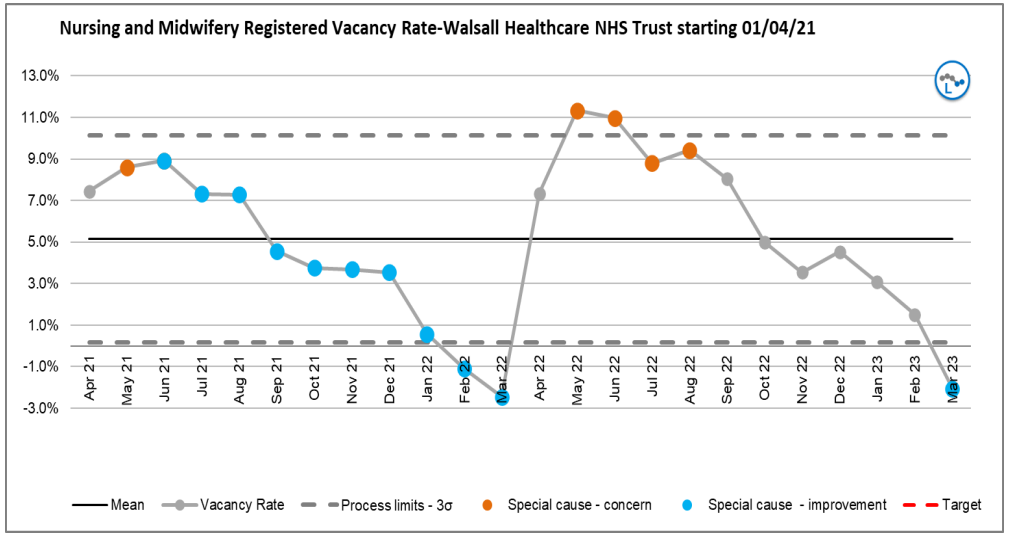
Key Issues & Challenges

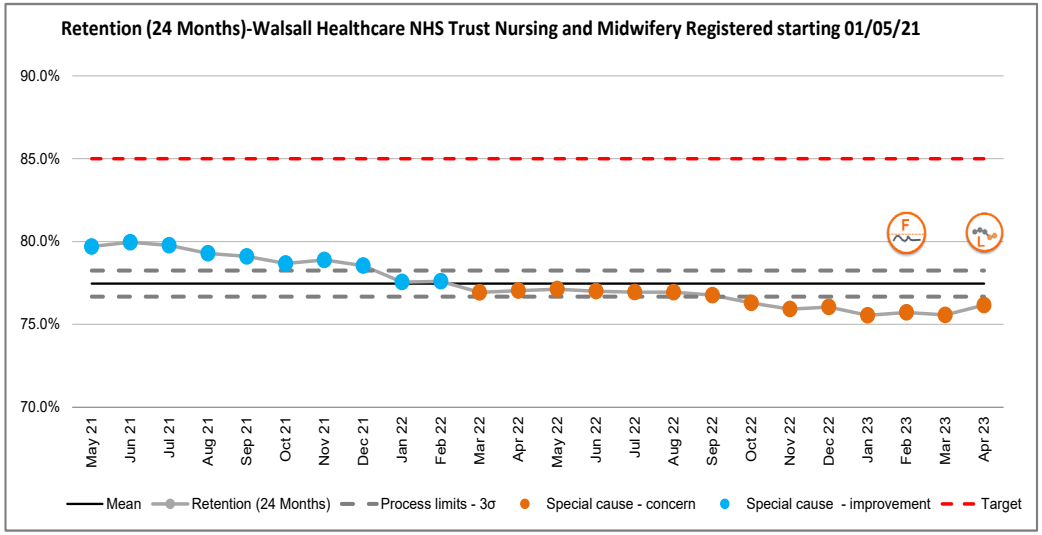
- Over-establishment reflects a month-on-month 80 FTE reduction in the budgeted establishment, reconciled against a 42 FTE increase in the actual workforce; as per the March 2023 month-end finance ledger.
- Long-term vacancy rate reductions, since the 9% peak during June 2022, reflect overall budgeted establishment reductions totalling 103 FTE, offset against an actual workforce increase of 340 FTE during the same period.
- This evidence of recruitment successes is challenged by continued concerns regarding retention rates, with the 24 months overall Trust indicator (79%) deviating below lower limits set during 22/23.
- In the absence of assurance regarding target achievement; the 12 monthly Turnover indicator confirmed a third month of improvement, consolidated within an 11-12% range.

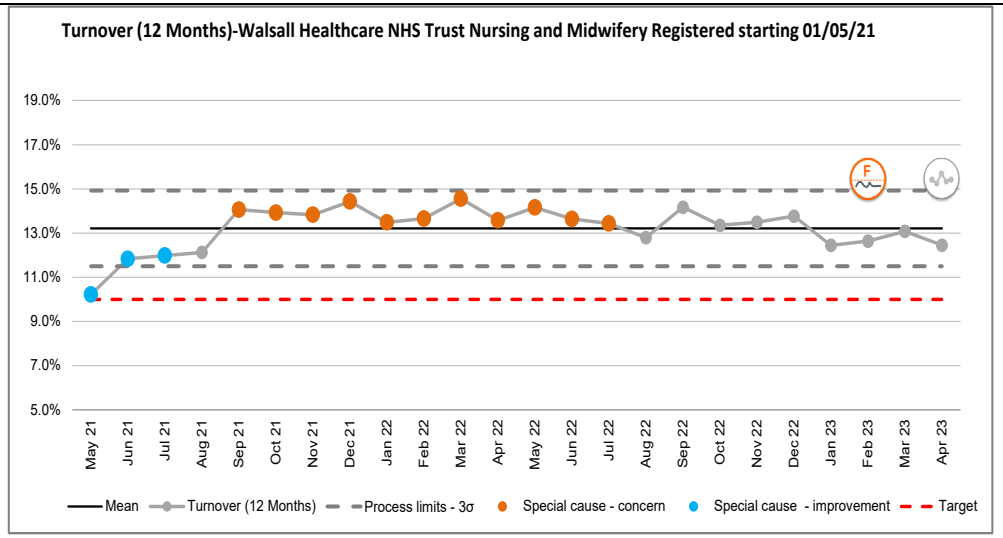
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







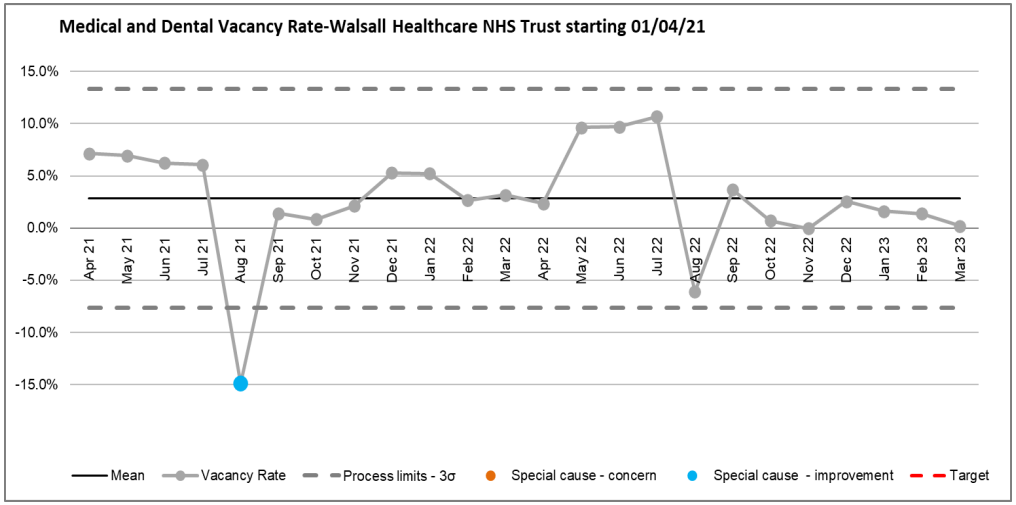
Key Issues & Challenges

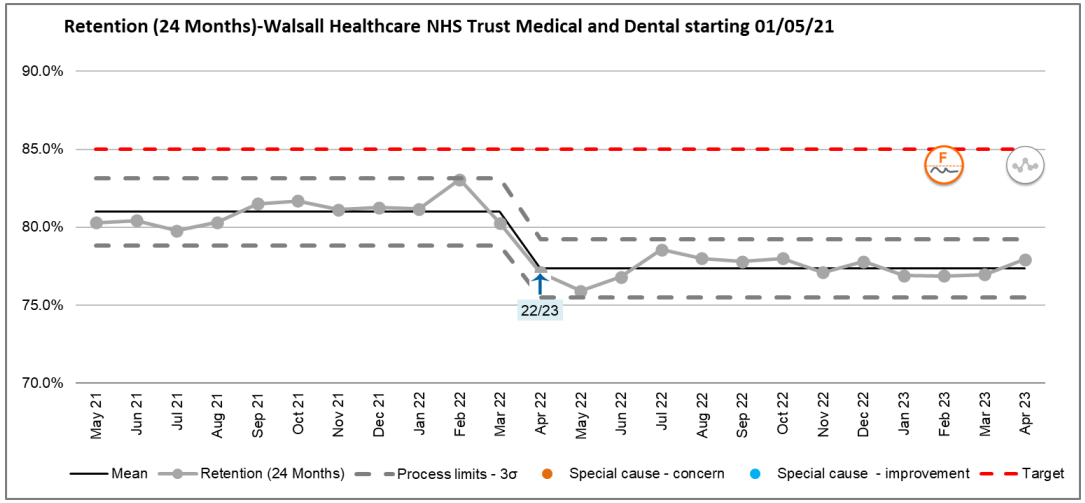
- Historically, 50% of colleagues onboarding to the Trust are transferred from existing NHS employment. During April 2023 this trend was exceeded, whereby 57% of new starters have come from other NHS organisations.
- There is continued special cause concern, regarding 24-month retention amongst qualified nursing and midwifery (N&M) colleagues. The 76% outturn for April 2023 extends several months of deviation below the 2-year lower process limit; signalling systematic intervention is required to improve trajectory long-term.
- A review of trends indicates that 'Work Life Balance' is declared as the reason for resignation or exit by 1 in 5 N&M colleagues leaving the Trust.
- 12-month Turnover performance remains stable for N&M.

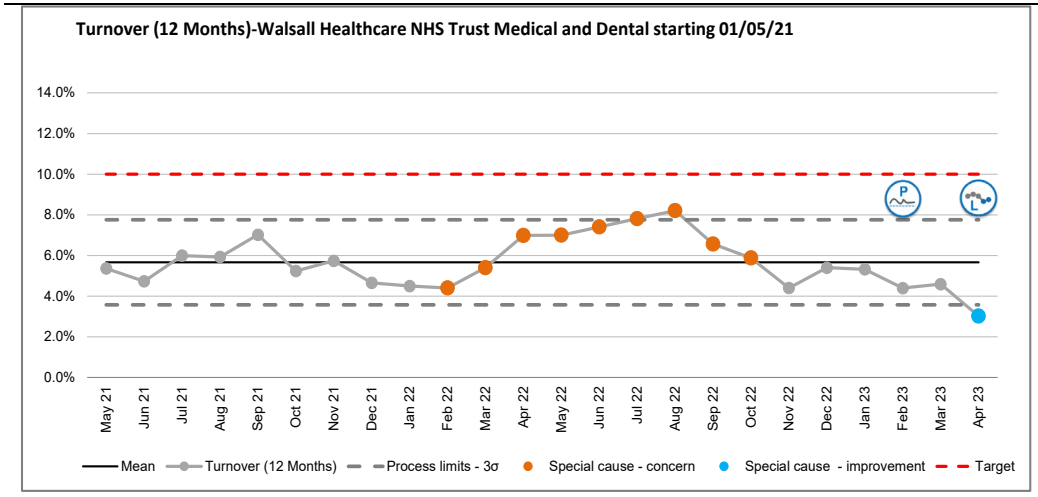
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







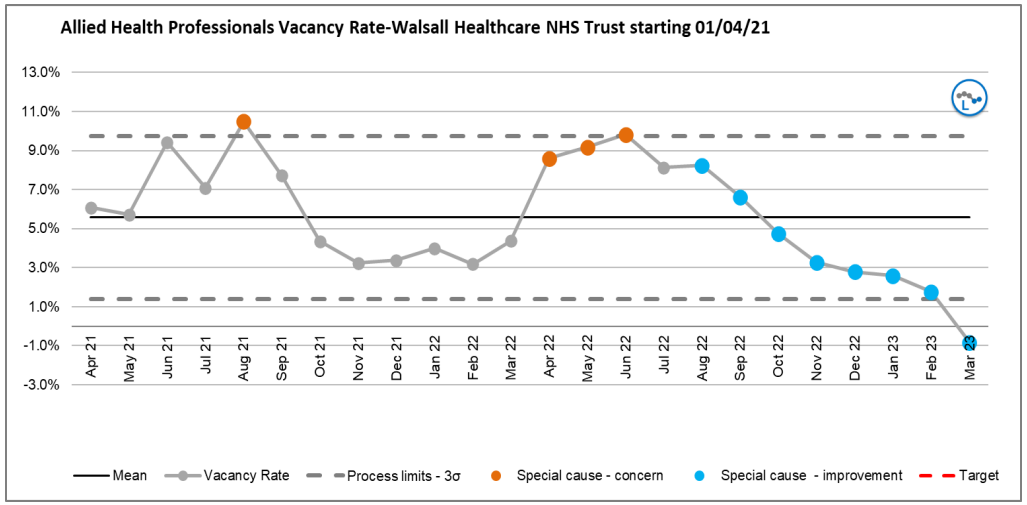
Key Issues & Challenges

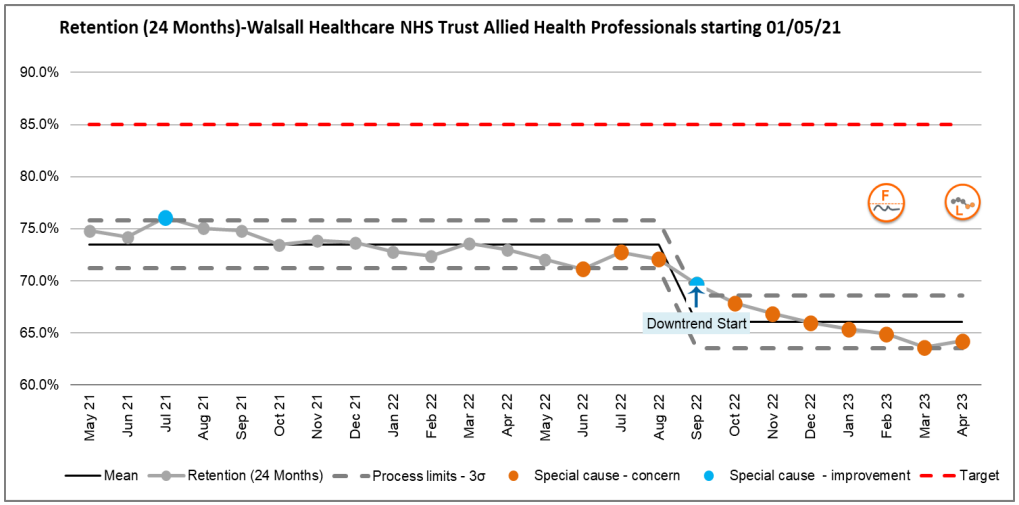
- During 22/23, 152 FTE Medical and Dental (M&D) colleagues left the Trust, versus 219 FTE new starters commencing service during the same period. This workforce growth is reflected by the reporting of low vacancy rates and the positive assurance of 12-month Turnover target achievement for this staff group.
- Despite the challenge regarding the achievement of the 85% target; 24-month retention amongst M&D colleagues remains stable within a 76-79% range begun during 22/23.
- Robust succession planning will be vital to maintaining stability within the M&D workforce, with 1 in 4 consultants who leave the Trust doing so due to retirement.

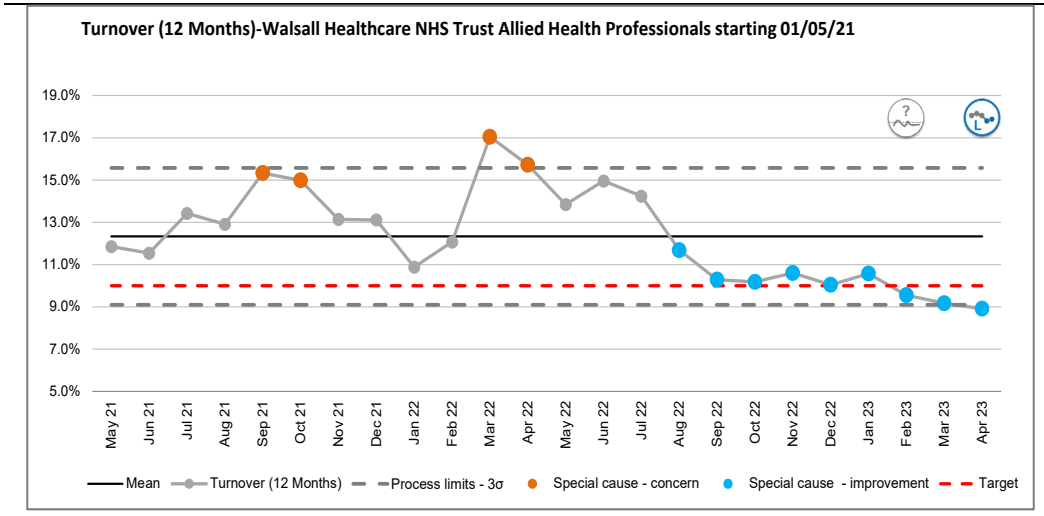
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







Key Issues & Challenges

- Whilst the budget establishment has remained static since the summer of 2022, the actual Allied Health Professionals (AHP) workforce has grown by 10% during the same period, resulting in a 9% vacancy rate reduction.
- 24-month Retention remains a concern amongst AHP, with a sustained downtrend beginning to consolidate at the lower limit of a 63-69% range.
- 12-month turnover represents a contrast, with a reducing number of AHP colleagues leaving the Trust during their first year of employment (9% during the 12 months to 30 April 2023).
- 4 in 10 AHP colleagues leaving during their first year declare 'Work Life Balance' as the reason, whilst for those leaving after 2+ years of service this reduces to 1 in 5.

Walsall Healthcare NHS Trust

Education and Organisational Development

Medicine & Long-Term Conditions - Mandatory Training Compliance			
	Mar-23	Apr-23	Movement +/-
*Division Overall	82%	82%	-0.04%
Acute Care Group	80%	78%	-1.96%
Cardiology	85%	86%	1.48%
Elderly Care Group	81%	81%	0.42%
Emergency Care Group	87%	87%	0.16%
Gastroenterology	78%	79%	0.71%
Long-Term Conditions	82%	82%	0.10%
Medicine & Long-Term Conditions Management	82%	83%	1.15%
Surgery - Mandatory Training Compliance			
	Mar-23	Apr-23	Movement +/-
*Division Overall	86%	86%	-0.57%
Cancer Services	89%	89%	0.17%
General Surgery	84%	84%	-0.21%
Head & Neck Care Group	86%	85%	-1.00%
Outpatient & Support Services	86%	82%	-3.91%
Surgery Management	88%	88%	-0.39%
Theatres, Critical Care & Anaesthetics	87%	87%	-0.24%
Trauma Orthopaedics and MSK Services	83%	84%	0.21%
Women's, Children's & Clinical Support Services - Mandatory Training Compliance			
	Mar-23	Apr-23	Movement +/-
*Division Overall	91%	92%	0.53%
Children's, Families and Neonates Care Group	90%	91%	0.70%
Clinical Support Services	91%	92%	0.30%
Women's & Children's Management & Support	91%	92%	0.89%
Women's Services	92%	93%	0.58%
Estates and Facilities - Mandatory Training Compliance			
	Mar-23	Apr-23	Movement +/-
*Division Overall	87%	87%	0.10%
Facilities	87%	87%	0.17%
Estates Management	92%	91%	-0.74%
Facilities	87%	87%	0.17%
Community - Mandatory Training Compliance			
	Mar-23	Apr-23	Movement +/-
*Division Overall	95.44%	94.82%	-0.61%
Place Based Teams	86%	84%	-1.91%
Adult Services Management	89%	90%	0.81%
Intermediate & Urgent Care	90%	91%	1.20%
Palliative Care & End Of Life Care	95%	95%	-0.61%

Division	Appraisal Compliance Numerator	Appraisal Compliance Outturn
*All	2824	81.27%
Add Prof Scientific and Technic	74	79.57%
Additional Clinical Services	538	82.64%
Administrative and Clerical	588	73.13%
Allied Health Professionals	205	83.33%
Estates and Ancillary	263	79.70%
Healthcare Scientists	33	78.57%
Medical and Dental	170	92.90%
Nursing and Midwifery Registered	953	84.64%
AfC Only	5478	80.95%

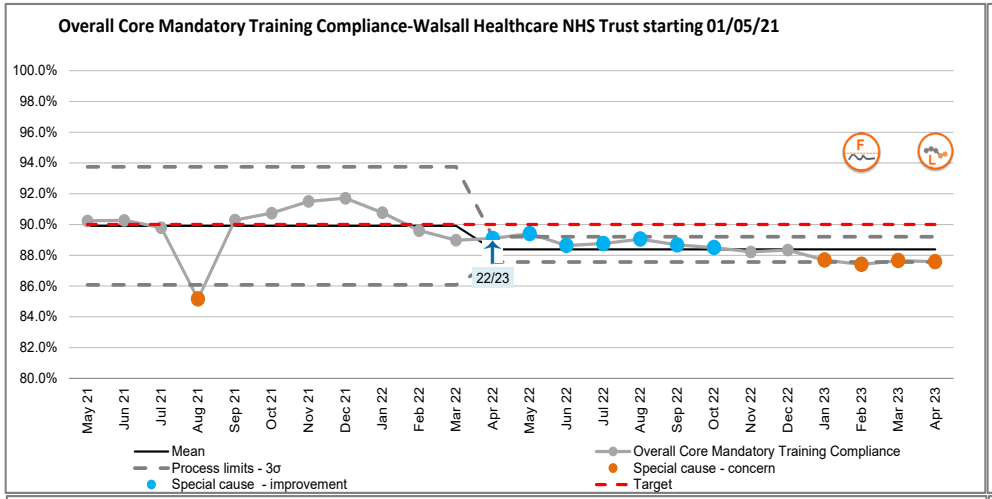
Key Issues & Challenges

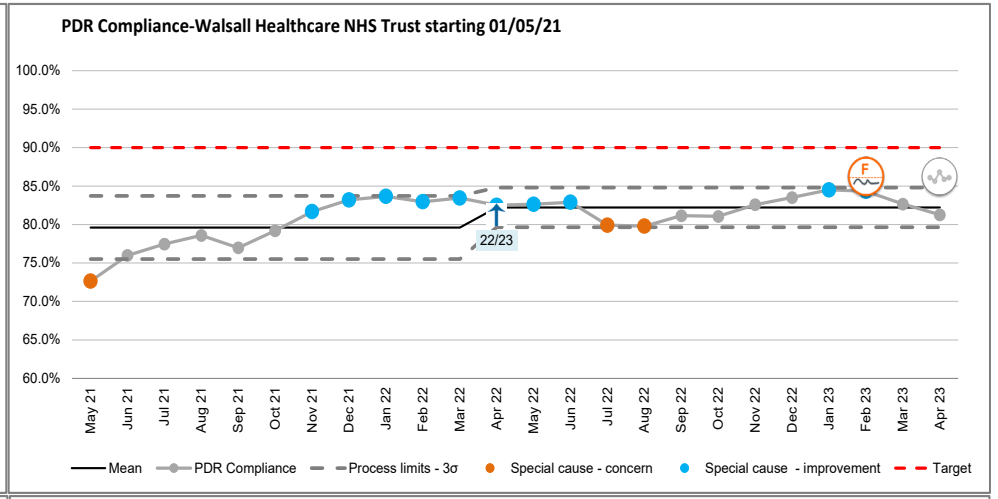
- Despite the 88% outturn for April 2023 Mandatory Training remaining an historically high level of compliance, the current 24 month trend is evidencing cause for concerns; with achievement of the 90% target no longer assured.
- Appraisal compliance remains stable, with 81% outturn for April 2023 maintaining the 79-85% range established during 22/23.
- The Medicine & Long-Term Condition division remains an outlier for Mandatory Training compliance, with a correlation identified between areas of concerns and rising sickness absence within the same care groups.

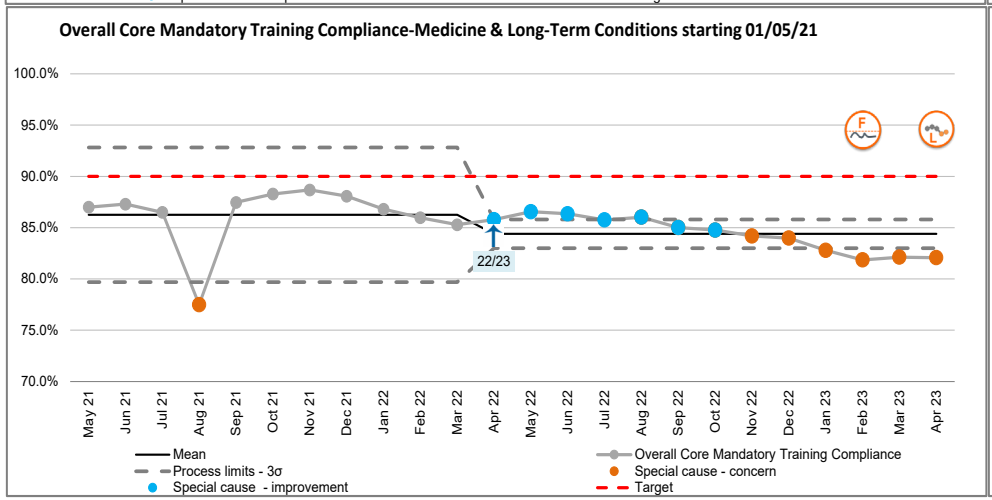
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

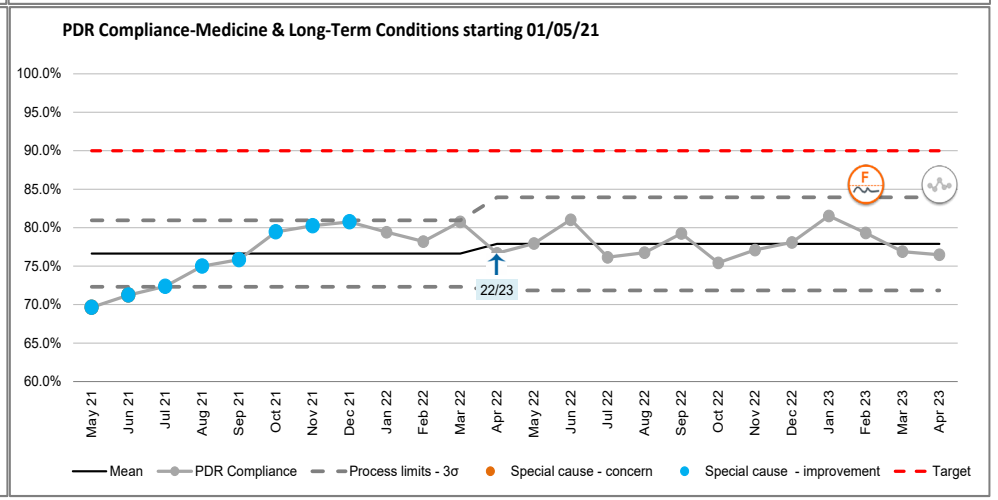
Walsall Healthcare NHS Trust

Education and Organisational Development





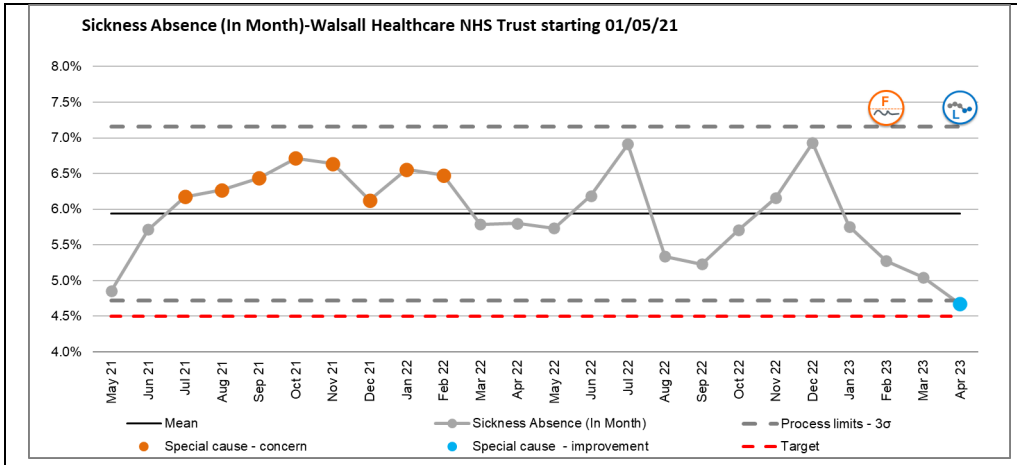


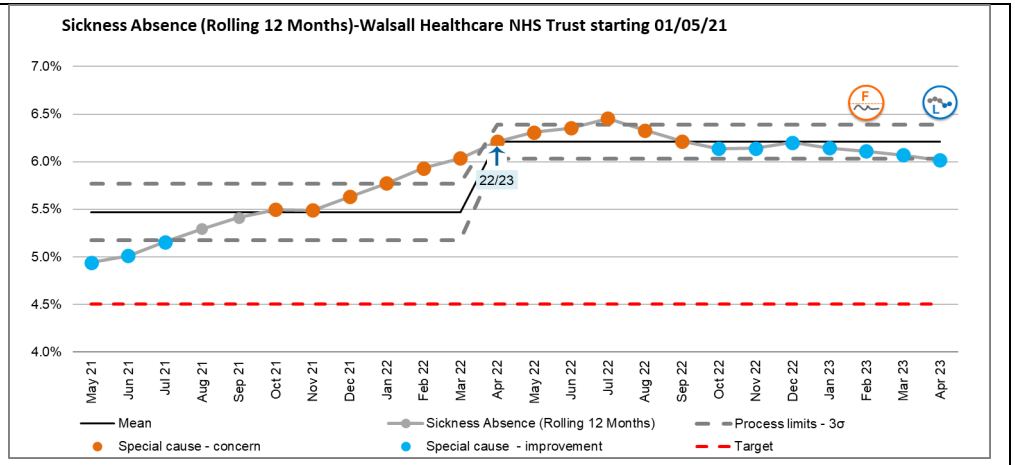


What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Health & Wellbeing





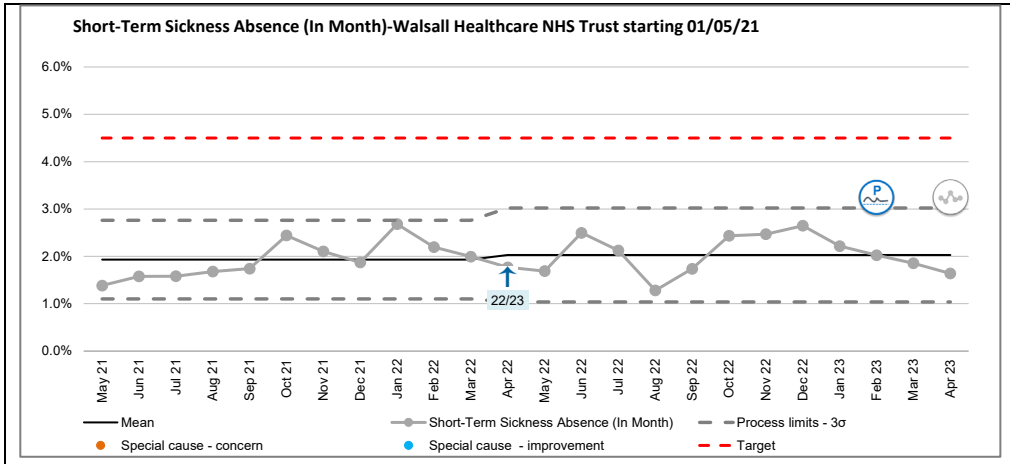
Key Issues & Challenges

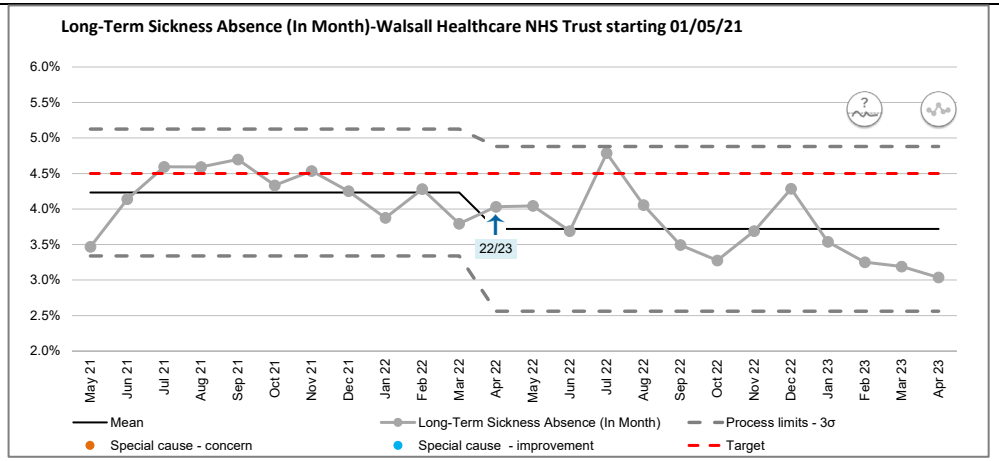
- In-month sickness absence, which was 4.67% during April 2023, is at the lowest levels during the previous 24 months. This is reflected in the above chart analysis, which illustrates a confirmed special cause improvement in performance, despite the remaining challenge regarding target achievement assurance.
- Monthly reductions in sickness absence are reflected within the above rolling 12 months analysis, whereby an improvement trend is now into the seventh month of a reduced absence trajectory.
- The Estates & Facilities division continues to have a disproportionately high level of sickness absence, driven by long-term absence reasons; namely stress/anxiety which accounts for every one in five days lost for colleagues within this service.
- Despite challenges at the related divisional level, the April 2023 absence rate of 7.7% for colleagues from the Estates and Ancillary staff group marks the fourth month of improvement and the lowest two-year sickness level.
- Absence levels amongst Medical & Dental colleagues evidence the greatest improvement; whereby in-month sickness rates have reduced by two-thirds since December 2022; with a current 1% outturn.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Health & Wellbeing





Key Issues & Challenges

- A 6:4 ratio of long-term versus short-term days lost during April 2023 confirms that sickness absence throughout the trust continues to be driven by absences totalling 28 days or more.
- The largest drivers for sickness absence remain stress/anxiety (long-term), gastrointestinal problems (short-term) and back problems (long-term). These three top reasons for absence accounted for more than 50% of FTE days lost during April 2023.
- Long-term absences during April 2023 occurred disproportionately amongst qualified nursing and midwifery colleagues based within one of the three acute-based divisions; with 1 in 4 long-term episodes attributable to this cohort.
- Despite these area-specific challenges, the rolling 12-month absence outlook for qualified nursing and midwifery colleagues remains favourable, with an improvement trajectory maintained for a thirteenth month.

Walsall Healthcare NHS Trust

Workforce Metrics

Workforce Profile	As at 31/03/2023	2023/24												YTD Change
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Substantive Staff FTE	4435.71	4434.69	-	-	-	-	-	-	-	-	-	-	-	-1.02
Substantive Staff FTE (Ex. Rotational Drs)	4341.71	4342.69	-	-	-	-	-	-	-	-	-	-	-	0.98
Substantive Staff Headcount	5112	5119	-	-	-	-	-	-	-	-	-	-	-	7
Bank Staff Only Headcount	1181	1198	-	-	-	-	-	-	-	-	-	-	-	17
% Staff from a BME Background	37.30%	37.60%	-	-	-	-	-	-	-	-	-	-	-	0.30%

Workforce Profile BY Staff Group (FTE)	As at 31/03/2023	2023/24												YTD Change
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Add Prof Scientific and Technic	103.29	101.00	-	-	-	-	-	-	-	-	-	-	-	-2.29
Additional Clinical Services	845.07	835.77	-	-	-	-	-	-	-	-	-	-	-	-9.30
Administrative and Clerical	921.93	920.29	-	-	-	-	-	-	-	-	-	-	-	-1.64
Allied Health Professionals	294.29	291.18	-	-	-	-	-	-	-	-	-	-	-	-3.11
Estates and Ancillary	256.83	255.87	-	-	-	-	-	-	-	-	-	-	-	-0.96
Healthcare Scientists	44.02	45.61	-	-	-	-	-	-	-	-	-	-	-	1.59
Medical and Dental	498.05	494.53	-	-	-	-	-	-	-	-	-	-	-	-3.52
Nursing and Midwifery Registered	1454.23	1470.44	-	-	-	-	-	-	-	-	-	-	-	16.21
Students	18.00	20.00	-	-	-	-	-	-	-	-	-	-	-	2.00

Starters by Staff Group (FTE)	2022/23	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Starters	765.10	53.57	-	-	-	-	-	-	-	-	-	-	-	53.57
Add Prof Scientific and Technic	13.17	2.40	-	-	-	-	-	-	-	-	-	-	-	2.40
Additional Clinical Services	176.28	15.48	-	-	-	-	-	-	-	-	-	-	-	15.48
Administrative and Clerical	124.51	14.36	-	-	-	-	-	-	-	-	-	-	-	14.36
Allied Health Professionals	47.80	1.00	-	-	-	-	-	-	-	-	-	-	-	1.00
Estates and Ancillary	29.57	0.00	-	-	-	-	-	-	-	-	-	-	-	0.00
Healthcare Scientists	5.20	1.60	-	-	-	-	-	-	-	-	-	-	-	1.60
Medical and Dental	219.34	6.00	-	-	-	-	-	-	-	-	-	-	-	6.00
Nursing and Midwifery Registered	134.22	12.73	-	-	-	-	-	-	-	-	-	-	-	12.73
Students	15.00	0.00	-	-	-	-	-	-	-	-	-	-	-	0.00

Apprenticeships	2022/23 Total	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Apprentices Started in month	17	0												0
Number of Staff Converted to Apprentices in month	68	0												0

Walsall Healthcare NHS Trust

Workforce Metrics

Leavers by Staff Group (FTE)	2022/23	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Leavers	623.91	47.90	-	-	-	-	-	-	-	-	-	-	-	**47.90**
Add Prof Scientific and Technic	13.24	0.00	-	-	-	-	-	-	-	-	-	-	-	0.00
Additional Clinical Services	112.73	11.06	-	-	-	-	-	-	-	-	-	-	-	11.06
Administrative and Clerical	119.94	11.65	-	-	-	-	-	-	-	-	-	-	-	11.65
Allied Health Professionals	36.30	1.00	-	-	-	-	-	-	-	-	-	-	-	1.00
Estates and Ancillary	20.20	0.47	-	-	-	-	-	-	-	-	-	-	-	0.47
Healthcare Scientists	6.57	0.00	-	-	-	-	-	-	-	-	-	-	-	0.00
Medical and Dental	152.30	10.00	-	-	-	-	-	-	-	-	-	-	-	10.00
Nursing and Midwifery Registered	161.63	13.72	-	-	-	-	-	-	-	-	-	-	-	13.72
Students	1.00	0.00	-	-	-	-	-	-	-	-	-	-	-	0.00

Retention	2022/23	2023/24												2023/24 Average
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Retention Rate (12 Months)	89.27%	90.11%	-	-	-	-	-	-	-	-	-	-	-	90.11%
Retention Rate (24 Months)	**79.39%**	**79.39%**	-	-	-	-	-	-	-	-	-	-	-	**79.39%**
Retention Rate (5 Years)	58.62%	58.09%	-	-	-	-	-	-	-	-	-	-	-	58.09%

Retention Rate (24 Months)	2022/23	2023/24												2023/24 Average
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Add Prof Scientific and Technic	**50.60%**	**47.65%**	-	-	-	-	-	-	-	-	-	-	-	**47.65%**
Additional Clinical Services	**77.63%**	**77.74%**	-	-	-	-	-	-	-	-	-	-	-	**77.74%**
Administrative and Clerical	**82.61%**	**81.96%**	-	-	-	-	-	-	-	-	-	-	-	**81.96%**
Allied Health Professionals	**83.42%**	**82.69%**	-	-	-	-	-	-	-	-	-	-	-	**82.69%**
Estates and Ancillary	**78.51%**	**79.93%**	-	-	-	-	-	-	-	-	-	-	-	**79.93%**
Healthcare Scientists	**81.79%**	**81.02%**	-	-	-	-	-	-	-	-	-	-	-	**81.02%**
Medical and Dental	**89.33%**	**91.50%**	-	-	-	-	-	-	-	-	-	-	-	**91.50%**
Nursing and Midwifery Registered	**78.99%**	**79.19%**	-	-	-	-	-	-	-	-	-	-	-	**79.19%**

Open Employee Relation Cases – Number of Cases	2022/23 Monthly Avg.	2023/24												YTD Monthly Avg.
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Open Formal Grievance Cases	3	7												7
Open Bullying & Harassment Cases	3	2												2
Open Capability Cases	1	7												7
Open Disciplinary Cases	5	18												18
Cases Closed	7	4												4

Walsall Healthcare NHS Trust

Workforce Metrics

Turnover % (Normalised) - Rolling 12 Months	2022/23	2023/24												2023/24 Average
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Overall Turnover	11.38%	11.33%	-	-	-	-	-	-	-	-	-	-	-	11.33%
Add Prof Scientific and Technic	12.45%	12.45%	-	-	-	-	-	-	-	-	-	-	-	12.45%
Additional Clinical Services	14.35%	15.09%	-	-	-	-	-	-	-	-	-	-	-	15.09%
Administrative and Clerical	9.14%	9.61%	-	-	-	-	-	-	-	-	-	-	-	9.61%
Allied Health Professionals	9.17%	8.91%	-	-	-	-	-	-	-	-	-	-	-	8.91%
Estates and Ancillary	8.04%	6.87%	-	-	-	-	-	-	-	-	-	-	-	6.87%
Healthcare Scientists	9.96%	9.45%	-	-	-	-	-	-	-	-	-	-	-	9.45%
Medical and Dental	4.59%	3.01%	-	-	-	-	-	-	-	-	-	-	-	3.01%
Nursing and Midwifery Registered	13.08%	12.45%	-	-	-	-	-	-	-	-	-	-	-	12.45%

Sickness Absence	2022/23	2023/24												2023/24 Average
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
% Sickness Absence In Month	5.05%	4.67%	-	-	-	-	-	-	-	-	-	-	-	4.67%
% Sickness Absence (Rolling 12 Months)	6.07%	6.02%	-	-	-	-	-	-	-	-	-	-	-	6.02%
FTE Days Lost	6917	6200	-	-	-	-	-	-	-	-	-	-	-	6200
% Short Term Sickness	34.68%	35.06%	-	-	-	-	-	-	-	-	-	-	-	35.06%
% Long Term Sickness	65.32%	64.94%	-	-	-	-	-	-	-	-	-	-	-	64.94%
Estimated Cost of Sickness £	£8,662,364	£586,363	-	-	-	-	-	-	-	-	-	-	-	£586,363

Top 3 Sickness Reasons (FTE Days Lost)	2022/23	2023/24												% Change - (YTD Avg)
	Monthly Avg.	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Anxiety/stress/depression/other psychiatric illnesses	2125.3	1961.8	-	-	-	-	-	-	-	-	-	-	-	-7.69%
Gastrointestinal problems	726.2	670.8	-	-	-	-	-	-	-	-	-	-	-	-7.62%
Back Problems	500.4	506.5	-	-	-	-	-	-	-	-	-	-	-	1.23%

Education / OD	2022/23	2023/24												2023/24 Average
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Core Mandatory Training	87.66%	87.58%	-	-	-	-	-	-	-	-	-	-	-	87.58%
Appraisal	82.66%	81.27%	-	-	-	-	-	-	-	-	-	-	-	81.27%

Inductions	2022/23 Total	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Trust Inductions Completed	886	141												141

Walsall Healthcare NHS Trust

Workforce Metrics

Freedom To Speak Up Engagements	2022/23 Total	2023/24											YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Trust Overall	132	0												0

Establishment Gap By Staff Group (FTE)	2021/22	2022/23												YTD Change
	Mar-22	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Establishment Gap	**2.47**	**235.78**	**383.93**	**392.87**	**371.83**	**295.38**	**310.47**	**193.54**	**124.15**	**166.35**	**120.06**	**64.26**	**-72.75**	**-75.22**
Additional Clinical Services	-67.71	-17.94	8.93	19.30	18.95	10.31	10.61	-19.40	-43.22	-21.26	-25.54	-47.32	-68.44	-0.73
Administrative and Clerical	32.09	68.51	75.18	73.49	81.00	81.86	80.21	65.30	43.73	32.86	33.95	20.14	-16.41	-48.50
Allied Health Professionals	10.84	22.04	23.42	25.49	20.98	21.30	17.30	12.29	8.46	7.27	7.17	4.52	-2.15	-12.99
Estates and Ancillary	39.74	43.59	51.74	54.21	56.73	55.01	53.95	53.89	47.56	50.93	52.29	52.00	53.71	13.97
Healthcare Scientists	5.88	5.83	5.78	6.98	8.38	10.38	5.58	3.98	4.27	3.27	1.27	-0.64	-1.05	-6.93
Medical and Dental	13.53	9.99	44.45	44.94	49.11	-29.62	17.81	3.34	-0.23	12.53	7.79	6.75	0.92	-12.61
Nursing and Midwifery Registered	-36.02	96.09	163.05	157.57	123.90	134.95	113.63	62.75	52.41	68.50	32.01	18.11	-47.50	-11.48
Professional and Scientific	4.12	7.67	11.38	10.89	12.78	11.19	11.38	11.39	11.17	12.25	11.12	10.70	8.17	4.05
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Agency Spend (£000's)	2021/22	2022/23												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Agency Spend	**£17,719**	**£1,776**	**£1,357**	**£1,472**	**£1,429**	**£970**	**£1,199**	**£1,237**	**£1,231**	**£1,239**	**£1,218**	**£1,192**	**£1,459**	**£15,777**
Nursing and Midwifery Registered	£9,623	£1,048	£659	£732	£717	£340	£467	£476	£465	£528	£518	£373	£493	£6,815
Qualified Scientific, Therapeutic and Technical	£1,052	£124	£126	£112	£123	£111	£105	£76	£70	£82	£114	£128	£162	£1,334
Support to Clinical Staff	£132	£56	£7	£13	£16	£5	£57	£54	£74	£100	£119	£198	£201	£900
of which support to nursing staff	£92	£53	£6	£13	£15	-£15	£16	£1	£24	£39	£18	£109	£12	£292
NHS Infrastructure Support	£3,119	£167	£155	£212	£176	£145	£158	£206	£206	£119	£172	£151	£163	£2,029
Medical and Dental	£3,794	£381	£410	£403	£396	£369	£411	£426	£415	£410	£295	£342	£440	£4,699
of which Consultants	£1,668	£207	£142	£191	£168	£100	£120	£122	£131	£114	£101	£67	£146	£1,609
of which Career/Staff Grade	£1,421	£70	£133	£87	£104	£79	£76	£107	£134	£126	£103	£159	£165	£1,345
of which Trainee Grades/Trust Grade	£705	£104	£135	£124	£125	£190	£216	£198	£150	£169	£91	£116	£129	£1,746

Bank Spend (£000's)	2021/22	2022/23												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Bank Spend	**£26,664**	**£2,229**	**£1,883**	**£2,341**	**£2,710**	**£2,932**	**£2,463**	**£2,364**	**£2,141**	**£2,355**	**£3,031**	**£2,781**	**£3,204**	**£30,435**
Nursing and Midwifery Registered	£8,119	£696	£618	£648	£737	£1,000	£728	£708	£709	£719	£961	£868	£909	£9,301
Qualified Scientific, Therapeutic and Technical	£7	£1	£1	£2	£2	£3	£3	£3	£2	£2	£2	£3	£2	£26
Support to Clinical Staff	£5,521	£486	£402	£486	£563	£800	£658	£540	£496	£633	£524	£492	£684	£6,765
of which support to nursing staff	£4,780	£403	£337	£398	£488	£711	£563	£458	£425	£562	£433	£408	£615	£5,801
NHS Infrastructure Support	£2,661	£182	£121	£177	£233	£313	£272	£228	£183	£165	£254	£216	£197	£2,541
Medical and Dental	£10,355	£864	£742	£1,028	£1,175	£817	£803	£884	£751	£835	£1,289	£1,202	£1,412	£11,802
of which Consultants	£5,872	£433	£394	£544	£564	£417	£254	£479	£373	£511	£721	£787	£795	£6,273
of which Career/Staff Grade	£2,908	£188	£191	£238	£316	£209	£254	£158	£141	£187	£312	£226	£344	£2,765
of which Trainee Grades/Trust Grade	£1,575	£243	£156	£246	£294	£190	£295	£247	£237	£138	£255	£190	£272	£2,763

Walsall Healthcare NHS Trust

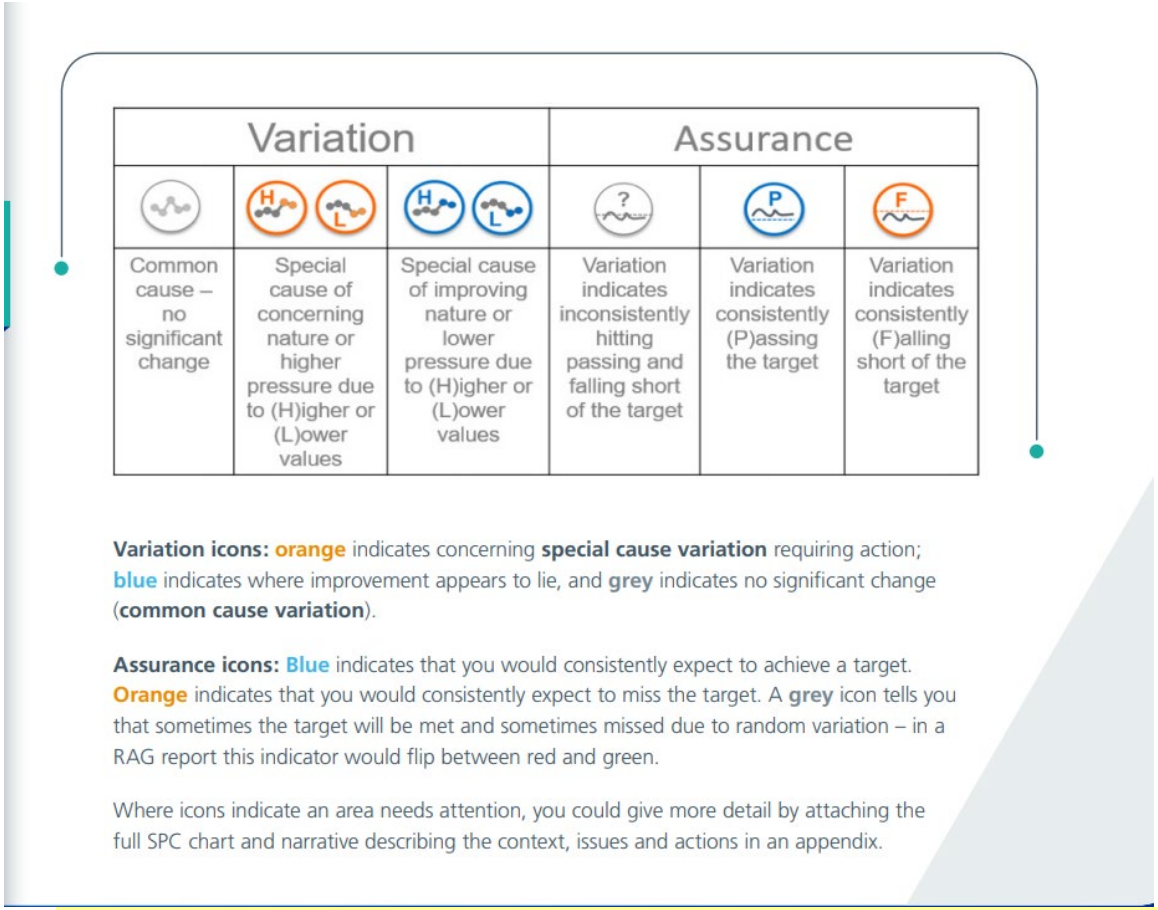
Appendix A - Supplementary Comments

- Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.
- Workforce Profile figures are reflective of Permanent and Fixed Term colleagues.
- Turnover figures are 'normalised' through the exclusion of Rotational Doctors, Students, TUPE Transfers and End of Fixed Term Temp contract.
- Absences totalling 28 calendar days or more are classified as being Long-Term.
- The 'Estimated Cost of Absence' is taken from the Electronic Staff Records (ESR) System and based upon the salary value of colleagues absent but not inclusive of potential on-costs.
- Retention Calculation: No. Employee with XX or more months of service Now / No Employees one year ago (Rotational Doctors, Students, TUPE Transfers & Fixed Term colleagues are excluded from both the numerator and denominator)
- Establishment Gap information is reflective of budgeted and actual workforce figures taken from the finance ledger, effective month-end. Due to this, establishment gaps are indicative of gaps within the financial establishment, and importantly, not necessarily wholly related to ongoing or historical recruitment campaigns.
- Training & Appraisal compliance is calculated using exclusion lists detailed within the Appendix of this document.
- As of January 2020, 'Core Mandatory' compliance is reflective of the national Core Skills Training Framework.;

  - Conflict Resolution
  - Fire Safety
  - Equality, Diversity and Human Rights
  - Information Governance and Data Security
  - Health, Safety and Welfare
  - Load Handling
  - Patient Handling
  - Infection Prevention and Control Level 1
  - Infection Prevention and Control Level 2
  - Adult Basic Life Support
  - Safeguarding Children Level 1
  - Safeguarding Children Level 2
  - Safeguarding Children Level 3
  - Safeguarding Adults Level 1
  - Safeguarding Adults Level 2
  - Safeguarding Adults Level 3
  - Prevent Level 1 & 2
  - Prevent Level 3

Walsall Healthcare NHS Trust

Appendix B - Using the SPC Charts



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Making data count | NHS Improvement. 2019. Making data count — strengthening your decisions. [ONLINE] Available at: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL.pdf. [Accessed July 2019].

Walsall Healthcare NHS Trust

Appendix B - Using the SPC Charts

Making data count | NHS Improvement. 2019. Making data count — strengthening your decisions. [ONLINE] Available at: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL.pdf. [Accessed July 2019].

Walsall Healthcare NHS Trust

Appendix C - HR KPI RAG Rating Scales

Mandatory Training Attendance	<81%	81% - 90%	>=90%
Appraisal rate	<81%	81% - 90%	>=90%
Sickness Absence %	>5%	4.5% - 5%	<=4.5%
Turnover	>11%	10% - 11%	<=10%

Appendix D - Training & Appraisal Exclusion Lists

Training	Annual Appraisal
• Bank Staff • Students • Anyone on Career Break • Anyone on External Secondment • Anyone on Suspension • Anyone on Maternity Leave • Anyone Long-Term Sick	• Bank Staff • Students • Anyone on Career Break • Anyone on External Secondment • Anyone on Suspension • Anyone Managed Externally • Anyone on a fixed-term contract. • Anyone who has been employed by the Trust for less than 1 calendar year. • Anyone on Maternity Leave • Anyone Long-Term Sick

Item 14.17

Walsall Healthcare NHS Trust

Trust Board	
Meeting Date:	07th June 2023
Title of Report:	Research & Development Report
Action Requested:	Members of the Trust Board are to be informed and assured this report reflects Research activity within the Trust at this current point in time - May 2023.
For the attention of the Board	
Assure	• Joint research strategy development day very well attended with great contributions and discussion. An enabling research strategy aligned to the joint Trusts strategy is currently being drafted. • An operational plan will support the delivery of the research strategy. • A joint research celebration event is planned for 15 September at the Village Hotel in Walsall where the research strategy will be launched. • Collaboration event with Aston University has presented potential opportunities. Phase two of the collaboration will be for WHC and RWT staff to visit Aston University to promote areas of expertise and potential research collaborations. • Funding agreed to appoint five Professors of nursing, midwifery and AHPs over the next three years. Joint funding approved from Birmingham City University and University of Wolverhampton. At least two posts will be appointed in the coming months. • Draft plans for a research framework for research in Walsall together are being developed. • The R&D department now delivers the highest number of both commercial and NIHR studies in the last five years. The number of own account studies continues to increase. • WHC now has two orthopaedic robot trials open. • Promotional material to demonstrate the service offering to commercial companies is being developed.
Advise	
Alert	• **Pharmacy issue**. Short term plan in place however not sustainable. Long term plan still outstanding.
Author and Responsible Director Contact Details:	Tel 01922 721172 ext. 5797: Catherine.dexter3@nhs.net Dr Manjeet Shehmar-Medical Director: manjeet.shehmar@nhs.net Pauline Boyle: Managing Director of Research and Development e: pboyle@nhs.net t: 07494919851

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement. b) Prioritise the treatment of cancer patients.
Support our Colleagues	a) Improve overall staff engagement.
Improve the Healthcare of our Communities	a) Develop a health inequality strategy.
Effective Collaboration	a) Improve population health outcomes through provider collaborative. b) Implement technological solutions that improve patient experience. c) Progress joint working across Wolverhampton and Walsall d) Facilitate research that improves the quality of care
Resource Implications:	**None**
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None
Risks: BAF/ TRR	As highlighted in Alert section
Risk: Appetite	None
Public or Private:	
Other formal bodies involved:	None
References	Not Applicable
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Research Activity across the Trust

Speciality areas Walsall Healthcare NHS Trust are currently Research active (**Ref Table1**).
At present, **27** studies opened, **12** in set up and **6 i**n the pipeline **(Ref Graph1)** and **7** expression of interests submitted since January.
Trust own account research increasing.
Shows recruitment as from April-March 2023 for Walsall Healthcare NHS Trust **(Graph 2).** Awaiting new reports from the CRN which will contain recruitment since April 2018.

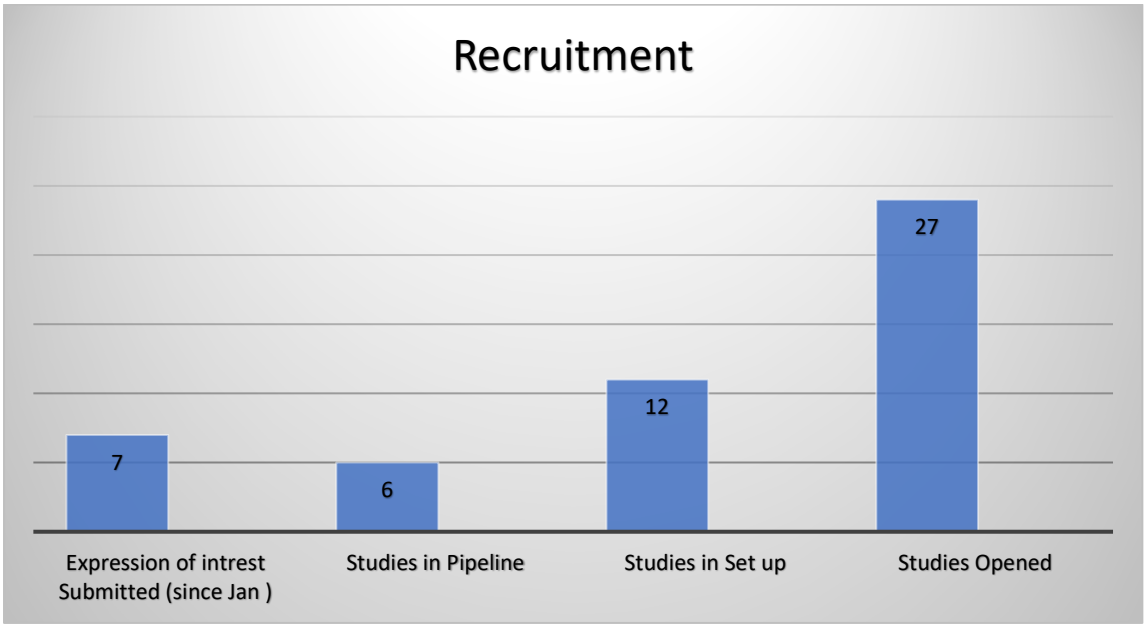
Table1: Outlines Speciality areas Walsall Healthcare NHS Trust are currently Research active.

Specialities Opened	Specialities In Set up	Specialities in the pipeline/potential /EOI's
Cancer	Paediatrics/Children	Cancer
Critical Care	Cardiovascular	Renal
Respiratory plus TB	Musculoskeletal	Anaesthetics
Gastroenterology	Surgery	Obstetrics and Gynaecology
Dermatology	Dermatology	Sexual Health -HIV
Cardiovascular		
Maternity/Women's	Cancer	
Children		
NuRS Study	Respiratory	
Paediatrics		
Tissue/Viability/Diabetes		
Maternity/Smoking cessation		
Education Related (RESTORE-2)		
Surgery (RACER -Knee/Hip)		
Emergency Medicine		
Pre Natal		

Advise

We currently have a good variation in specialities undertaking research. Both RACER trials are now open with potential patients planned for the 10/05 for the knee study . The GIANT Panda (Pre - Natal) study has now opened with a number of O&G studies in the pipeline. Site selection notification received for two more commercial trials (Dermatology & Cardiology). Awaiting outcome of selection process for commercial Renal and HIV (Sexual Health Study).

Graph 1: Reflects the number of studies opened, in set up and in the pipeline



Own account research across the Trust
The following projects are currently supported by R&D at Walsall Healthcare NHS Trust. Specialties include Podiatry, Breast Care, Education and Community services. Influx of queries received from staff undertaking academic courses and requiring help/support re projects.

Exploring the experience of a community front door team of integrated working in an acute setting – A master's in advanced clinical practice (early stages). This project is part of a MSc and is being undertaken by Kirsty Donaldson who is Community Lead for Integrated Front Door Services.

***Exploring student and staff behavioural intent and actual use of the EPAD in their practice placements using the Unified Theory of Acceptance and Use of Technology model (UTUAT): a cross-sectional study* (early stages).** This is an educational project exploring the use of the electronic nature of the practice document and students and staff perceptions of how easy/difficult it is to use. This project is being undertaken by ***Sarah* Shaw who is a** Senior Lecturer in Adult Nursing/ Deputy Head of Practice at Wolverhampton University.

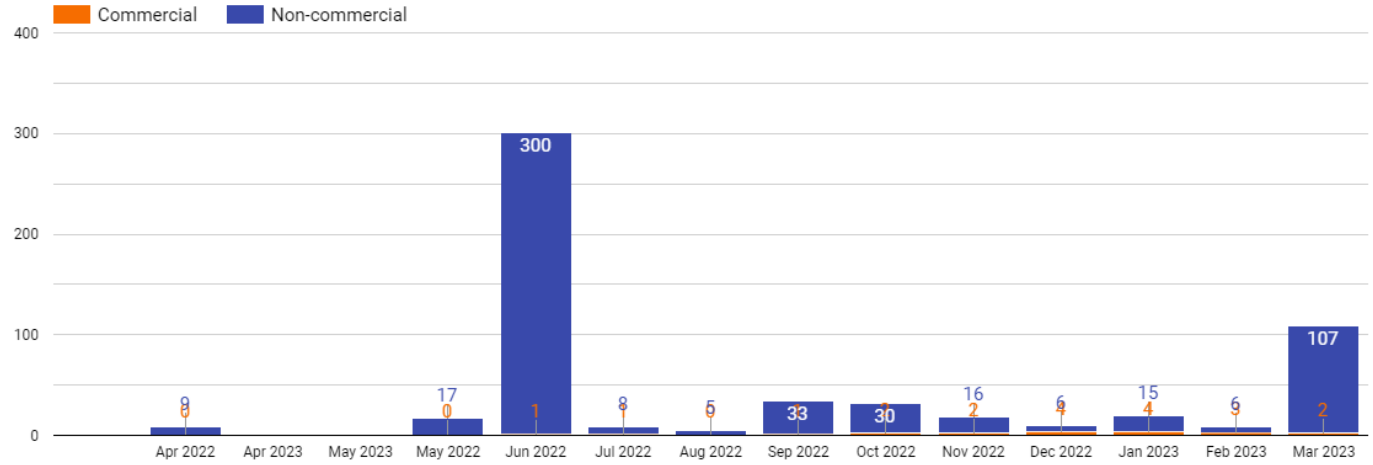
VR Podiatry- *To investigate the effects of Visual Reality (VR) technology headsets on patient experience and anxiety levels during Podiatry nail surgery procedures under local anaesthetic, in children ages 8-16* (early stages). This project is being undertaken by **Rianna Millington (Podiatry Team Leader) who has an interest in VR and its impact on patients.**

A primary research project exploring the perceptions of the Clinical Nurse Specialist (CNS) independently breaking significant news in the hospital setting. To investigate the experience of the CNS, giving a true insight into their lived experience in the hospital setting (early stages).

This project is being undertaken by Jayne Kanwar- Macmillan Advanced Nurse Practitioner- Breast Care

CLiPP Study (*A Pilot observational study to determine the impact of Collaborative Learning in Practice (CLiP) on newly qualified nurses reported outcomes in relation to confidence compared to their non-CLiP trained counterparts)* --Kay Wilson (FORCE Team) is leading on this project, the project is currently at the protocal design stage.

Graph2: Shows recruitment for April -March 2023 at Walsall Healthcare NHS Trust.



Recruitmen in **Graph 2** is accountable up to March 2023, main recruitment for April/May 2023 is related to the following studies: SNAP 3 (Maternity/Smoking) trials, AZ Track (Cardiovascular), Badbir (Dermatology) and MucACT(COPD) Respiratory . We still await our first recruit into the Victor study (MSD Commercial Study) its proving difficult to find patients which meet the criteria ..

The team continue to scope for studies which reflect the needs of Walsall's population.

Alert
Ongoing issue with pharmacy regarding research sign off from pharmacy. Main issue relates Aeseptics.

R&D Update-General

- Ben Jones our Research Practitioner has been nominated for the NIHR's New Researcher in the Spotlight feature, the NIHR wish to shine a spotlight on the community and celebrate the many talented researchers working across the country.
- GeNOMICC Study presentation on Nature publication-Walsall continue to be part of this study.
- Add-Aspirin Thromboxane sub-study paper update-Await publication in the British Journal of Cancer, Walsall involved in this study -Dr Kunene
- SAS Research dates set for 2023 14th June 5th September, November-Date TBC, to be rolled out to AHP, Nursing Staff across both Trusts.
- Research podcast planned the week of the 15th, working in collaboration with RWT.

Item 14.18

Walsall Healthcare NHS Trust

Trust Board (Public)	
Meeting Date:	7th June 2023
Title of Report:	Medicines Management Report
Action Requested:	To discuss and inform
For the attention of the Board	
Assure	• It is through the Medicine Management Group that audit compliance is being monitored and escalated to Divisions where necessary. • Monthly Divisional Medicines Management Group meeting across all divisions now in place with agreed TOR and membership to further strengthen the effectiveness of medicines management through Divisional and Care Group engagement and the risk register. • Following Section 29A Notice in October 2023 measures have been put in place to address the specific issues raised in the Notice concerning medicines management. • The Trust have responded back to the CQC as requested within the timeframe allocated with an update position regarding the Section 29A notice. • Projects to support communication and education of staff are in place which include e-Learning, video training and face-to-face.
Advise	• The auditing of medicines management and prescribing quality is done locally on a weekly basis and is available on the intranet. • Key information which underpins medicines management are available on the Medicines Management dashboard on the Trust intranet. • Electronic drug storage units have been installed and in operation within wards 16 & 17 and the newly opened UECC. • Electronic drug storage units have been purchased for refurbs on Ward 5/6, Wards 14&15, Maternity & Ward 24/25. The units for wards 14 & 15 are available and need to be installed+/-ward refurbishment. The installation of electronic drug storage units will largely resolve compliance issues and further enhance drug security. • The Trust is reviewing implementing an EPMA system and a project manager has been appointed to address the requirements for procurement, business case and timelines. In the meantime, a review of the paper charts has been completed and is due for roll-out in the coming months, accompanied with training video to support the launch of the revised WHT chart. • External EL Audit in aseptic unit completed on 16th March 2023. Awaiting full report and actions, but verbal feedback provided. • Home Office Inspection visit for Controlled Drugs Management scheduled May 2023. All pre-visit documents completed & submitted.
Alert	• The ward audit of medicines management continues to show gaps in compliance.

	• Pharmacy Homecare Services Team capacity reached (risk 2929) preventing service expansion & impacting the sign up of any further new patients. Likely negative impact: patient experience, patient flow, government care closer to home initiative, reduced gainshare opportunities. Homecare Business Case tabled for approval at Trust Investment Group meeting April 23.
Author and Responsible Director Contact Details:	Author – Tony Chopra, Deputy Director of Pharmacy – Gurdeep.chopra1@nhs.net Responsible Director – Dr Manjeet Shehmar, Chief Medical Officer – manjeet.shehmar@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care d) Deliver the priorities within the National Elective Care Strategy e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care
Resource Implications:	Resources will be required for purchase of further electronic drug storage units, an electronic prescribing system, clinical staff for implementation and Controlled Drug management software, if supported in principle by TMC. Business cases to follow.
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	There are no legal or equality & diversity implications associated with this paper.
Risks: BAF/ TRR	The main risks identified are concerned with the level of compliance with the Medicine Policy which is managed through Corporate risk 2737 and associated Divisional and Care Group risks.
Risk: Appetite	
Public or Private:	
Other formal bodies involved:	
References	

Walsall Healthcare
NHS Trust

NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Medicines Management Report

1. PURPOSE OF REPORT

The purpose of this report is to inform and assure the Board on the management of medicines within the Trust. This is achieved through the activity of the Medicines Management Group and its sub-groups.

2. PHARMACY AND MEDICINES MANAGEMENT

The responsibility for medicines management within the Trust rests with the Chief Medical Officer with delegated responsibility to the Director of Pharmacy, who is also the Controlled Drugs Accountable Officer (CDAO) for the Trust.

The Medicines Management Group (MMG) is the group which has oversight of medicines management and usage. The MMG is chaired by the Chief Medical Officer or by the Director of Nursing in the absence of the Chief Medical Officer. The MMG meets on a monthly basis with the exception of August and December.
The MMG met on:

- 25th January 2023
- 3rd March 2023 – deferred from February 2023
- 22nd March 2023

The MMG reports directly into the Clinical Effectiveness Group on a quarterly basis.
The MMG receives reports from a number of sub-groups.

Section 29A Notice

The Section 29A notice was served on 17th October 2022 following a CQC visit to MLTC in October. An executive led, Medicines Management action plan group was set up on 26th October to monitor the action plan in response to the notice. The group after initially meeting on a weekly basis, reverted to monthly and has now been superseded by the Medicines Management Improvement Group which will continue provide assurance specific to the Section 29A action plan.
A response was provided to the CQC at the end of December 2022 in line with their requirements. The Trust is continuing to collate the evidence requested from the CQC to show ongoing progress.

Following the appointment of a Specialist Advisor to support the action plan response, assurance was quickly provided that the patients identified in the Section 29A Notice had not come to any harm as a direct consequence of the issues raised by CQC.

The concerns raised by CQC in the Notice were (i) examples of unsafe prescribing – either illegible or not in accordance with Policy, (ii) medicines not available for patients such that doses were missed, (iii) patients weights not recorded where weight dependent drug doses are administered, (iv) poor diabetes management, (v) medicines available for administration were beyond the expiry date, and (vi) ambient temperature in the drug storage room on ward 1 was regularly out of range from June to October. The following actions were covered as part of the plan and CQC response:

1. A letter was sent out to all medical and nursing staff in November 2022 jointly signed by Chief Medical Officer, Director of Nursing and Director of Pharmacy. The letter set out the legal and professional obligation for all staff with regard to the safe handling, storage, prescribing and administration of medicines.
2. The process for date checking of medicines stored in ward areas was reviewed and clarified. Date checking is part of the top up process and records are kept of each time a ward is checked. In addition, a full sweep of the Trust for expired medicines was caried out on 9th November 2022, and 6 & 8th December 2022 by Pharmacy and all expired stocks identified were removed and destroyed. A once-monthly sweep is now in place, the results of which are recorded electronically for audit & assurance purposes. Weekly checks are also carried out in each area as part of the weekly matron's audit on Tendable.
3. The recording of patient's weights on the treatment chart is now part of a weekly medicines management checklist audit carried out in all clinical areas by the matrons. This data is captured on Tendable.
4. All ward areas were checked for correct ambient temperatures and where issues identified E&F provided temporary or permanent solutions. The temperature checks are also part of the weekly Tendable audit checklist and where issues are identified, escalated to E&F for resolution.
5. eLearning for Health prescribing module is now mandatory for all prescribers to complete – compliance is monitored via the Divisional structure. Compliance for the Division of MLTC is currently reported around 70%. The Division are validating the data to remove duplicates, forwarding training evidence and addressing individuals who have not completed the training by the end of January.
6. Ward stocklists have been reviewed and missed doses are audited on a weekly basis at part of Tendable which also requires evidence of what actions were taken to address the cause of the missed dose. In addition, the revised drug chart contains a new section relating to improved documentation for reason of omission to help promote timely intervention where clinically appropriate.
7. Pharmacist interventions are now collated and available as part of the medicines management dashboard on the Trust intranet. Interventions are where a pharmacist or a pharmacy technician have acted to correct errors, rationalise prescribing, advise on drug choice, optimise therapy, etc. Rarely is pharmacy advice not followed. Interventions demonstrate the value of the pharmacy ward service as the "safety net" for drug use and as such are a valuable source of near miss data to help drive learning and change.
   Supported by a pharmacist, medical and nursing staff are reviewing the interventions data as part of the board round for the week so that any themes around prescribing can be highlighted, discussed and actioned if necessary. Further to this, the ward pharmacy teams

are working on a similar roll-out to support training & education to nursing staff in relation to drug administration interventions captured.

In addition to the above, the following is also being reviewed/developed:

1. **Treatment chart.**

The Trust is an outlier with regard to still using paper prescription charts. It is recognised that many of the issues raised within the Section 29A Notice would be resolved by the implementation of an EPMA system. Such systems also incorporate a decision support function which directs safer prescribing and administration, and avoids all the risks around omission of details, errors or illegibility inherent in a paper system. The Trust is working towards the implementation of an EPMA system at the earliest opportunity. However, work has been undertaken to review and revise the current paper chart. A revised chat has been developed which will mitigate as far as possible the factors which lead to prescribing and administration errors and omissions. The new chart will also incorporate sufficient space for medicines reconciliation, pharmacy notes, antibiotic review/stop, recording of omitted doses, etc. The new treatment chart has undergone its third and likely final pilot phase, following which plans for launch of the revised WHT treatment chart alongside an a newly created training video on its use are in progress.

2. **Medicine Policy review**

It is recognised that as the Medicine Policy is a large single document it can often be difficult for users to refer to and find relevant information to guide their practice. The Specialist Advisor is leading on a review of the policy and it is envisaged that the ideal document would be to have a simplified overarching Policy document which sets out basic principles, but which is supported by a suite of procedures which describe specific legal and professional elements of medicines management. The Medicines Policy is being addressed in conjunction with RWT and an initial review meeting is being scheduled imminently to progress this. Action Plan from this will be set and attached to the Section 29a Action Plan. In the interim, to highlight key messages from the Medicines Policy, posters for ward/clinical areas setting out the “Eight Rights” for medicines prescribing and administration have been circulated, and a credit card sized prompt card for correct prescribing has now been made available to all prescribers & non-medical prescribers.

3. **Medicines Management Group**

A review of the terms of reference for the MMG has recently been completed & ratified to ensure that robust assurance and accountability is provided. The agenda has been reviewed to ensure that the appropriate levels of assurance are received from the MMG sub-groups.

4. **Divisional Medicines Management Groups**

Each of the four Divisions (MLTC, Surgery, WCSS, Community Services) have now set up a monthly divisional medicines management group to oversee actions and improvements for the Section 29A Notice. The group receives reports from each of the Care Groups within their Division to provide update and assurance on actions based on the weekly Tendable audits, Safeguard intervention data, PGDs, pharmacy interventions and medicine-related risks on the Care Group risk register. As part of the wider review of Divisional governance structures, it is

recommended that this is taken as the standard Divisional model for reporting and assurance from care groups, through Division, to MMG.

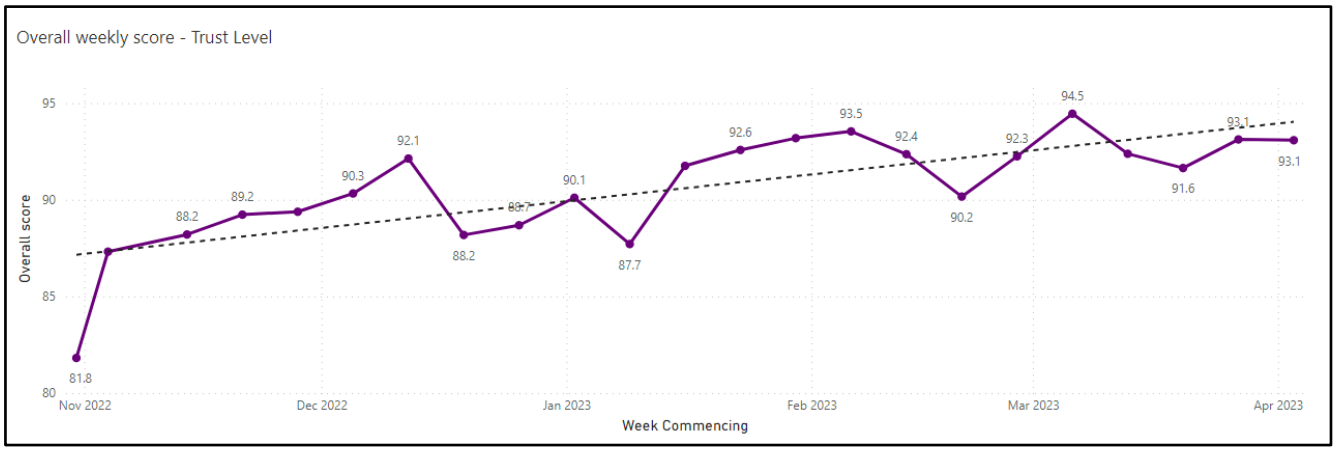
Medicines Management Dashboard

A dashboard of key medicines management metrics has been set up on the Trust Intranet:

1. Weekly Audit Data (Tendable)

The ward weekly audits comprise 13 audit criteria which covers drug storage, patient identification, prescribing quality, recording of patients weights, allergy recording, and CD record keeping. The audits are carried out by the matron or deputy and the results for each ward is discussed at the care group huddle. Data is presented below on a weekly basis with the overall scores for each criteria across the Trust.

Figure 1



Whilst the overall score shows a gradual improvement (figure 1), and each criterion shows an improvement from the starting position on 31/10/2022, there are still some areas which require improvement (see table 1). These are:

RED

- The nature of the allergy recorded on the chart
- All prescribed medication have prescribers name in block capitals or stamp

AMBER

- Evidence that action has been taken to address an omitted dose
- The patient's weight is recorded on the chart
- All medications are prescribed in block capitals

Table 1: 2022-23 Quarter 4

Week Commencing	Overall score	Medicine room / CD	Does patient have a wrist band insitu with appropriate allergy status	Patient prescription charts have details of patient name,date of birth and hospital number or NHS number?	Is allergy status documented on the prescription chart?	Is the nature of the allergy documented on the prescription chart?	If there has been an omission of a medication, has a code been used?	Is there evidence that action has been taken to address theomission, unless there is a valid clinical reason for theomission?	Is the patient's weight documented on the prescription chart?	Are all the medication names on the prescription chart written in block capitals?	Are all the medications prescribed on the prescription chart signed?	Are all the medications prescribed on the prescription chart signed with name printed in block capitals/or stamp used?	Are all the medications within their expiry date? (5 random medications checked)	Controlled drugs
03 April 2023	93.08	93.97	98.10	99.52	99.05	79.58	98.42	89.86	84.55	84.60	99.52	79.05	100.00	92.55
27 March 2023	93.12	96.67	92.27	99.24	96.55	76.50	93.27	82.08	77.38	81.49	99.55	79.67	100.00	95.08
20 March 2023	91.64	90.54	97.62	99.05	100.00	88.37	95.89	89.60	86.45	80.64	99.40	76.34	100.00	93.34
13 March 2023	92.38	93.24	96.67	100.00	99.63	67.62	95.41	91.07	83.56	79.37	100.00	85.56	100.00	95.67
06 March 2023	94.45	95.31	98.04	99.13	98.21	73.99	95.19	91.56	82.19	85.09	99.13	87.70	100.00	100.00
27 February 2023	92.25	93.24	96.15	99.19	99.57	84.05	98.15	85.07	82.63	80.96	99.60	78.21	100.00	96.67
20 February 2023	90.17	93.46	91.50	99.62	99.62	77.26	89.90	80.47	77.76	73.16	98.85	72.42	98.46	90.97
13 February 2023	92.36	92.30	98.89	99.26	99.22	76.55	94.65	87.14	82.42	83.29	98.33	80.62	100.00	97.67
06 February 2023	93.54	95.21	95.85	99.45	99.43	77.24	94.27	88.62	85.16	80.34	99.36	84.55	100.00	95.00
30 January 2023	93.19	96.52	98.21	100.00	99.64	80.24	87.89	80.94	81.72	78.87	97.03	77.05	98.57	97.76
23 January 2023	92.58	92.82	96.67	99.23	98.46	84.36	94.58	94.58	81.90	83.38	98.68	82.70	99.26	91.00
16 January 2023	91.76	92.99	97.16	99.00	98.20	67.20	97.26	95.34	81.09	78.36	98.00	75.01	100.00	96.88
09 January 2023	87.71	89.45	95.93	98.89	97.40	68.11	91.98	88.62	73.02	62.01	99.26	72.27	98.77	86.34
02 January 2023	90.11	93.56	95.84	98.01	99.19	71.30	91.62	84.33	63.75	76.60	98.85	70.26	100.00	93.91

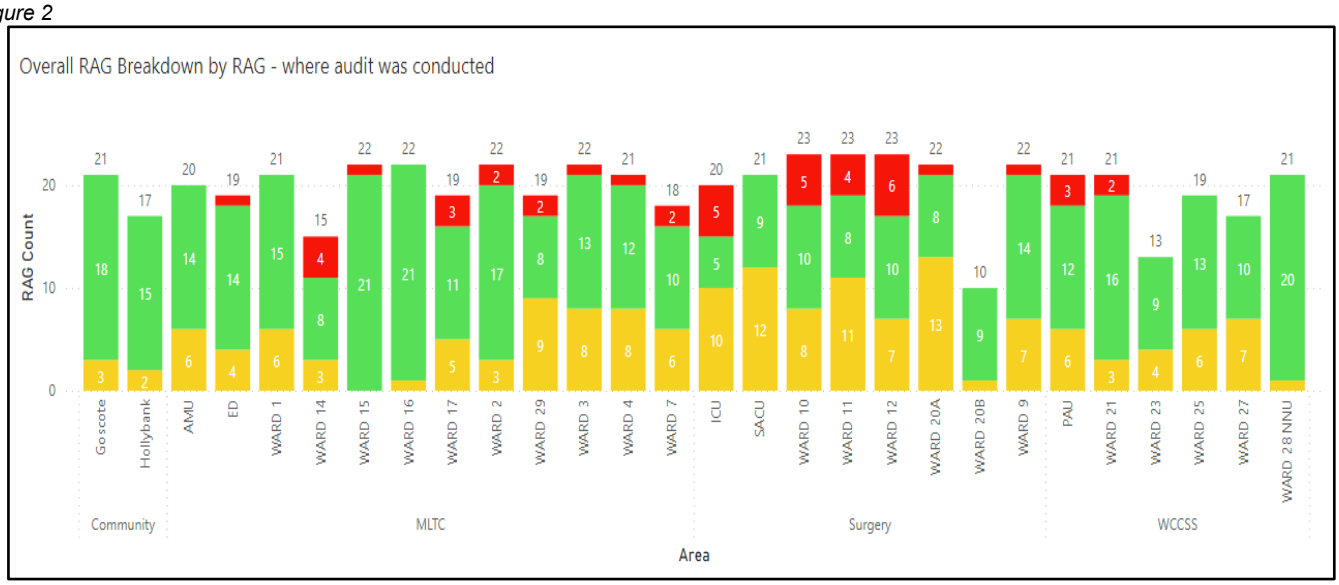
Table 2 below highlights further highlights an improved picture against results from the previous quarter.

Table 2: 2022-23 Quarter 3

Week Commencing	Overall score	Medicine room / CD	Does patient have a wrist band insitu with appropriate allergy status	Patient prescription charts have details of patient name,date of birth and hospital number or NHS number?	Is allergy status documented on the prescription chart?	Is the nature of the allergy documented on the prescription chart?	If there has been an omission of a medication, has a code been used?	Is there evidence that action has been taken to address theomission, unless there is a valid clinical reason for theomission?	Is the patient's weight documented on the prescription chart?	Are all the medication names on the prescription chart written in block capitals?	Are all the medications prescribed on the prescription chart signed?	Are all the medications prescribed on the prescription chart signed with name printed in block capitals/or stamp used?	Are all the medications within their expiry date? (5 random medications checked)	Controlled drugs
02 January 2023	90.11	93.56	95.84	98.01	99.19	71.30	91.62	84.33	63.75	76.60	98.85	70.26	100.00	93.91
26 December 2022	88.69	90.47	94.00	97.00	97.45	62.65	94.51	71.78	65.93	80.03	99.50	78.52	100.00	92.50
19 December 2022	88.18	88.37	96.99	99.62	95.48	68.38	88.39	90.74	60.80	74.57	99.62	68.33	100.00	95.34
12 December 2022	92.13	93.82	97.50	100.00	98.89	75.76	97.88	92.93	66.67	77.38	96.80	80.96	100.00	93.12
05 December 2022	90.33	92.94	92.06	99.09	100.00	73.48	96.67	95.93	68.04	69.67	98.64	68.67	98.10	93.26
28 November 2022	89.38	92.61	93.64	99.13	97.25	74.02	99.21	87.79	70.45	69.52	99.02	68.39	100.00	86.75
21 November 2022	89.23	92.83	97.73	97.02	97.20	64.66	94.45	89.41	67.78	64.83	98.31	58.22	100.00	92.00
14 November 2022	88.21	91.94	96.50	100.00	97.84	72.02	98.04	87.73	61.58	56.95	98.17	51.95	100.00	90.79
04 November 2022	87.32	90.80	90.00	96.34	96.89	63.96	99.00	75.75	66.66	64.68	98.05	56.62	98.33	91.67
31 October 2022	81.82	91.41	89.58	93.38	98.24	58.68	91.86	73.75	26.98	46.81	98.43	39.49	97.78	

The table below sets out the occurrence of the overall RAG rating for each ward covered by the audit. The new paper drug chart will enable better documentation by providing space for block capitals and a name stamp.

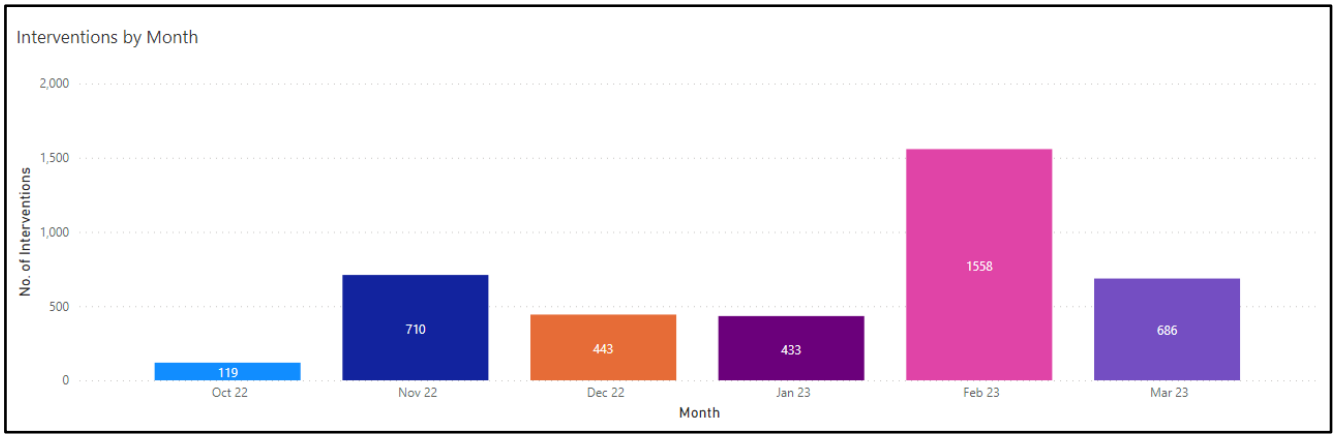
Figure 2



2. Pharmacist Interventions

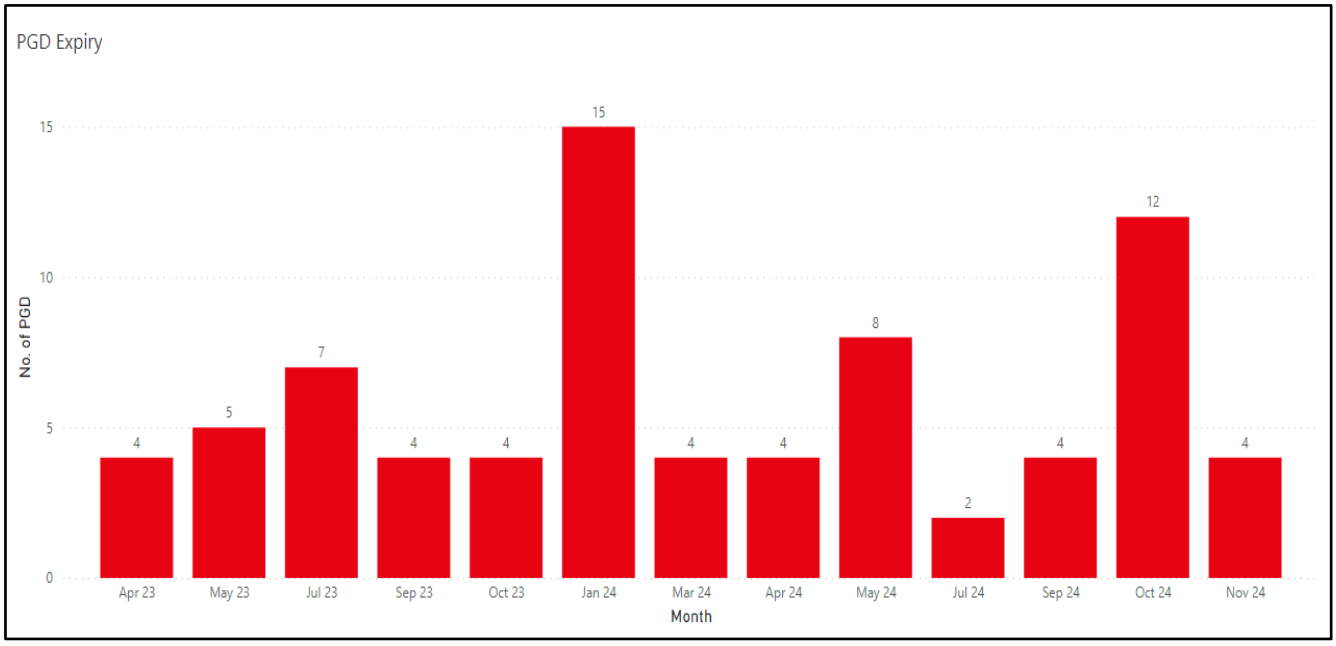
The number of pharmacist interventions since 17/10/2022 is set out below. The interventions can be viewed as near misses and demonstrate the value of the clinical pharmacy service. The detail of each intervention is available on the dashboard and can be sorted by consultant. It is essential that teams review their intervention data on a regular basis and learn from common themes.

Figure 3



3. Patient Group Direction (PGD)

The PGD dashboard allows Divisions and Care Groups to review their PGD and to anticipate when a review is due. Currently there are 91 PGDs across the Trust and all are in date. The table below shows the schedule of expiry – that are 4 PGDs due to expire by April 2023. The Care Groups are aware and are in the process of reviewing and updating.



The Medicines Management dashboard also includes information on:

- Medication Supply Shortages
- Formulary status of all drugs
- Ward stocklist for drugs for all locations
- Yellow card reporting for any adverse events
- Log in to Medusa Guidelines
- eBNF

The dashboard will be developed still further based on feedback from users.

Risk Register

Risk 2737 has been placed on all Divisional and Care Group risk registers around the non-compliances to the Safe and Secure Handling of Medicines and Controlled drugs Audit. This has shown to improve local ownership of the management of medicines at ward level which is evidenced by some improvement in the management of controlled drugs which has been presented in the above section. The care groups are currently reviewing their evidences with a view to downgrading the risk scores. The Corporate risk was reviewed in January 2023 and has now been reduced from 20 to 16.

Divisions and Care Groups continue to manage their own risks based on audit results. These are reviewed regularly and can be reduced based on improvements based on audit data. The risks are reviewed at the Divisional Performance Reviews.

Ward storage

As discussed above, wards are required to use the Tendable app to complete ward storage audits which provide evidence towards divisional care group medicines management risk. The information is available on a weekly basis on the Medicines Management dashboard and form the basis for discussion at care group and divisional safety huddles and Medicines Management Groups.

Further Developments

- Funding secured to purchase automated ward storage cabinets across Wards 14-17 and Ward 5 as part of the refurbishment programme. The projects also include swipe card access to drug storage areas, electronic temperature monitoring and air temperature control. this will allow for the above standards to be achieved consistently across these ward areas. The refurbishment of Wards 16 &17 has been completed and the Pyxis units are installed.

- WCSS have purchased automated ward storage cabinets for 21, PAU and wards 24-25, this will help to ensure that there is a robust process for the handling of To Take Out pre-packed medication which has been an area of concern for this division. The installation for wards 24-25 is awaiting a Go-live date.

- The new build ED will include air temperature monitoring, swipe card access to drug areas and electronic drug storage units in four locations – ED, PAU, AMU and ED Resus. The Pyxis units are on-site and are being loaded and configured in ready for installation.

- A quote from BD has been obtained for the installation of BD pyxis units on the remaining inpatient areas. Options for a managed service are being explored between BD and finance. A business case will be developed.

- Pharmacy has installed an electronic cabinet for controlled drugs. This will enhance security within pharmacy and has allowed the audit trail to become paperless

- Pharmacy has begun some work with Corporate Quality Nurses – Rachel Tomkins and Kelly Saville – to set up workshops for nursing staff to focus on discussions around NMC professional accountability & responsibility, and legal aspects of practice and medicines. Initially the work will focus on Divisions, but potentially will be expanded and become part of regular professional updates.

3. REGULATORY

- General Pharmaceutical Council pharmacy premises – renewed annually in October, no inspection due.
- Wholesale Dealers Licence [WDA(H)] – last inspection July 2019. No inspection due.
- Home Office Controlled Drug Licence – visit scheduled for May 2023. All pre-visit documents completed & submitted.

4. RECOMMENDATIONS

The Board is to note that since the Section 29A Notice, a wide range of measures have been put in place to drive improvement in Medicines Management, particularly regarding storage of medicines and prescribing quality. The newly developed Medicines Management dashboard enables full transparency of data relating to medicines management. Whilst there are areas where further improvements are required, it is possible to evidence progress so far.

The above measures will also improve accountability, especially through the Divisional governance structures, and the newly formed Divisional Medicines Management Groups.

Item 14.19

Walsall Healthcare NHS Trust

Trust Board (Public)	
Meeting Date:	7th June 2023
Title of Report:	Mortality Report (December 2022 - March 2023)
Action Requested:	Members of the Trust Board are asked to: Approve ☒ Discuss ☒ Inform ☒ Assure ☒
For the attention of the Board	
Assure	The most recent published SHMI value for the 12 month rolling period (published by NHS Digital March 2023) November 2022 - October 2023 is 1.003 which is within the expected range (this relates to the acute Trust excluding palliative care). Please note - this is the most up to date data available at the time of writing the report.
Advise	• The medical examiner team reviewed 100% of the total eligible inpatient deaths for the months November and December. • Community ME is now being rolled out to all Walsall GP Practices with 24 practices (at the time of the report) signed up, 47% of the total Walsall GPs. • 4 LeDeR deaths were reported during this period.
Alert	• The Community ME service did not become statutory in April 2023 as planned and is delayed until Summer 2023. • There are currently 20 SJRs outstanding, however good progress is being made within specialties to clear this.
Author and Responsible Director Contact Details:	Mr Salman Mirza Email salman.mirza2@nhs.net Mrs Lorraine Moseley Email lorraine.moseley3@nhs.net Manjeet Shehmar, CMO Email: manjeet.shehmar@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care
Support our Colleagues	a) Improve overall staff engagement b) Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	a) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care
Resource Implications:	None
Report Data Caveats	Data is correct at the time of reporting. NHS Digital reporting is 3 months in arrears.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations.

	• National legislation relating to the review of child and perinatal deaths has been implemented.
Risks: BAF/ TRR	• BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm • Performance against SHMI is recorded on the trust risk register
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Walsall Healthcare NHS Trust

Brief/Executive Report Details	
Brief/Executive Summary Title:	Mortality Report – December 2022 – March 2023

Introduction

This report details:

1. **Performance** data relevant to the trust, compared with regional and national comparator sites, where appropriate
2. **Key areas for attention**, together with analysis, actions and outcomes
3. **Future actions** and developments in understanding mortality data

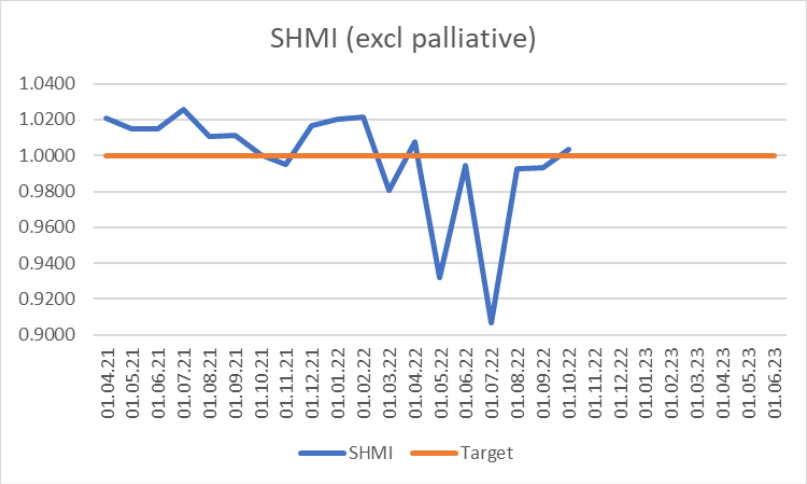
1. Update on Standardised Mortality Rates (SMRs) and inpatient data relevant to these calculations

1.1 Activity levels over this period is as follows:

	Admissions	Hosp Deaths	Total Discharges	Covid Deaths
Jan 23	7273	168	7754	25
Feb 23	7662	113	7604	10
March 23	7532	149	Data not available at time of report	17

1.2 SHMI (Inpatient deaths plus 30 days post discharge - please note data not updated at the time of writing)

The most recent published SHMI value for the 12 month rolling period (published by NHS Digital March 2023) November 2022 - October 2023 is 1.003 which is within the expected range (this relates to the acute Trust excluding palliative care).



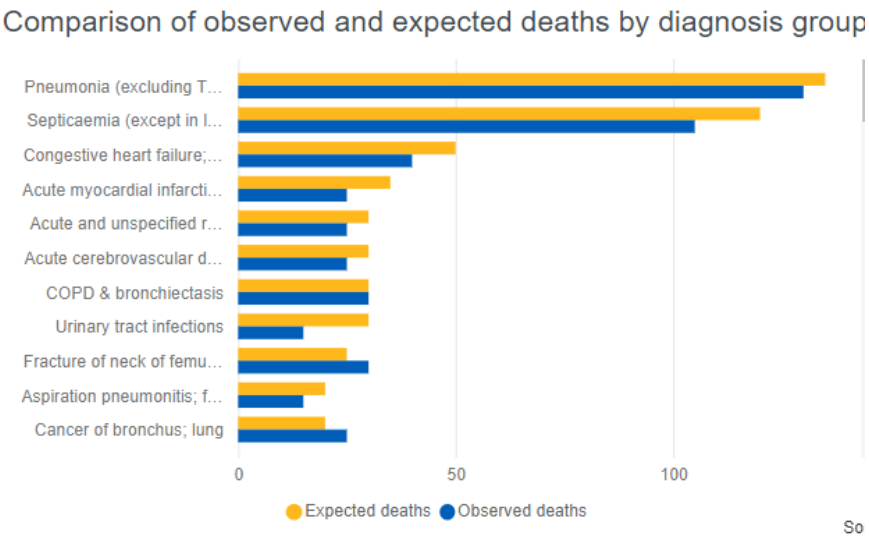
SHMI in comparison with neighbouring Trusts (*NHS Digital)

Trust	November 2022 - October 2023
Walsall Healthcare NHS Trust	1.003
The Royal Wolverhampton NHS Trust	0.929
The Dudley Group NHS Foundation Trust	1.139
Sandwell And West Birmingham Hospitals NHS Trust	1.044

The overall Trust SHMI breakdown is as follows:

Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
Manor Hospital	60,815	1,395	1,390	1.0033	As expected SHMI
Holly Bank House	110		15		
Walsall Hospice	160	115			

Comparison of observed and expected deaths:



It can be seen from the above that there are two areas where observed deaths are higher than expected deaths: cancer of bronchus and fracture of neck of femur. Patient level data has been provided to the relevant specialty and will subsequently be reported at the Mortality Surveillance Group.

SHMI and SDEC (Same day emergency care)
There are plans to remove SDEC activity from SHMI. To estimate the impact on the Trust's SHMI values, an internal analysis will be undertaken to estimate the impact of this action.

The following methodology will be used. The SHMI patient level data for the Trust will be accessed and linked to inpatient data to identify admitting ward and spell details.

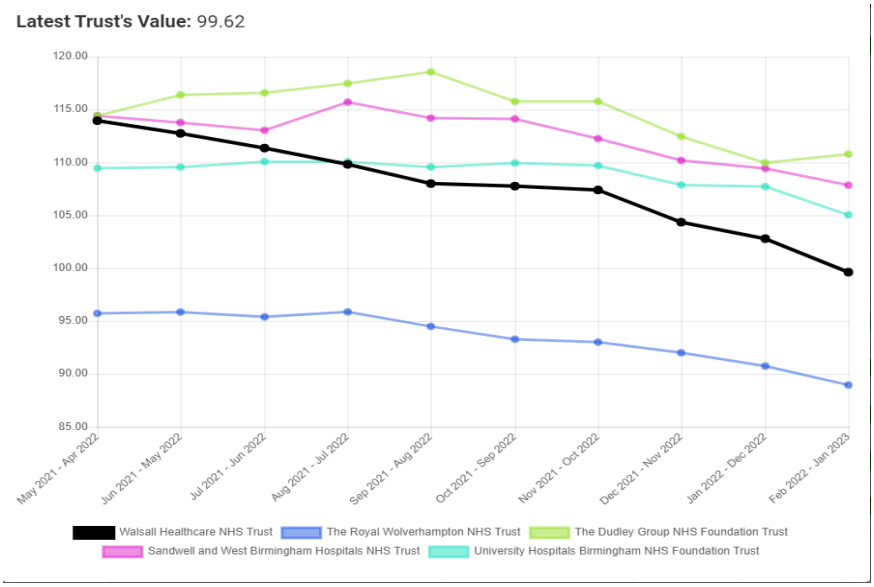
For each patient record in the SHMI dataset there is a risk of death, the SHMI is calculated as sum of observed deaths / sum of expected deaths, SDEC activity will be identified and excluded with SHMI then recalculated.

This work is currently underway and results will be available for the next report.

2. HMSR

The chart below is taken from available data within HED and illustrates the Trust's performance in relation to peer group. HMSR for this period is lower than the national average (101.16) and continues to show a steady reduction in HMSR.

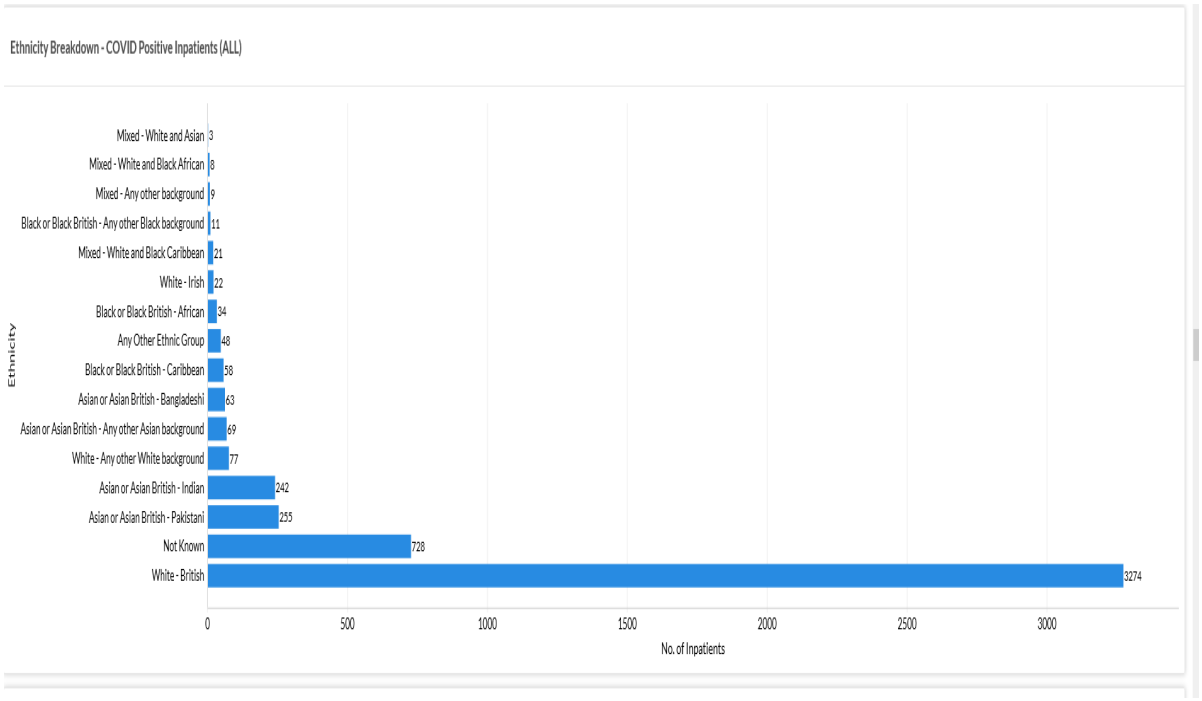
The following table includes the expected HMSR level to January 2023 and illustrates a continued decrease in HMSR.



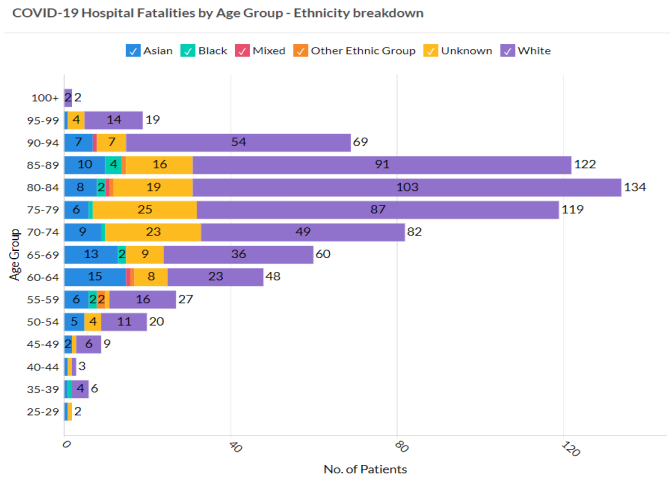
3. Covid 19 inpatient/ethnicity

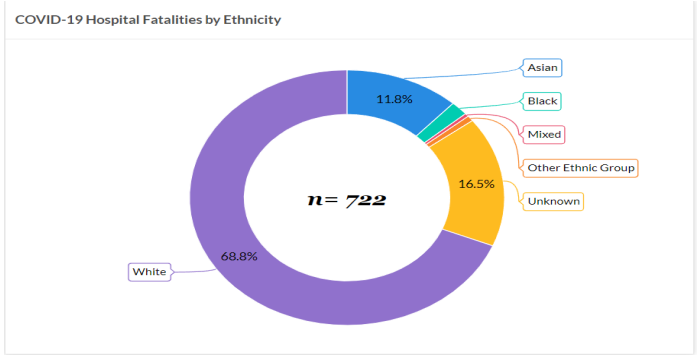
Please note: this section has not been updated, data is unavailable as a result of a recent cyber incident.

The graph below shows ethnicities for all covid positive inpatients.



The graphs below show ethnicities for all covid positive deaths.





Alerts

The Trust received the following alerts during this period:

INDICATOR	PERIOD	VALUE	
Mortality Cumulative Summary Aggregated (HSMR) - 127 - Chronic obstructive pulmonary disease and bronchiectasis	Nov-22	5.97	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) 15,19 Cancer of bronchus; lung	Nov 22	144.43	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) 35;59 Deficiency and other anaemia, 60 Acute post haemorrhagic anaemia	Nov 22	188.7	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - 18 :: 24 - Cancer of breast	January 2022 - December 2022	372.69	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - 37 :: 55 - Fluid and electrolyte disorders	January 2022 - December 2022	155.39	
Mortality Cumulative Summary Aggregated (HSMR) - 100 - Acute myocardial infarction	Jan-23	3.28	

Patient level data has been provided to the specialties for subsequent reporting at Mortality Surveillance Group.

Updates from alerts

Breast cancer

Upon review of the clinical notes, there were no concerns in care. Separately, the team have been expanded with a breast cancer nurse to help reduce delays in the cancer performance pathway.

Colorectal

- Mandated FIT prior to GP referral January 23
- NHSE/WMCA guidance for Urgent referral for suspected colorectal cancer 27/01/23 circulated to major stakeholders.
- MDT / Lead education session arranged with GP/PC Feb/March 23.
- Additional CNS triage post advertised.
- Additional ICB funding to support Endoscopy capacity- extra list through November- January 23 reduce backlog of colonoscopy requests as well as:

  - Endoscopy Equipment – approved (and now delivered) 38 scopes and 4 stack systems, costing £1.87M.
  - Endoscopy Suite Business Case – submitted to the Trust Investment Group, for a £781k expansion, delivering an additional 1,434 endoscopies/year.
  - Endoscopy Recovery Action plan - available if required.
- Cancer services have seen reduction of >62 day patients within PTL for February 23.
- Audit of MDT process and plan to address delays.

Lung

- New ACP/CNS Oncology clinics to support Oncologists commenced 06/02/23
- Less patients waiting excessive time for surgery- Change of SLA September 22
- Additional endoscopy session (3rd list) providing Bronchoscopy/ EBUS.

4. Specialty Learning / Feedback

The following specialties presented at the Mortality Surveillance Group.

End of Life - This presentation was based on a particular case to highlight ongoing care and good practice together with learning points.

Learning points:

- Excellent admission and support
- Good support from haematology
- Consideration of deterioration and end of life
- DNAR (do not resuscitate) decision left to the family and not completed by the medical team. It was noted that it is good practice that the DNAR needs to involve the person and family but is a medical decision.
- Patient's views not heard

Improvements as a result

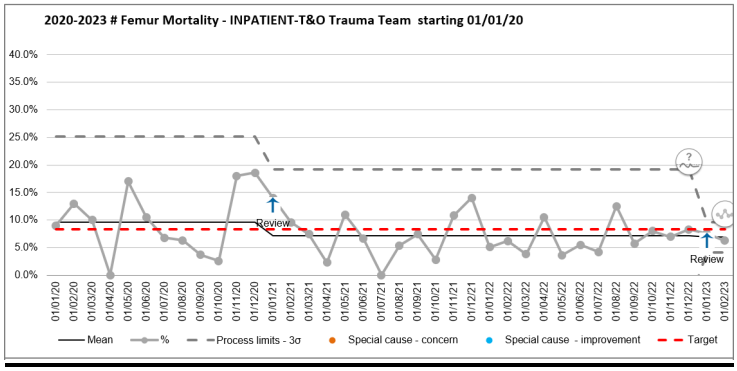
The Gold Standard Framework programme in the hospital commenced in October 2022 which helps to offer a systematic approach to end of life care on the wards. The End of Life Task & Finish group is supporting the first cohort i.e. ward 2 (MLTC) & ward 11 (Surgery). Currently both wards are using their daily board rounds to discuss these patients and support their wishes and preferences. The second cohort of six wards will commence training in June 2023 and the final cohort of six wards in October 2023. This will include areas such as ITU and AMU.

The ReSPECT group commenced in March 2023 with the aim to provide;

- Oversight and governance of ReSPECT across the Trust (Acute and Community)
- Look at training compliance

- Review data completeness audit reports (once established on Tendable)
- Review any incidents relating to DNAR decisions and ReSPECT plans
- Feedback to the group from the national meeting

Fractured Neck of Femur



The trauma and orthopaedic team are presenting their improvements in May

Elderly Care

Elderly care reviewed a total of 14 deaths over the period 01.09.22 to 31.12.22, 2 cases were referred to the Coroner.

The reviews highlighted the following areas for improvement:

- The reviews highlighted concerns over access to a complete patient record to do their reviews.
- Learning points included but were not associated with the outcome:
    - Need to improve oxygen prescribing via a QIP being led by the clinical director
    - Hypoglycamia recognition with ward based training on arranged to improve recognition.
    - Delay in post take ward round for 20 hours which needs to be completed within 12 hours of admission. The team are continuing with a recruitment strategy for gaps in their establishment.
    - Delay in providing Specialist opinion following referral, this has been escalated and discussed at Medical Advisory Committee
    - In one case a patient was admitted with low K+ of 2.2 where the team could have intervened and treated earlier. This did not affects the outcome.
- Other points raised have been addressed via specific training in the Geriatric Education Meeting attended by both consultants and post graduate doctors in January and February:
    - A catheter passport documentation is to be introduced
    - Feeding issues- NG tube was sited but was not used (for 3 days) and on 4th day patient was allowed to eat and drink

- There was a gap in following NICE guidance on Head Injury
- Recognising /Considering Necrotising Fasciitis in patients with Cellulitis

The reviews acknowledged good communication with families which is an improvement on previous findings.

Quarterly Perinatal mortality

Reporting requirements were outlined:

- PMRT review commenced within 2 months of death (standard = 95% of cases)
- Multidisciplinary Team review within 4 months of death (standard = 50% of cases)
- Review of case validated using the PMRT within 6 months (standard = 50% of cases)
- Parents involved in the review process (standard = 95% of cases)
- Quarterly Report submitted to trust board

Internal PMRT Cases for Review– Quarter 3 2022

Q3 2022	Late Fetal Loss <22/40	Late Fetal Loss 22-23+6/40	Stillbirth	Neonatal Death <22/40	Neonatal Death >22/40	Termination of Pregnancy	Total Monthly Losses	TOTAL ELIGIBLE FOR REVIEW
October	2	0	0	2	1	3	8	1
November	1	0	1	0	1	0	3	2
December	3	0	0	0	1	0	1	1
Total Loss by type	6	0	1	2	3	3	12	4

Blue cells indicate those cases which are suitable for review using the PNMR tool

Internal PMRT reviews – CNST Standards (information as of 10.02.23)

Reporting Period	Deaths eligible for review by PMRT	No Reported to Coroner	PMRT Reviews commenced within 2 months (standard = 95%)	No of deaths reviewed by MDT (at PNMM) within 4 months)	No PNMM draft reports within 4 months (standard = 50%)	PMRT validated report within 6 months (standard = 50%)	No of parents involved in review (standard = 95%)	No of SI/RCA/ Concise/ HSIB	No of complaints
Q3 2022	4	2	4 (100%)	4(100%)	4 (100%)	1(25%)	4	0	0

Reports have been finalised pending final post mortem repots, placental cytogenetic reports and placental histology reports.

External PMRT Cases for review – Quarter 3 2022

Q3 2022	Late Fetal Loss 22-23+6/40	Stillbirth	Neonatal Death >22/40	TOTAL ELIGIBLE FOR REVIEW
October	0	0	0	0
November	1	0	1	2
December	0	0	2	2
Total Loss by type	1	0	3	4

External PMRT reviews – CNST Standards (information as of 10.02.23)

Reporting Period	Deaths eligible for review by PMRT	No Reported to Coroner	PMRT Reviews commenced within 2 months (standard = 95%)	No of deaths reviewed by MDT (at PNMM) within 4 months)	No PNMM draft reports within 4 months (standard = 50%)	Case Reviewed and returned to assigning trust	No of parents involved in review (standard = 95%)	No of SI/RCA/ Concise/ HSIB	No of complaints
Q3 2022	4	2	4 (100%)	2 (50%)	2 (50%)	2 (50%)	4	1	0

Grading of care

	Not yet graded	A No issues in care	B Issues in care would not have changed the outcome	C Issues in care may have changed the outcome
Number	2	6	4	2

The following sets out the number of serious incidents, RCAs and HSIB investigations relating to deaths:
Quarter 3 (October/ November/ December 2022)

- 1 x Case for concise review

- 1 x Case reported as a Serious Incident
- 1 x Cases Reported to HSIB (Healthcare Safety Investigation Branch)
- 4 x JAR Meeting / Review
- 5 x Reported to CDOP

The presentation included a case study for each month. The following top 5 themes for improvement were identified with improvement methodology:

Issue	Aim	Method	Results
Bereavement Care & Support – Accident and Emergency Department	To ensure all parents receive a standard of Bereavement care as per the National Bereavement Care Pathway, following the loss of their baby in A&E department	1. Liaise with A&E lead Matron / Consultant to ascertain the best point of contact regarding Bereavement care	
Out of area women accessing maternity care	To ensure that all out of area women have a booking appointment and are able to access maternity care	1. Liaise with community midwifery team leaders to scope what failsafe's are in place for OOA women	CMW Team Leader confirmed that for all out of area women, if they contact Walsall CMW team they have now put in place that they book them then email the out of area hospital to arrange her antenatal care
Availability of CT scanning for babies admitted to the Neonatal unit that are ventilated	To develop a pathway / guideline that allows babies whom are admitted to the NNU and are ventilated to be able to have a CT scan onsite.	1. PMRT Lead Neonatal Consultant to lead on this quality improvement. 2. Set up a working group to explore implementing this new pathway / guideline	
CFM Machine (Cerebral Function Monitor) - Availability	To ensure that a CFM machine is available at all times on the Neonatal Unit. - The CFM machine allows long-term evaluation of electric brain activity without interfering with the nursing of the newborn.	1. To scope a replacement I the absence of the machine having been sent away for repair 2. Scope the possibility of having a second CFM machine	1. CFM machine has been obtained on loan from New Cross Hospital, in the absence of the one currently away for repair.
Neurological examinations on the Neonatal Unit	To ensure that Neurological examinations include checking of the pupils and documenting these results	1. Review both current paper and electronic Neurological examination forms to ensure that checking of the pupils is included and there as a prompt	

It will take six months to embed the improvements which will be monitored on the PMRT action log monthly.

The following areas of good practice were identified:

Neonatal Staff – Parent debriefs	It has been feedback from New Cross Hospital that babies that have had an ex-utero transfer to them, the parents have been debrief exceptionally prior to transfer, so that upon arrival to the other hospital the parents have had realistic expectations regarding their babies care and clearly understand the reason for transfer.
Appropriate Referrals	In Two cases in Quarter 3, there have been two good examples of appropriate referrals to ensure the woman and her baby are in a setting appropriate to their clinical needs. The pathways / guidelines adhered to are; - Stoke Pathway for referral to Stoke Hospital for women whom have a low lying placenta / placental acreta - Preterm spontaneous rupture of membranes – woman on this pathway are referred to New Cross Hospital to ensure a higher level of neonatal care is available should the baby be born prematurely < 27 weeks. - Fetal Medicine – Babies identified abnormalities that require tertiary level care / intervention following birth have been appropriately referred during the pregnancy to ensure the woman and baby are in a clinical setting appropriate to their needs.

The team also have a number of projects currently underway:

- Working group to review the admission of gestation between Obstetric care and Gynaecology care. Currently < 20 weeks pregnant women are seen in Gynaecology and >20 weeks pregnant women are seen in Obstetrics. Working group working towards amending this to 16 weeks gestation. This will not influence the overall reduction in mortality, however, it will improve the care provided to patients and will demonstrate alignment with Local Maternity Neonatal Services (LMNS).

- GAP Analysis – MBRRACE & PMRT National Reports
- Thematic Review being undertaken of Mid Trimester losses (20+0 – 23+6 weeks) occurring in 2020, 2021 and 2022 to identify and themes, issues and any links.

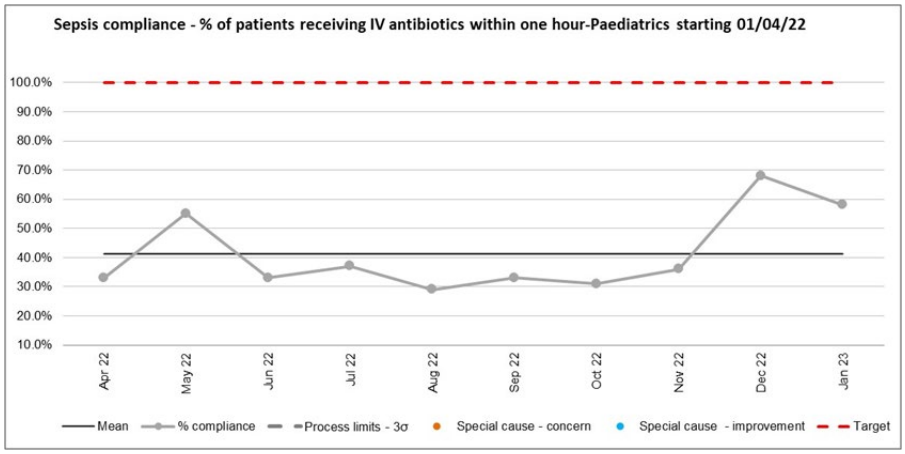
The Thematic Review will be presented at Mortality Surveillance Group in May 2023.

Deteriorating patient

Developments

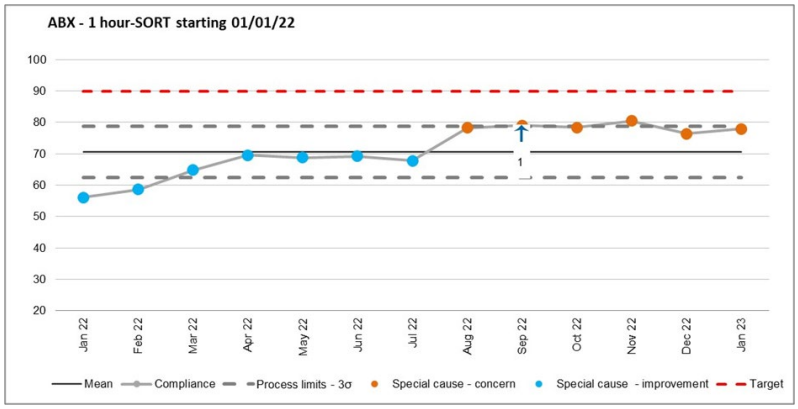
The Deteriorating Patient Group has submitted a business case to introduce a 24-hour service from the sepsis team.

The SORT team has supported the Paediatric Team in providing assurance in sepsis performance and compliance with the Sepsis Bundle.



Sepsis Training has been prioritised using the data available from Vitals to identify individual wards and their own needs in terms of bundle priorities for improvement.

Since its introduction in January 2022 there has been a significant improvement in the Trust-wide performance against delivery of the Sepsis Six and in particular administration of antibiotics within 60 minutes.



5. Mortality Reviews - Structured Judgement Reviews (SJRs)

5.1 The number of outstanding SJRs for the period of this report is 20. This consistent with 21 previously reported. (These are being followed up by the Learning from Deaths Administrator and supported by the Deputy CMO through Mortality Surveillance Group.

6.2 SJR training was held in March 2023. The training session is available for review and presentation has been shared with mortality leads.

6.3 1 LeDeR review was identified in January, 1 in February and 2 in March. The outcome of these reviews are not know at the time of writing this report. There is a backlog of LeDeR reviews (these are completed by external reviewers not employed by the Trust).

6.4 The issue around missing notes/loose filing remains an issue. The Learning from Deaths Administrator is working closely with the Coding Team to develop a process to mitigate as far as within their gift to do so.

SJR outcomes (total deaths reviewed categorised by outcomes)*

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 2 Strong evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	2	12.0%
This Year (YTD)	5	8.2%

Score 3a Probably avoidable (more than 50:50)		
This Month	1	25.0%
This Quarter (QTD)	3	17.6%
This Year (YTD)	7	11.5%

Score 3b Probably not avoidable (less than 50/50)		
This Month	1	25.00%
This Quarter (QTD)	4	23.5%
This Year (YTD)	12	19.7%

Score 4 Probably not avoidable		
This Month	2	50.0%
This Quarter (QTD)	8	47.1%
This Year (YTD)	35	57.3%

Score 5 Slight evidence or definitely not avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	2	3.3%

*This data refers to the number of SJRs completed.
The total number of deaths in the Trust for this quarter = 430.
Number of completed SJRs with scores of 1-3a = 5.
% of avoidable deaths in this quarter = 1.2%

6. Medical Examiner

The medical examiners reviewed 100% of deaths in this reporting period.

The number of community deaths referred to the ME service has increased with the number of GPs now signed up to the programme. The following community deaths were reviewed:
January - 12
February - 24
March - 50

The community ME programme continues to be rolled out to all Walsall GPs with 48% of Walsall GPs now part of the programme with meetings arranged for April to encourage GPs to sign up in advance of the statutory date.

The ME programme in the community was due to become statutory in April 2023 however this has been moved to Summer 2023 and we are awaiting notification of the exact date.

7. Matters for escalation to QPES from Mortality Surveillance Group

The following matters were raised at the February 2023 meeting for escalation to QPES:

- New guidance has been received from the Coroner relating to terminations of pregnancies for fetal abnormalities. In future every termination of pregnancy for fetal abnormalities would have to be referred to a coroner.

Item 14.20

NHS
Walsall Healthcare
NHS Trust

Board Meeting held in Public	
Meeting Date:	07 June 2023
Title of Report:	Covid – 19 National Inquiry
Action Requested:	Update
For the attention of the Board	
Assure	• Members of the Trust Board are asked to note the progress to date in participation in the National Inquiry into Covid-19 specifically Module 3 – '*The impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland*'.
Advise	• The National Inquiry was established on 28 June 2022 to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future. • Module 3 relates to the specific impact on healthcare systems and commenced on 8 November 2022.
Alert	• That the Trust has complied with the Inquiry's requirement to notify all staff of their legal duty in relation to record-keeping to support the Trust's preparation for the Inquiry. This is called a 'STOP Notice' and the requirement is for colleagues to ensure that all records are saved, whether they are/were working directly on Covid-19 recovery, or as part of business-as-usual activities. • That the Preliminary Hearing was held on 28th February 2023 • That there has been a Webinar update, a precis of which is in the body of this report
Author and Responsible Director Contact Details:	Stephanie Poulter – Governance Team Support Kevin Bostock – Director of Assurance Tel 07989275283 Email stephanie.poulter@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement. b) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Improve overall staff engagement.
Improve the Healthcare of our Communities	a) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative. b) Implement technological solutions that improve patient experience. c) Progress joint working across Wolverhampton and Walsall d) Facilitate research that improves the quality of care
Resource Implications:	Resources will be met from current staff and technology within teams.
Report Data Caveats	None
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:
Equality and Diversity Impact	There are no equality & diversity implications associated with this paper.

Walsall Healthcare
NHS Trust

Risks: BAF/ TRR	No
Risk: Appetite	Low
Public or Private:	Public
Other formal bodies involved:	None
References	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Covid – 19 National Inquiry
Item/paragraph 1.0	The purpose of this report is to inform the Trust Board and its associated committees that all appropriate and necessary steps have been taken in preparation for Walsall Healthcare NHS Trusts (WHT) involvement in the Covid-19 National Inquiry which opened in June 2022. It is also to inform the Trust Board of relevant updates on next steps and likely expectations on the Trust regarding its input to the Inquiry.

COVID-19 NATIONAL INQUIRY UPDATE

1. PURPOSE OF REPORT

The purpose of this report is to inform the Trust Board and its associated committees that all appropriate and necessary steps have been taken in preparation for Walsall Healthcare NHS Trusts (WHT) involvement in the Covid-19 National Inquiry which opened in June 2022.

2. BACKGROUND

On 28th June 2022 the Rt. Hon Baroness Heather Hallet DBE PC, was appointed Chair of the Covid-19 National Inquiry, which was established to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future.

In support of this Terms of Reference for the Inquiry was published which set out the high-level scope, aims, the overall response expected of the health and care sector, the economic response and impact and the overall lessons learned.

The approach Baroness Hallet has taken is modular and in October 2022 a preliminary hearing was held on '*Module 1- Government Planning and Preparedness'*. The group is scheduled to meet again on 14 February 2023 with '*Module 2 – Political and Administrative Decision Making'* meeting on 1 March 2023 and '*Module 3 - looking at the impact of the pandemic on healthcare'* on Tuesday 28 February 2023.

3. Update following Webinar on 19th April 2023

The Inquiry held its first preliminary hearing for Module 3 '*looking at the impact of the pandemic on healthcare'*, on Tuesday 28 February 2023.

Following this the UK Covid-19 Inquiry Team facilitated a Webinar on 19th April 2023 with key speakers from Browne Jacobson; Capsticks and Hempsons Solicitor's each offering a perspective from different aspects of the hearing.

The following are key aspects covered by this Webinar including what progress has been made to date and what the expectation is likely to be on NHS Trusts going forward:

- Evidence gathering exercise and Rule 9 requests now received for the Preliminary Hearing
- Module 3 Full Hearing to take place in 2024, no date set as yet.
- There is a lot of overlap and inter-relationship with the other 2 modules and of particular concern to the Core Participants are the links to Module 1 (resilience and preparedness of the United Kingdom for a Coronavirus pandemic) and the preparedness of the NHS immediately prior to the pandemic.
- The published scope largely remains the same with the Chair of the Inquiry resistant to formal expansion of the scope as published although note has been made of Mental Health and Inequalities issues raised by Core Participants.
- 36 Core participants took part in Module 3 representing particular interest groups.
    - 19 made written submissions to the preliminary hearing.
    - 18 attended to present to the hearing in person.
- NHSE are a Core Participant but have stated that they cannot and will not be speaking for NHS bodies or their actions.
- The Inquiry is keen to hear the voice of the NHS Workforce and how they were supported by their employing bodies. 'Every Story Matters' along with targeted face to face listening sessions will facilitate this as part of Module 3.
    - Staff should be encouraged to take part at:
        - https://share.covid19.public-inquiry.uk/share-your-experience/
    - Note these methods are to seek experiences of the workforce from a generic and thematic (not individual experiences) perspective, including impact on certain groupings.
    - If organisations receive a Rule 9 request specifically about staff experiences the advice is to tell the story of how our workforce was impacted by the pandemic
        - Talk about your workforce general structure.
        - Key decision makers
        - Staffing levels
        - Challenges to the workforce
        - Impact on the workforce e.g., childcare, transport etc
        - Impact on certain group members e.g. ethnicity, disadvantaged etc
    - It is not the story or perception of the Senior Management Team that is of interest to the Inquiry.
    - Go back over concerns raised via FTSU, Datix, HR and reflect the workforce issues as a collective.
- Learning from Rule 9 Requests received to date:
    - Questions were extensive and wider in scope that expected.
    - It is imperative to get together the right team of people to respond.
    - They needed dedicated resource to collate the response and respond in the given timeframe.
    - It is advisable to seek legal advice.
    - Timeframes are short ranging from 28 days to 6 weeks maximum.
    - It is advisable to engage with the Inquiry Legal Team
    - They want to see compassionate leadership and a response that reflects the workforce experience.

  - Consider external support for your submission.
  - Involve a well-being guardian throughout.
  - Show how you have continually signposted to information and support.
  - Show how you prepared for increased sickness absence.
  - Reinforce the positives.

- It was asked at the Webinar how likely the panel feel it is that the Inquiry will be contacting individual Trusts for Rule 9 requests?
  - The decision has been made that all Ambulance Trusts are contacted (this has happened already). The list of documents they have been asked to produce is extensive.
  - Therefore, it is thought by the panel to be unlikely that other Trusts will be asked to respond but if yours is the exception, preparation is key, and guidance provided is good.

4. RECOMMENDATIONS

Trust Board members are requested to note the content of the report.

Item 14.21

Walsall Healthcare
NHS Trust

Trust Board Meeting - held in Public	
Meeting Date:	25th May 2023
Title of Report:	The Quality Improvement Team – Q4 update
Action Requested:	To note
For the attention of the Board	
Assure	• Capacity and capability building in the QI Approach continues with an expansion of training to include Healthcare Systems Engineering and bespoke QI training packages. • Continue to respond to the CQC requirements for organisations to develop a mature QI and Quality Management System approach via the QI Board Action plan. • The new Adult Patient Prescribing and Administration Record (Drug Chart) underwent 3 PDSA cycles over 4 months involving 2 medical and one surgical ward and engaged a wide range of stakeholders throughout its development.
Advise	• The QI team are working more widely with partners across the Black Country and beyond with an established network of QI leads meeting regularly to share good practice, ideas and reviewing opportunities for closer working. • QI team (joint) development sessions are progressing well with many ideas for sharing resources, collaborative working and ensuring a consistent offering across both sites.
Alert	• NHSE have recently published the NHS delivery and continuous improvement review and recommendations (Appendix 2) following a request by Amanda Pritchard, NHS Chief Executive (April 2022). The Review considered how the NHS, working in partnership, can both deliver effectively on its current priorities and continuously improve quality and productivity in the short, medium and long term. The leadership team are collaborating across the BCPC and wider to review the findings and recommendations, produce a gap analysis and formulate an action plan which will be submitted in a separate report. The report recommends the following: a) Establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work b) Launch a single, shared 'NHS improvement approach' c) Co-design and establish a Leadership for Improvement programme
Author and Responsible Director Contact Details:	Joyce Bradley, Head of Quality Improvement Simon Evans, Group Chief Strategy Officer Email simon.evans8@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	**a) Embed a culture of learning and continuous improvement** **b) Safe and responsive urgent and emergency care**

Walsall Healthcare
NHS Trust

Support our Colleagues	**a) Improve overall staff engagement**
Improve the Healthcare of our Communities	**a) Reduction in the carbon footprint of clinical services by 1 April 2025**
Effective Collaboration	**a) Improve clinical service sustainability** **b) Progress joint working across Wolverhampton and Walsall**
Resource Implications:	None
Report Data Caveats	This is a standard report using the previous quarter's data.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None identified
Risks: BAF/ TRR	TRR 2737 Trust-wide: Medicines Management. TRR 25 Failure to achieve 18 Week RTT constitutional standards in the Division of Surgery.
Public or Private:	Public
References	B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	The Quality Improvement Team – Q4 update
1.0	The purpose of the report is to inform the Board of the progress with increasing the capacity and capability of colleagues in an agreed QI Approach, namely the Quality Service Improvement and Redesign (QSIR) programmes across the organisation and beyond through quarter 4 of financial year 2022/23. The paper also informs the Committee of the specific projects that are being supported by the wider QI team, ensuring a QI approach is adopted in making improvements across the Trust. The QI subject matter experts have been able to support the organisation more broadly in a variety of ways, according to the requirements of the service and/or specific project.
2.0	The QI methodology delivered by the joint QI Team is the Quality, Service Improvement and Redesign (QSIR) programmes that are promoted by NHS England. The organisation has accredited trainers who deliver the training to a consistent and monitored quality.

3.0	The report sets out the progress being made in recruiting to the Divisional Clinical Lead roles, the progress on delivering actions to address the recommendations of the QI Board action plan and the QI support provided to teams. Other areas supported during the last quarter include the Paediatric Assessment Unit, Medicines' Management improvement programme and specifically the development of the new Adult Patient Drug chart, WCCSS Consultant & Team Leaders session and development work with the integrated Dermatology service. As requested by the Practice Development Nurses specific training was delivered to the team as well as the core QSIR Programmes. The report identifies the areas which will be the focus of work for the QI Team during Q1 2023/24 and sets out three broad areas of work:- • Building Capacity & Capability • Supporting Patient & Work Flow • Patient and Staff Safety
4.0	The main pieces of work that will be ongoing during the next quarter:- • Review the recommendations from the published guidance on the NHS Delivery of Continuous Improvement (DCI review) with colleagues across the BCPC to produce a gap analysis and action plan. • Patient Flow through Gynae and Antenatal Clinics – to look at how these can improve efficiency by applying the Health Care Systems Engineering (HCSE) principles. • Reduction in on the day cancellations • The roll-out of the new Drug chart • Supporting colleagues across the organisation with Poster and nomination submissions for the first Joint QI Awards (to be held on 5th July). • Installation and support to new teams using QI Huddle Boards
5.0	Details of the QI Performance pack can be found at Appendix 1.
6.0	The Board is asked to **Note:** • the ongoing delivery of face-to-face and virtual training in the Trusts QI approach. • the ongoing support by the QI Team to service and trust-wide projects using a QI approach to make improvements. • the work plan for quarter 1, 2023/24.

Quality Improvement Team

Appendix One

NHS

Quality Improvement Team Update

Quarter 4 – 2022/23

Quality Improvement Team
Joyce Bradley – Head of Quality Improvement

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

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Care Colleagues
Collaboration Communities

Executive Summary

- Good progress has been made addressing the actions in the QI Action plan following the Board QI Development Sessions during 2022, one of which is to hold a joint QI Awards with RWT. Planning has been underway during this quarter. The event will be held on 5th July 12.30-5pm at the GTG (see flyer).
- The development of the new Adult Patient Drug Chart (to be introduced in early June) has involved a number of members from the QI team, as well as a facilitated session to establish the Medicine's management programme of work.
- The new Divisional QI Leads have undertaken an induction to ensure they understand their role, that they are signposting and promoting QI within the Divisions and are spreading the QSIR approach to ensure improvement becomes part of everyone's job.

Update from the Divisional QI Leads

- Community – Involved in the development of the new Drug Chart, supported a number of Junior Drs in data collection for QI Posters, introduction of SPC charts to analyse incident reporting, inclusion of ½ day QI in job plan for Virtual Ward pharmacist, supporting submission of new QI projects to the Register.

- WCCSS – Supporting teams to identify aims and measure for new projects including an Osteoporosis fractures project, the Clinical Measurement Unit, supporting registration of QI projects, developing a consistent approach across the Division including liaison with maternity transformation team and the Improvement Team.

- Surgery – Identified 2 lead consultants to improve flow in outpatient clinics, process mapping undertaken with Chemotherapy services.

Care Colleagues
Collaboration Communities

Capacity & Capability

- <u>QI Training Delivery</u>

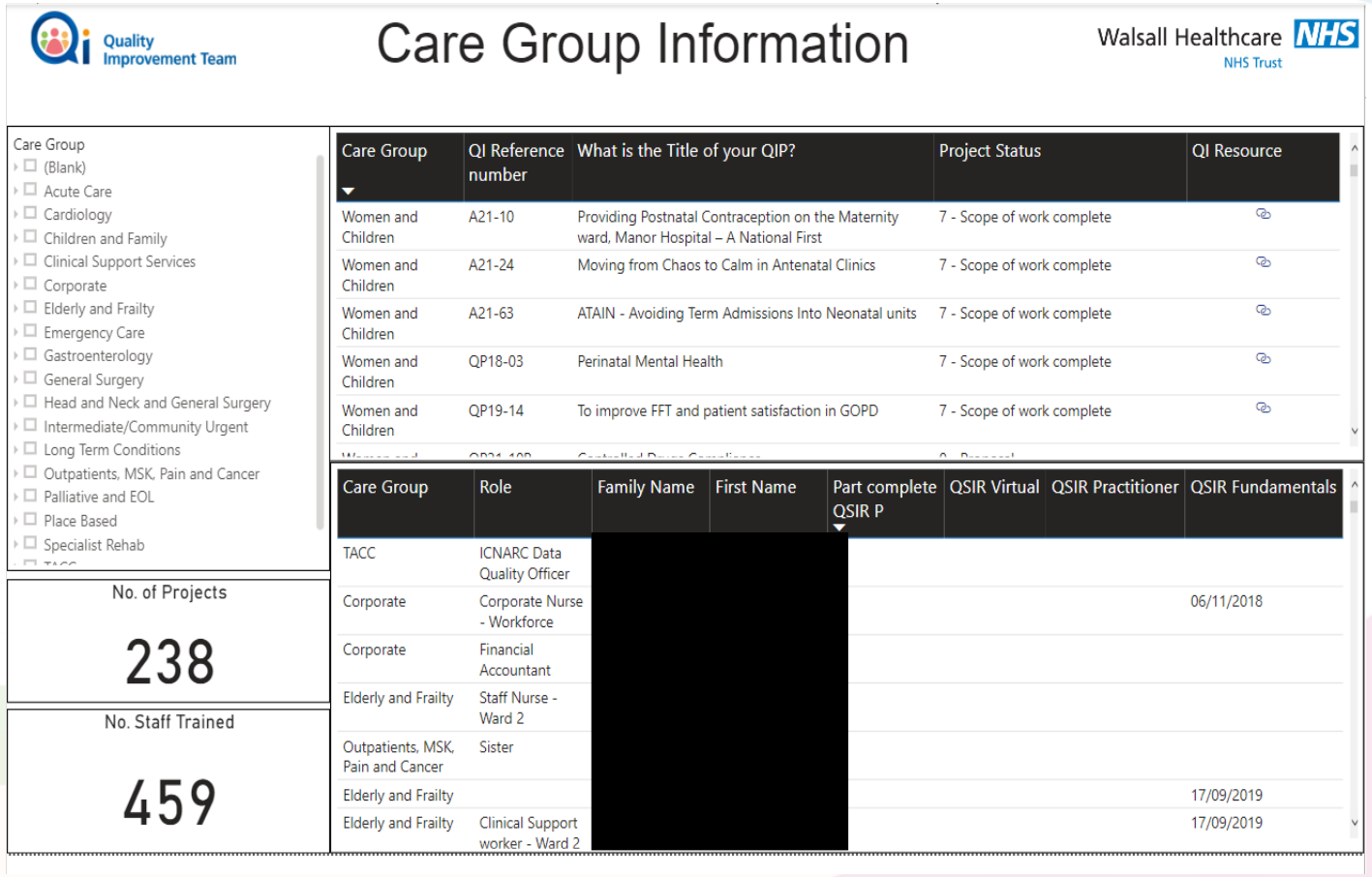
- Training numbers are no longer restricted by social distancing although the training being split across venues has meant that the maximum number of delegates is restricted to 20.
- Cohort 18 which commenced on 29th March 2023 includes 9 delegates from across the Black Country ICS, including delegates from the Black Country Healthcare NHS Foundation Trust and NHS England.
- There are two more team members with QSIR Accreditation and will be supporting the delivery of training.
- Working closely with our RWT colleagues we have developed a bespoke Estates & Facilities QI Training package with specific plans for Bands 3-4 (half day sessions) and Bands 5-6 supervisors (full day sessions), to be rolled out during Q1 2023-24. This training will include portering, catering, medical physics, domestics, waste managers, fire officers etc with the ambitious plan for up to 90 staff to have received this training across all site. This also coincides with the roll-out of the QI huddle board, trialled with the Portering team at RWT.

Care Colleagues
Collaboration Communities

Capacity & Capability – continued (1)

QI Projects

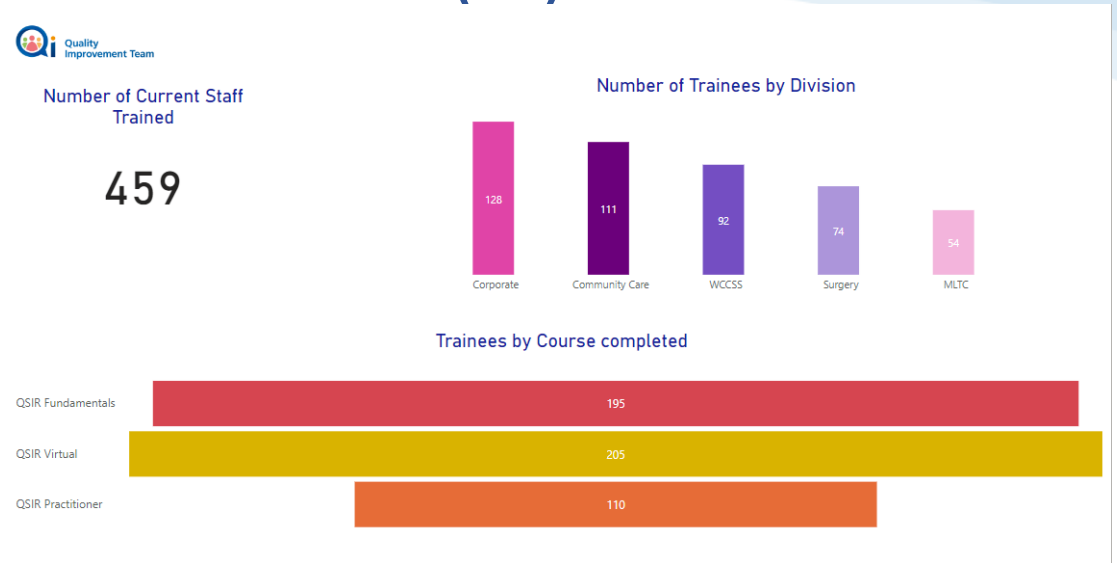
- The QI project registry has been rebuilt since the migration to NHS.net
- All historic and live/active QI projects known to the QI Team have been uploaded to the registry
- The link is accessible to ALL Walsall Healthcare Staff using their usual login credentials
- During Q4 the QI Team has finalised elements of the Project part of the Registry so that Wolverhampton can record their projects in the same system.

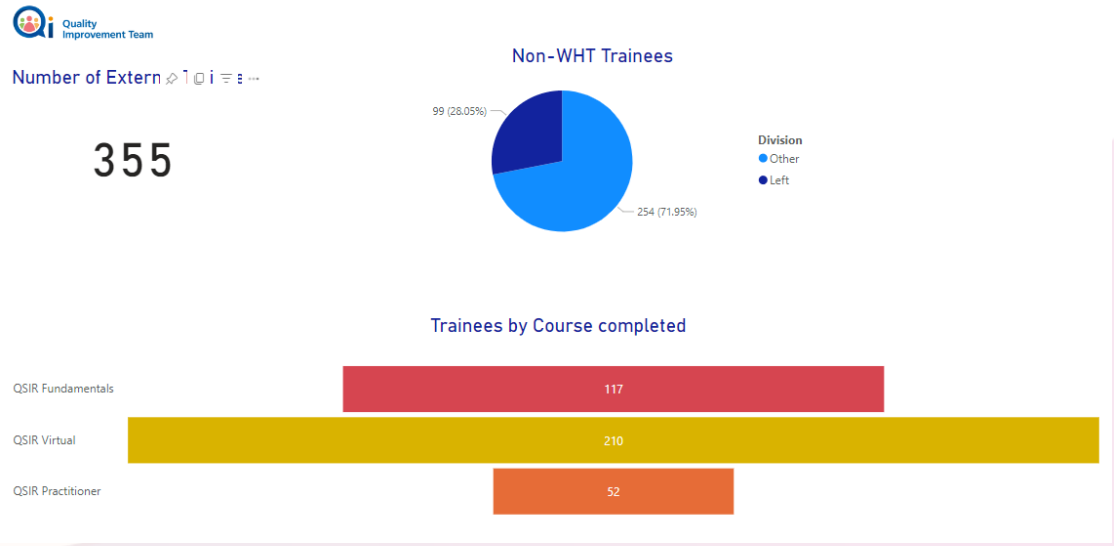


Capacity & Capability – Continued (2)

QI Training – Monitoring Progress

- The total number of Walsall Healthcare staff who have undertaken QSIR Training is 459 which brings us to 10.2% of the staff.
- The register counts individuals once whether they have undertaken more than one programme (i.e. a count of delegates on the courses will be larger than the total).
- This number excludes the staff who have left the organisation (99) or are not employed by WHT (254).
- Staff external to WHT have included colleagues from Sandwell & West Birmingham, Black Country Healthcare NHSFT and RWT.





Patient flow and staff engagement

Service / Profession specific QI Training

- The QI team supported the Professional Development Nurses during Q4 with a specific QSIR Fundamentals programme exclusively for them.
- Antenatal Clinic colleagues undertook a one day Flow workshop during Q4 and want to develop the approach in how they schedule clinics (see next slide).

Facilitation of Sessions

- The Nurse Education Team at Wolverhampton had requested facilitation of an Insights Discovery session. The member of the QI Team who is an accredited trainer supported the newly accredited colleagues from across Walsall Healthcare to delivered this.
- Members of the QI Team have facilitated sessions for work on the Medicine's Management Improvement, WCCSS Team Leaders & Consultants Away Day and the integrated Dermatology team.

Patient & Work Flow– Antenatal Clinic Team

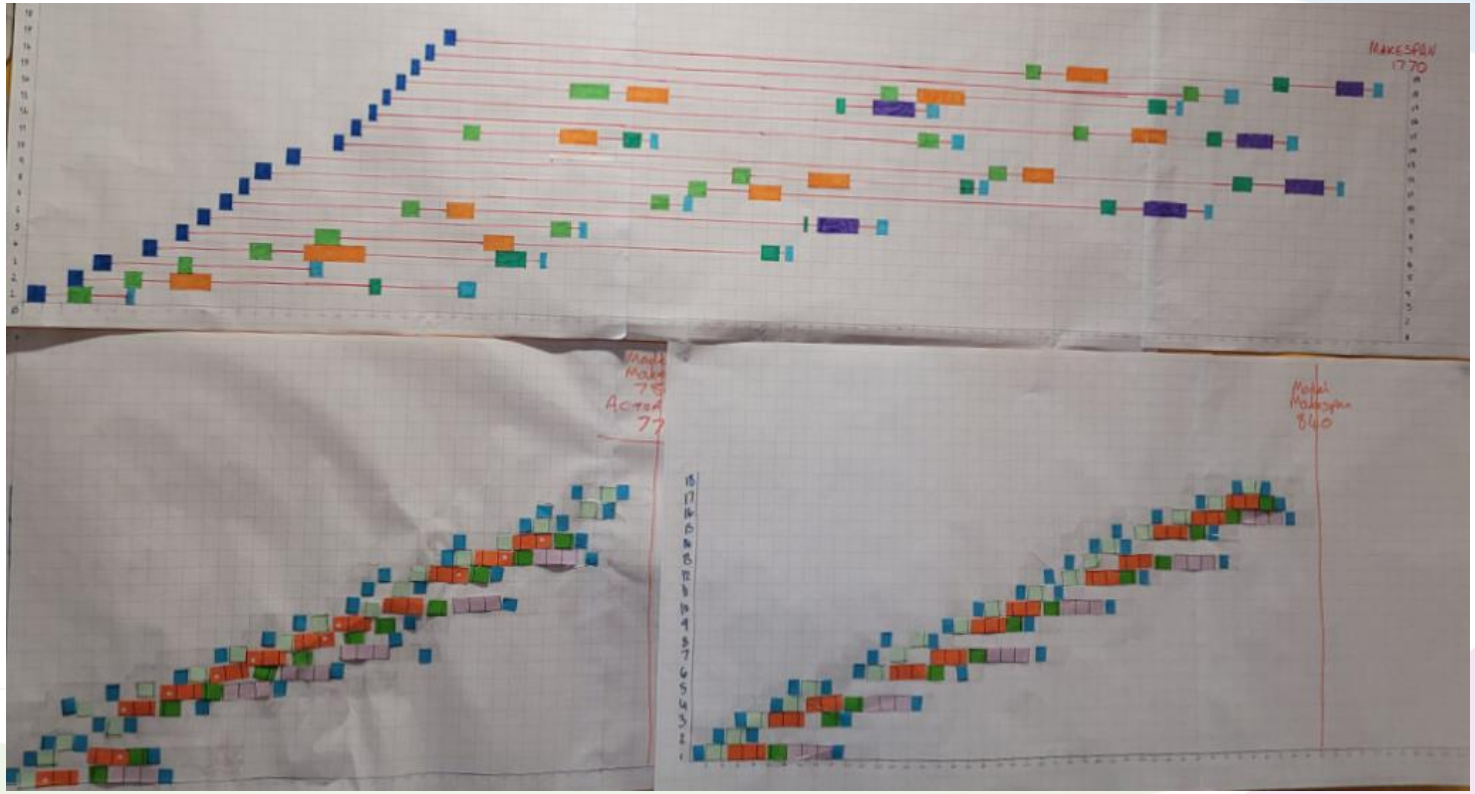
Workflow simulation (Healthcare Systems Engineering)

- The Antenatal Clinic staff, including consultant, midwives, Maternity Support workers, Manager, Care Group manager, specialist midwives and sonography colleagues, took part in a Health Care Systems Engineering (HCSE) Flow session during Q4.
- The workshop is a simulation of a clinic with work identified by tasks to show length of time for appointments of different complexity.
- The workshop is specifically designed to demonstrate the impact of poor flow which the delegates then work on during the session to improve flow and address other negative consequences which they experienced during the simulation.
- The simulation is a simplified fracture clinic which has been run across the country in organisations applying HCSE (Kent & Medway imaging network, Mid-Yorkshire NHS Trust , Royal Devon University Healthcare NHSFT, Oxford University Hospital NHSFT, Swansea Bay Health Board, Queen Elizabeth Hospital Belfast)
- This particular group of staff significantly raised the benchmark on streamlining the flow.

Patient & Work Flow– Antenatal Clinic Team

<u>Workflow simulation</u>

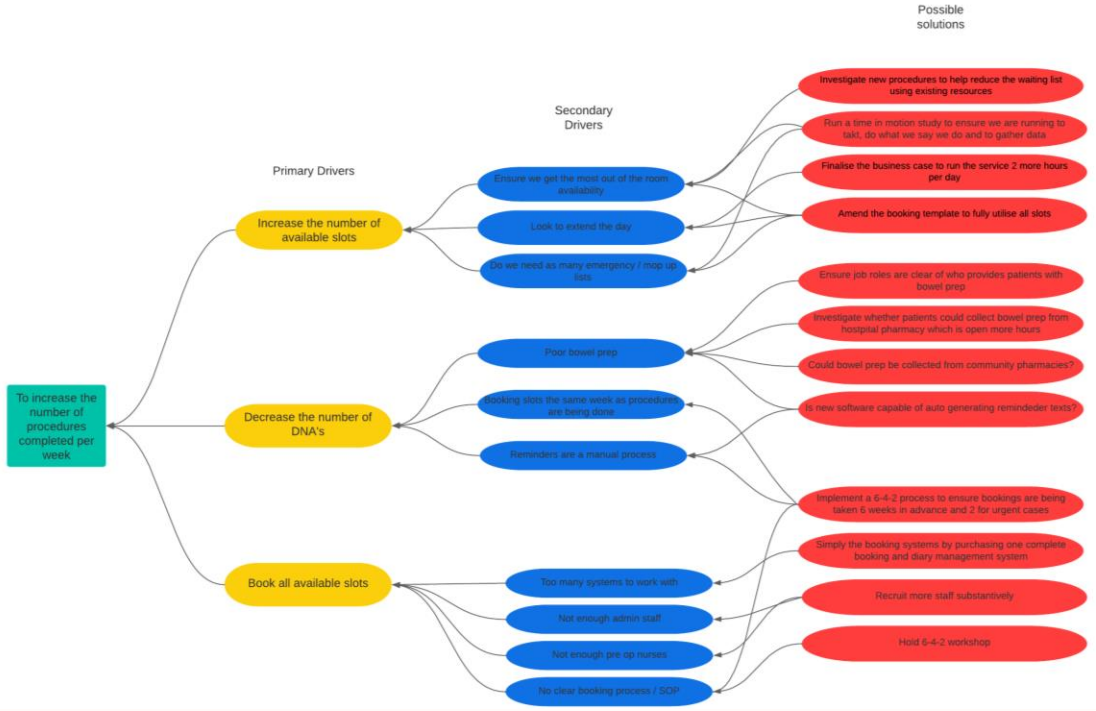
- The photograph to the right shows the original clinic flow which had 18 patients seen in a total simulation time of 1770 mins.
- Each block represents a face-to-face contact with a member of the team, each thin line – the amount of time waited by patients.
- The two clinic templates beneath are the proposals developed by the two groups in the training. Both proposals would see 18 patients each ie. 36 patients in total in a total simulation time of 1610 mins.



  - The load on each team member in the clinic was calculated to ensure that they could accommodate the additional work
  - The Antenatal clinic team will now undertake a simulation of their own clinic with the output of improving flow and redesigning the way they work to improve efficiency.

Endoscopy QI project – increasing utilisation

This project is currently ongoing and has followed QI methodology including stakeholder mapping, driver diagram, baseline metrics, observational audits etc. A revised endoscopy room template has been created and will be implemented in the coming months. We will review the progress and report the increase in utilisation in the next quarterly update.



Session utilisaton

Session Description	Endoscopist	Procedures Booked	Procedures Completed	Session Utilisation	Case Opportunity
13/02/2023 Room 1 AM	[redacted]	9	9	88%	
13/02/2023 Room 1 PM		4	3	75%	
13/02/2023 Room 2 AM		4	4	71%	
13/02/2023 Room 2 PM		7	7	56%	
13/02/2023 Room 3 AM		5	5	98%	
13/02/2023 Room 3 PM		4	4	79%	
14/02/2023 Room 1 PM		8	6	51%	
14/02/2023 Room 2 AM		4	4	70%	
14/02/2023 Room 2 PM		1	1	14%	
14/02/2023 Room 3 AM		5	5	63%	
14/02/2023 Room 3 PM		4	4	102%	
15/02/2023 Room 1 AM		7	6	103%	
15/02/2023 Room 1 PM		10	7	55%	
15/02/2023 Room 2 PM		8	8	101%	
15/02/2023 Room 3 AM		9	7	63%	
15/02/2023 Room 3 PM		6	6	51%	
16/02/2023 Room 1 AM		3	3	40%	
16/02/2023 Room 1 PM		4	4	62%	
16/02/2023 Room 2 PM		9	7	43%	
16/02/2023 Room 3 AM		4	4	80%	
16/02/2023 Room 3 PM		4	4	37%	
17/02/2023 Room 1 PM		5	5	34%	
17/02/2023 Room 2 AM		4	4	108%	
17/02/2023 Room 2 PM		4	4	48%	
17/02/2023 Room 3 AM		4	4	76%	
17/02/2023 Room 3 PM		2	2	10%	
Overall		**138**	**127**	**65%**	

Patient & Staff Safety

QI Huddle Boards

- Joint training and development session with QI Teams across RWT and WHT as an introduction to QI Huddle Boards
- 4 Huddle boards have been installed this quarter and are being supported to embed the process.
- The Imaging board has been particularly well received and ideas are being received from other staff working in their area (i.e. porters contributing to ideas).
- The training for the boards has been delivered collaboratively with RWT colleagues. The ongoing support to those areas with huddle boards will be provided by the local QI team.

Boards installed this Quarter	
Location	**Installation date**
North Locality	25th January 2023
Strategy & Planning	15th February 2023
South Locality	15th February 2023
Imaging Department	22nd March

Existing and Proposed Boards and Their Status	
Location	**Installation date**
Ward 23	Active
Gynae OPD	Active
Neo Natal Unit (NNU)	Board installed – yet to meet
Theatre 10	Proposed
Community Therapies / Specialist services	Proposed
Performance & Information	Proposed
Estates & Facilities	Proposed

Care Colleagues
Collaboration Communities

Plans for Quarter 1 - 2023-24

Capacity & Capability

- Additional Trainer undertaking the Accreditation process for QSIR delivery
- Delivery of Health Care Systems Engineering mini-masterclass – a half-day session on improving patient flow in unplanned care.
- Review the recommendations from the published guidance on the NHS Delivery of Continuous Improvement (DCI review) with colleagues across the BCPC to produce a gap analysis and action plan.

Patient Flow

- Support work in Lymphoedema Service to map out processes and handovers, support clinic booking templates
- Support collaborative working between Pharmacy & Chemotherapy
- Support Fair Oaks Day Hospice in development session
- Work with the Improvement team on the reduction of on the day Cancellations

Care Colleagues Collaboration Communities

Plans for Quarter 1 - 2023-24 continued (1)

Other Developments

- Further develop the Community of Practice to maintain interest in QI for delegates who have completed QI Training
- Deliver against actions for the report following the Board Development sessions
- Work more closely with the QI Team in Wolverhampton to develop a consistent offer across both organisations
- Recruit to the outstanding Divisional Clinical Lead posts
- Marketing strategy to encourage identification and registration of QI projects from across the divisions
- Roll-out of the new Drug chart across the organisation
- The organisation and preparations for the First Joint Qi Awards including nominations for individuals and teams
- Supporting and promoting development of posters for the event

Care Colleagues
Collaboration Communities

Capacity & Capability – Training FY 2023-24

Training Schedule for 2023-24

- The Team has set out the proposed training through 2023-24 and have actively started to advertise and recruit to the training
- There will be 6 Cohorts of QSIR Practitioner run during 2023-24 financial year
- There will be 11 Open Fundamentals QSIR programme during 2023-24, any service specific sessions will be in addition to these planned cohorts.
- QSIR Virtual will continue to run and currently planned for one cohort per month
- Health Care Systems Engineering (HCSE) Flow sessions will take place through the year including a specific Antenatal Clinic scenario workshop
- A training package on ‘Making Data Count’ with a specific emphasis on understanding SPC charts and measurement will be developed to launch in Q3.

NHS delivery and continuous improvement review: recommendations

How can improvement-led delivery enhance the quality of outcomes for our patients, communities and our health and care workforce?

19 April 2023

Publishing ref: PRN2137

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Foreword

Our health and care systems have navigated the impact of an unprecedented global pandemic, which has taken its toll on our workforce, our communities and the services we deliver. Current challenges across the NHS in its immediate aftermath have posed the question of how we use learning to effectively and systematically deliver real-time improvements at scale and at pace on our shared priorities, while developing the capacity and capability of the service to improve over time.

As a result, I was asked to lead the delivery and continuous improvement review in April 2022, to consider how the NHS can develop a culture for continuous improvement while focusing on its most pressing priorities.

NHS England understands that its role is to support and champion providers and systems in delivering for people (both those who deliver and use our services) and cannot do this in isolation. To this end, while NHS England has co-ordinated this review, its content has been co-designed by engagement with more than 1,000 patients, health and care leaders including clinicians and frontline staff, managers, improvement leads, senior executives across local government, the VCSE sector, NHS providers, ICSs, regional and national teams, and the Care Quality Commission.

We felt these partnerships were crucial in ensuring that recommendations were driven by those who deliver and receive NHS services, and that this document was relevant and reflective of your experiences.

The outcome of this review is 10 recommendations that have been consolidated into three actions, which collectively have the potential to provide immediate practical support to meet the short- and medium-term challenges outlined. This document is not intended to be static. In fact, it will be refined and iterated as we receive feedback from its users on how it has been used, and where it can be improved.

Over the last year, I have been overwhelmed by the interest in this work which I believe has the capacity to give not only hope, but real benefit to every layer of our health and care system, every staff member and every patient.

Together we can learn and embed process improvement, building clinical leadership for results and in doing so address the unwarranted variation in care.

We look forward to taking the next steps with you on this continuous improvement journey.

Anne Eden, Regional Director South East, NHS England

Review findings at a glance (1)

The delivery and continuous improvement (DCI) review considered how the NHS, working in partnership through integrated care systems (ICSs), delivers on its current priorities while continuously improving for the longer term. We know that focusing on improvement, as an essential component of quality, enables us to achieve more consistent, high-quality care. The review team explored how we 'improve with purpose', using all the assets at our disposal: data and evidence, digital transformation and the skills and experience of our health and care workforce.

Having assessed the current approach to delivery-led improvement both within NHS England and more widely, the review team made 10 recommendations which were endorsed by NHS England's Executive Group (outlined in this report). NHS England's Board has now consolidated these recommendations into three actions:

1. Describe a single, shared **NHS improvement approach**. NHS England will set an expectation that all NHS providers, working in partnership with their integrated care boards, will embed a quality improvement method aligned with the improvement approach to support increased productivity and enable improved health outcomes. This will require a commitment from NHS England itself to work differently, in line with the improvement approach and the new Operating Framework.

2. Co-design with our health and care partners a **leadership for improvement programme**, commissioned and supported by NHS England, enrolling all providers and systems (including primary care) in it to support a whole-system focus on improving healthcare outcomes with our workforce, patients and communities.

3. Establish a **national improvement board**, to agree the small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work, with national co-ordination and regional leadership. The new board will support more consistent, high-quality delivery of services to improve performance and reduce unwarranted variation.

Review findings at a glance (2)

NHS England's structures and governance

do not yet optimise our ability to focus on a small number of shared national priorities effectively. Creating the new NHS England gives us the opportunity to bring together specialist delivery and improvement resource in a centrally co-ordinated, regionally-led way, with delivery of improvements through systems

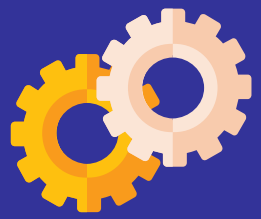
Effective improvement-led delivery of shared national priorities

requires NHS England to invest in a new approach to engaging with clinicians and operational managers at the point of care. We now need to develop a new model for how we tackle improvement challenges system-wide, sharing our learning and good practice more effectively.

A systematic approach to improvement

is embedded in many NHS organisations that deliver consistent, high-quality services with improved patient outcomes. All evidence-based quality improvement methodologies share common principles. We now need to support all leaders across providers and integrated care systems to embed those principles in practice.

Improvement methodology is important



to support a focus on improved quality and better patient outcomes. But it isn't enough. Our quality improvement efforts need to be focused on our most pressing operational and strategic challenges, within an overall focus on quality across planning, improvement and assurance.

There are further opportunities to support our most challenged organisations and systems

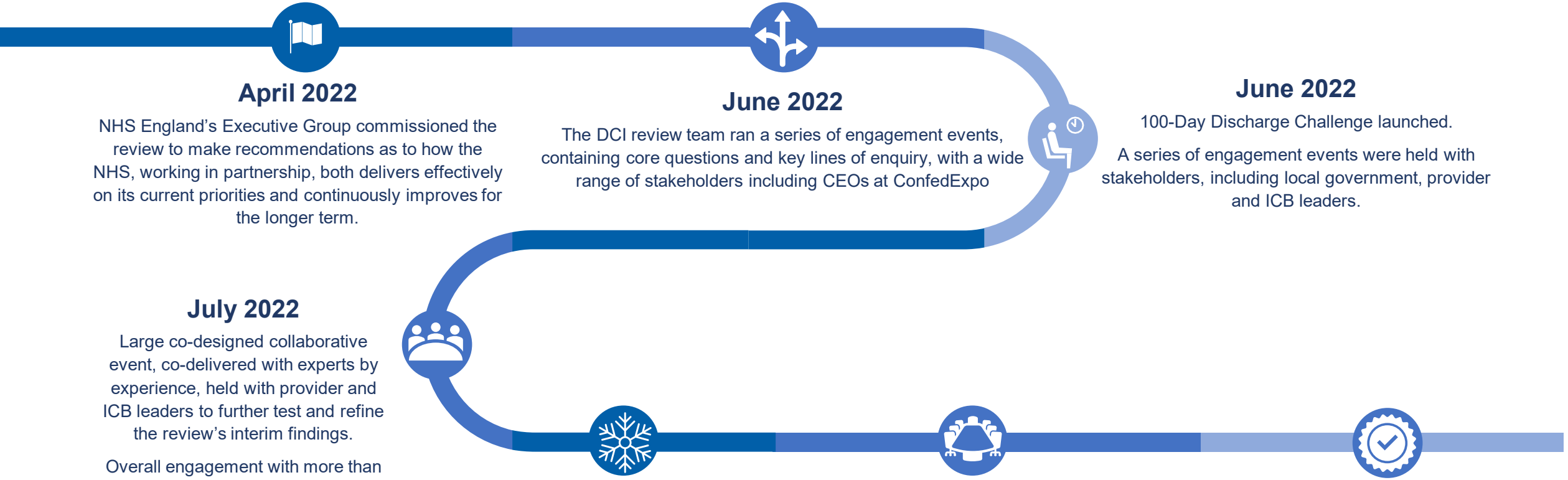
more consistently and effectively. During the DCI review, people told us that NHS England's recovery support programme works well and marks a positive shift from the previous special measures regime. We increasingly need to focus on earlier intervention for support and sustainable improvement.

NHS England can do more to provide credible and practical support for improvement-led delivery.

NHS England has a key role to incentivise a universal focus on embedding and sustaining improvement practice across our providers and integrated care systems. This includes regulatory incentives alongside clearer and more timely offers of support.

Background to the DCI review

In April 2022 Amanda Pritchard requested a review of the way in which the NHS, working in partnership, delivers effectively on its current priorities while developing the culture and capability for continuous improvement. Led by Anne Eden, NHS Regional Director South East, with a steering group chaired by Sir David Sloman, Chief Operating Officer, NHS England, the review team co-developed 10 recommendations with health and care leaders that have been consolidated into 3 actions.



April 2022

NHS England's Executive Group commissioned the review to make recommendations as to how the NHS, working in partnership, both delivers effectively on its current priorities and continuously improves for the longer term.

June 2022

The DCI review team ran a series of engagement events, containing core questions and key lines of enquiry, with a wide range of stakeholders including CEOs at ConfedExpo

June 2022

100-Day Discharge Challenge launched.

A series of engagement events were held with stakeholders, including local government, provider and ICB leaders.

July 2022

Large co-designed collaborative event, co-delivered with experts by experience, held with provider and ICB leaders to further test and refine the review's interim findings.

Overall engagement with more than 1,000 health and care leaders.

Endorsement of the review's final lines of enquiry by NHS England Executive Group.

September 2022

100-Day Discharge Challenge concluded.

Winter Collaborative launched.

October 2022

The review's findings were presented at the NHS England leadership event with ICB and provider chief executives. The review reported its findings and 10 recommendations to NHS England's Executive Group.

February 2023

NHS England's Board consolidated the 10 recommendations into three actions.

The three NHS England actions

Three actions formed from the consolidation of the DCI review's initial recommendations

	NHS improvement approach	Leadership for improvement programme	National improvement board
What is it?	Universal application of one shared high level 'NHS approach to improvement' to draw and build on the best approaches to organisational quality assurance, planning and improvement and to support increased productivity and enable improved health outcomes.	A leadership for improvement programme, commissioned and supported by NHS England, enrolling all providers and systems (including primary care) in it to support a whole-system focus on improving healthcare outcomes with our workforce, patients and communities.	A board that sets the direction for improvement-led delivery across the NHS, working with our partners. The scope and remit of the board will be informed by the new Operating Framework, with a focus on local delivery through system-working, with regional leadership and national co-ordination.
What does it mean?	All NHS providers, working in partnership with their integrated care systems, will embed an improvement method and culture aligned with the NHS improvement approach. This includes acute, community, mental health, primary care and ambulance providers.	It will create a more standardised approach to supporting providers and systems with shared priorities across England. It will help to support our most challenged organisations and systems more consistently and effectively by offering focused board level training.	It will agree a small number of shared national priorities and oversee the development and quality-assure the impact of the NHS improvement approach across all providers and systems.

NHS improvement approach

The NHS improvement approach

NHS England

NHS England will set an expectation that all NHS providers, working in partnership through integrated care systems, will embed a quality improvement method aligned with the NHS improvement approach. This will inform our ways of working across services at every level of place: primary care networks, local care networks, provider collaboratives and integrated care systems. It will require a commitment from NHS England itself to work differently, in line with the new NHS operating framework.

Drivers and enablers:

- Co-production with people and communities
- Clinical leadership
- Workforce, training and education
- Digital transformation (including federated data platform and model health system)
- Addressing health inequalities

Building a shared purpose and vision
Our workforce, trainees and learners understand the direction and strategy of the organisation/system, enabling an ongoing focus on quality, responsiveness and continued learning

Building improvement capability
All our people (workforce, trainees and learners) have access to improvement training and support, whether embedded within the organisation/system or via a partner collaboration

Developing leadership behaviours for improvement
A focus on instilling behaviours that enable improvement throughout organisations and systems, role-modelled consistently by our Boards and Executives

Investing in culture and people
Clear and supported ways of working, through which all staff are encouraged to lead improvements

Embedding a quality management system
Embedding approaches to assurance, improvement and planning that co-ordinate activities to meet patient, policy and regulatory requirements through improved operational excellence

Context: the evidence for improvement-led delivery

What is improvement-led delivery?

Improvement-led delivery involves a whole-system (or whole-organisation) focus on quality, using evidence-based quality improvement methods to increase productivity and deliver better health outcomes for patients and communities. It is underpinned by the use of data and measurement to achieve these outcomes.

Improvement-led delivery and people and communities

In organisations where improvement-led delivery has been embedded, the needs of people and communities have remained at the centre and resulted in the following:

- **Increased engagement:** People (patients and staff) have been involved in new improvement projects focused on organisational priorities, with outcomes informing the future of service provision. This has contributed to reduced health inequalities and PALS complaints and improved feedback.
- **Increased patient awareness:** Results of improvement initiatives are made visible to patients and in turn accelerates implementation.
- **Evaluation of improvement ideas:** Patients are able to support testing and evaluation of improvement ideas, before they are delivered more widely.

NHS University Hospitals Sussex NHS Foundation Trust

University Hospitals Sussex NHS FT fall reduction programme oversaw a 30% reduction in in-hospital falls.

NHS East London NHS Foundation Trust

Increase in accepted referrals for early intervention psychosis from 21% to 62% using improvement principles.

Improvement-led delivery and our health and care workforce

Our health and care workforce are tired, having supported people and communities through one of the toughest periods in the NHS's history. Organisations where improvement-led delivery has been embedded have noted the following:

- **Empowerment:** The workforce, including clinical leaders, have been engaged and equipped with the tools, routines and autonomy to drive improvements.
- **Purpose and direction:** The workforce is aligned in how their work feeds into the organisation and / or system's strategy, contributing to improved staff survey scores.
- **Improved staff morale:** They are encouraged to work on a small number of priorities that align with national and regional priorities.

NHS Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS FT finished in the top 5 and 3 nationally in the NHS Staff Survey for questions related to empowerment to make changes and improve.

NHS Surrey and Sussex Healthcare NHS Trust

SASH+ improvement work is embedded across the organisation with leaders ranging from AfC Band 4 to executives able to train and coach their own staff.

What is the evidence?

Improvement-led delivery is a long term approach to delivery that facilitates stronger organisational governance, productivity and positive cultural change over time. Many parts of the NHS have a long tradition of embedding approaches focused on quality improvement:

Alder Hey Children's NHS Foundation Trust

- Jumped from a baseline patient experience score of 59% at the beginning of the approach in 2020 to 92% in August 2022.
- 20% reduction in administration and prescribing errors for 2021-2022.
- HR time-to-hire fell from 68 to 28 days.

Surrey and Sussex Healthcare NHS Trust

- Consistently rated "Outstanding" by CQC since 2019.
- SASH+ improvement work is embedded across the organisation with leaders ranging from AfC Band 4 to executives able to train and coach their own staff.
- Collaborative quality improvement award in 2021 for their ICU clinic, increasing patient experience.

Berkshire Healthcare NHS Foundation Trust

- Rated "Outstanding" by the CQC since March 2020. CQC commented that 'staff across the trust felt valued and there was a real focus on doing what was best for staff, patients and carers'.
- NHS Staff Survey results were in the top 20 percent of scores.
- Reduced prone restraint use in adult acute and children settings by 61% in 15 months.

University Hospitals Sussex NHS Foundation Trust

- Transitioned from "Quality / Financial Special Measures" to "Outstanding" on all sites in all domains in 2019.
- The CQC noted exceedingly high 'buy in' from staff.
- Fall reduction programme oversaw a 30% reduction.
- Reduced 24 hour delayed discharges by as much as 75%.

East London NHS Foundation Trust

- Consistently rated "Outstanding" by CQC.
- A Total Quality Management System has been embedded. This applies across quality planning, assurance and improvement.
- Increase in accepted referrals for early intervention psychosis utilising improvement methods.

The Leeds Teaching Hospitals NHS Trust

- Rated "Good" by the CQC, improved from "requires improvement".
- Transitioned from a £100m deficit to a £19m surplus.
- 26% reduction in falls across the organisation - equating to approximately 65 falls per month and 780 falls per year.

Appendices

These DCI review's 10 recommendations were presented to NHS England's Executive Group in October 2022

Create a more standardised approach to shared priorities across England

1. NHS England's Executive Group will agree a small number of more consistently executed priority improvement initiatives, offering national co-ordination and regional leadership to support delivery.
2. NHS England will consolidate capability and expertise into a national priority improvement function, whose role is to co-ordinate action on a small number of pan-national improvement priorities on a rolling basis.
3. NHS England will test the model for the new priority improvement function through delivery of a winter collaborative. Action co-ordinated through the winter collaborative will be codified into more standardised approaches to delivery and improvement to support the spread and scale of learning.

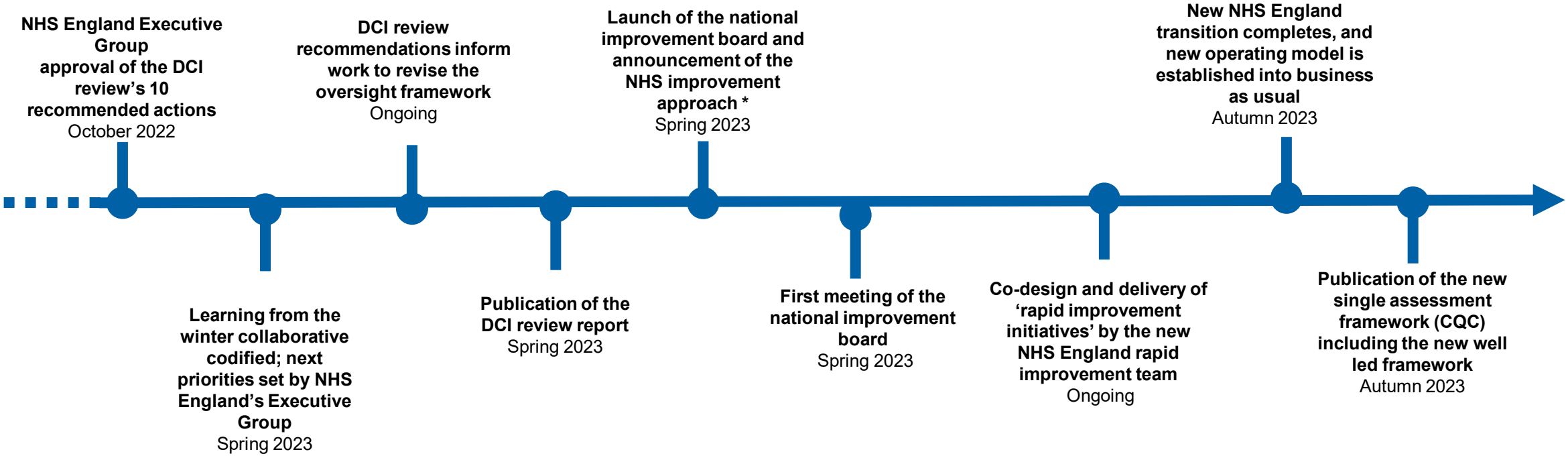
Embed continuous improvement-led delivery across all providers and integrated care systems

4. NHS England will set an expectation that all NHS providers, working in partnership with integrated care boards, will embed a quality improvement method aligned with the NHS improvement approach.
5. NHS England will collaborate with partners to co-develop leadership development products that support health and care boards, executives and the wider workforce to embed the NHS improvement approach in their organisations and systems.
6. NHS England will work with the CQC to align the revised CQC well-led with the improvement approach.
7. NHS England will critically review the NHS oversight framework, to incentivise providers and systems to embed improvement-led delivery.

Support our most challenged organisations and systems more consistently and effectively

8. NHS England's Support for Challenged Systems team will work with and through the regions to more consistently co-ordinate intensive support. This will include continued collaboration with other regulators and royal colleges to ensure consistent support and no duplication.
9. Further develop peer support between providers and systems, including through enhanced support for provider collaboratives programmes and pre-existing provider peer support networks.
10. NHS England will review the balance of national and regional resources between intensive support, pathway programmes and general capacity building. This will include an assessment of how national and regional teams more consistently support organisations in segment 3 and offer longer-term support to organisations exiting segment 4.

Proposed timeline for implementing the three actions



*** 19 April 2023: Publication of this Delivery and Continuous Improvement Review at NHS England's NHS leadership event with ICB and trust CEOs**

DCI review method and engagement process

The review team gathered evidence and insights directly from more than 1,000 people across the health and care system. Participants who have provided their insights and feedback include:

- Lived experience partners through NHS England's experience of care team
- ICB chief executives and non-executive directors (NEDs)
- Provider chief executives and NEDs
- Clinical leaders and people working at the point of care, such as nurses, GPs, consultants, and pharmacists
- Strategic roles including operational, improvement and transformation specialists
- ALB partners and collaborators, such as AQUA, CSUs and Health Data Research UK
- Networks, think tanks and academics, such as Q community, The King's Fund, and The Health Foundation.
- National bodies, such as CQC, local government representatives, and NHS Confederation
- Regional groups, such as local health and social care partnerships, and Academic Health Science Networks
- NHS England national and regional teams

Emerging insights were reported to the review's fortnightly steering group chaired by Sir David Sloman and Anne Eden.

During the course of the review, we provided inputs into several concurrent work programmes, seeking to align our emergent findings where appropriate. These included:

- The operating framework programme
- The Creating the new NHS England change programme
- Finance and productivity board
- NHS England business planning and guidance

The review team did not undertake original quantitative research or analysis. It focused on collating and considering existing research and evidence to inform our recommendations.

While we have set out implementation plans to sit alongside these recommendations, we recognise that:

- our recommendations are closely interdependent with the ongoing NHS England change programme, which will shape how NHS England's operating framework is realised.
- full implementation of our recommendations across the NHS (and, in time, health and care systems) will require ongoing co-design between national and regional teams with leaders in systems and providers as well as wider partners, using a collaborative approach centred on learning.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PERFORMANCE AND FINANCE COMMITTEE
HELD ON WEDNESDAY 29TH MARCH 2023 AT 15:00
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mrs Mary Martin	Non-Executive Director **(Chair)**
Ms Dawn Brathwaite	Non-Executive Director
Mr Ned Hobbs	Chief Operating Officer
Mr Matthew Dodd	Interim Director of Transformation
Dr Manjeet Shehmar	Chief Medical Officer

In Attendance

Mr Dylan Morris	Head of Contracting and Income
Ms Kate Salmon	Deputy Chief Strategy Officer – Improvement and Collaboration
Mr Keith Wilshere	Group Company Secretary
Mr Robin Andrews	Interim Operational Director of Finance
Mr Brad Allen	Executive Assistant **(Minutes)**

Apologies

Mr Paul Assinder	Non-Executive Director
Mr Dan Mortiboys	Interim Director of Finance
Mr Simon Evans	Group Chief Strategy Officer
Mr Kevin Stringer	Group Chief Finance Officer

164/23	**Chair's welcoming remarks, apologies and confirmation of quorum**
	Mrs Martin welcomed everyone to the meeting, allowing each member to introduce themselves. The meeting was declared quorate, with necessary apologies being noted above.
165/23	**Declarations of interest**
	There were no declarations of interest raised by members for noting.
166/23	**Minutes of the Previous Meetings from 31st January 2023 & 22nd February 2023**
	Mr Hobbs requested amendments be made to the first paragraph of page 4 to reflect there had been a process of adjustment for staff working within the Urgency and Emergency Care Centre, resulting in a slight impact to performance figures. Despite this, Mr Hobbs stated that no patient safety concerns had been raised.

	Mr Hobbs requested that a correction be made to one item of escalation be amended to reflect the Trust had a Cost Improvement Plan £6.1 million out of the £6.3 million are that, as opposed to we had achieved £6.1M. **RESOLVED** That the minutes from 31st January 2023 and 22nd February be approved as a true and accurate record of discussions and decisions that took place.
167/23	**Matters Arising and Action log**
	There were no outstanding items due for discussion on the action log.
168/23	**Emergency Preparedness, Resilience & Response – Mid-Year Review.**
	Mr Hobbs introduced the item and began by giving a brief overview of the paper's requirements and reporting timeframe for committee assurance. Mr Hobbs then reported the following points for the committee's information. Emergency Preparedness, Resilience and Response was intrinsic in the preparation and introduction of the Trust's Winter Plan, of which the Board had approved earlier in the year, including NHS England 's request to ensure power resilience for the UEC move. As a result of this, the transition of the UEC has been successful, including the transfer of the Acute Medical Unit (AMU). Future planning meetings have been held for several months to prepare for Industrial Action by both Doctor, Nursing and Midwifery colleagues to minimise impact to patient care and experience. Business continuity and/or critical incidents will be brought to committee for oversight and assurance, as well as to identify patterns in concern. There was a commitment to present these in a graphical format to easily see patterns in occurrences. It was noted that incidents due to be compromised to maintain safe urgent and emergency care was unusual and unprecedented and reflects the scale of pressure on this service. It was noted that key actions against core standards required strengthening. Despite this, actions were progressing and were on track to become substantially compliant as opposed to partially, with evacuation and sheltering arrangements requiring further attention. Mr Hobbs assured committee that this would be completed by Summer 2023. Mr Hobbs alerted the committee to potential increase in critical incidents for the UEC and advised the progress to core standards were still targeting substantial compliance, with further assessments to be made during summer 2023.

	Mrs Martin thanked Mr Hobbs for his report and queried whether additional recruitment initiatives were required to ensure the Trust meets compliance targets and whether this was in the financial plan for 23/24. Mr Hobbs responded to advise Mrs Martin that further recruitment would be needed and this would form part of the Emergency Preparedness, Resilience and Response (EPRR) team's business case developments, with a formal case for this being approved at the Trust's last Investment Group. Mr Hobbs assured the committee that the Executive had held this as a priority since May 2022 and this focus would continue into the next financial year, ensuring sufficient non-pay budgets are in place to support training and exercises. There were no further comments from members. **RESOLVED** That the committee **note** the contents of the report for their assurance.
169/23	**Integrated Care System Update**
	Ms Salmon introduced the report in the absence of Mr S. Evans and gave a brief summary of the revised structure as outlined in the report, advising the committee of the Boards support for amendments made. Committee were assured that following approval, this would then be tabled at both Walsall and Wolverhampton Trust Board meetings for formal approval. Ms Salmon requested that should members have any queries, that these be emailed to Mr Evans directly. Dr Shehmar reflected on what the statutory role of the ICB would be and how they would support healthcare within the Black Country. Mr Hobbs stated that the programme structure was reasonable, but reflected on the devolution of decision making to relevant programme boards, it may be worth the Executive team reflecting and ensuring that sufficient representation is made at all boards. Mrs Martin thanked Ms Salmon for the report, noting that all comments were to be directed to Mr Evans for clarity. **RESOLVED** That the committee **note** the contents of the report for further approval at Walsall and Wolverhampton Trust Board meetings.
170/23	**Financial Report**
	Month 11 Update Mr Andrews presented the report and began by advising committee of the Trust's £7.5 million deficit, but informed members that the organisation was forecasted to break-even at the end of the financial year 22/23.

	Mr Andrews noted the ICB's position of £17 million deficit advising an agreement would be made between the Trust and the Care Board to review our position, whilst also taking into consideration the Trust's recent increase in spend of non-pay and agency usage. Mr Andrews then referred committee to consistency in debtors issues being high but assured members this would form part of the year-end settlement. In terms of capital, Mr Andrews advised a CRL total of £40 million that had recently increased to £42 million, with £32 million of this being spent, £8m on purchase orders and £2 million receiving attention for use on individual schemes. Mrs Martin queried whether the PDC £25 million had already been received or whether it would be received at the end of the financial year. Mr Andrews confirmed this funding had already been received. Mrs Martin expressed her support for the report but queried what factors would be needed to be implemented during March to ensure the Trust would break even. Mrs Martin also requested clarity as to how funding could be aligned when the ICB was in deficit. Mr Andrews explained that all Trusts had pledged to release Over provisions in their balance sheets towards the year-end and advised that some Trusts had released their figures early whereas Walsall would submit theirs during month twelve. It was noted that annual leave payments and downtime days had restricted the figure release. Other restraints included energy costs not being up to date as well as education and training income. Mrs Martin referred committee to page 5 of the report, sighting a balance of £1.6 million and queried whether this had been brought to the attention of Trust Auditors. Mr Andrews confirmed that Auditors had been sighted of the funds and that necessary action plans had been implemented. Mrs Martin queried when this year's audit would commence. Mr Andrews confirmed it would take place towards the end of April or the beginning of May. Mrs Martin then referenced high agency spend sighting which areas were performing well and which were not. It was requested an analysis be collated for committee reference. Dr Shehmar advised that with the support of finance colleagues, individual meetings with each Clinical Director had been implemented to identify agency spend usage and suggest ways in which this can be reduced. It was noted that there had been a recent increase due to operational pressures and that all agency usage authorisation sat with the Executive team to ensure sufficient oversight.

ACTION
Dr Shehmar to provide an agency usage progress update at the next committee in April 2023.

Mr Hobbs referred colleagues to Appendix 4 of the report and assured committee that in the absence of the Director of Nursing, similar assurances would be made relating to Nursing and Midwifery agency usage and governance processes. Mr Hobbs then advised a further £2.08 million of funding had been acquired to support recruitment initiatives to mitigate agency usage. Mrs Brathwaite concurred with Mr Hobbs and assured committee that similar conversations had been held at the recent People and Organisational Development committee.

Dr Shehmar concluded by assuring committee that a more-robust governance structure would be in place to monitor medical agency use by next year mirroring that of the Nursing agency structure with some slight amendments.

Non Pay Expenditure
Mr Morris began by summarising the Trust's position on non-pay spend of which a total of £5.6 million was reported to be over budget. Overall pressures on consumables within the Division of Surgery had increased due to the purchase of the Robotic Arm to support Trauma and Orthopaedic procedures. It was reported that the Women's, Children's and Clinical Support Services Division contributed to approximately £1.7 million towards non-pay costs due diagnostic services, with approximately £200,000.00 worth of insourcing costs being generated from Health Harmony initiatives.

Committee noted that the community Division generated £1.3 million towards non-pay spend, with £0.5 million of this being related to diabetic spend.

Mr Morris advised there had been an underspend of £100,000.00 in Trust website costs, but there had been pressures to the wheelchair service.

Mr Morris concluded by summarising the position of the Estates, Facilities and Corporate Services Divisions contributing £1.3 million towards non-pay costs due to an increase of £200,000 in postage costs and £300,000.00 in food provisions.

Mrs Martin queried whether cost pressures mentioned were allowed for within the budget for 23/24. Mr Morris advised that some were covered by cost pressure bids and some would be mitigated by using external additional capacity, however did warn that consumables costs within the Division of Surgery were a cause for concern.

Mrs Martin queried whether these issues were picked up with Divisions directly at performance reviews to ensure issues are dealt with swiftly. Mr Hobbs responded to advised that each operational team were in possession of necessary information to provide and inventory system to

	identify where issues lie with consumables and feedback to the committee following discussions with recommended suppliers via procurement. Mrs Martin concluded by requesting a report on Divisional Consumables be brought back to committee within three months for oversight. **ACTION** **Mr Morris to collate a report detailing Divisional consumable spend for committee reference at June's committee.** **Debtors and Cash Management** Mr Andrews began by advising committee that there were a number of outstanding invoices awaiting payment but a year-end settlement agreement that were not related to any disputed payment requests. Committee were informed that a cash injection would be provided to deliver payments at year end. Mrs Martin queried whether this cash injection would take place post-year end. Mr Andrews advised that this was not the case and that credit notes had been raised to settle any payments. Mrs Martin queried if any disputed costs were related to any services concerns had been raised against and queried whether the ICB had requested confirmation of the services being delivered until funding is agreed. Mr Morris responded to advise the ICB had given commitment but the Trust was edging closer to the deadline of payment. Mrs Martin. suggested this be added to the Corporate Risk Register (CRR). Mr Andrews agreed to action this, but informed committee that this issue currently sat at Divisional level. Mr Wilshere queried whether these would be escalated at the beginning of financial year 23/24. Mr Andrews assured that this would be the case. Mrs Martin requested assurance around cash balances on a month-to-month basis and queried where the Trust stood with this. Mr Andrews assured committee that the Trust had sufficient funds until the end of financial year 24/25. There were no further comments from members. **RESOLVED** That committee **note** the contents of the report for assurance.
171/23	**Efficiency Plan**
	Mr Hobbs introduced the report and assured committee that a total of £6.15 million of Cost Improvement (CIP) schemes had been identified against the 2022/23 target of £6.3 million as set out. Committee were sighted that there had been a total delivery of £4.68 million against a plan

	of £5.19 million as at month 11 with a further £0.09 million confirmed for delivery during financial year 22/23. Mr Hobbs confirmed that 70% of current CIP is non-recurring. Mr Hobbs then advised committee that improvement plan figures of £0.03 million between months 10 and 11 related to non-recurrent schemes within the Estates and Facilities Division. Committee were also advised that the vast majority of shortfall savings had been identified within the Medicine and Long-Term Conditions Division with receipts being received for additional development support for financial year 23/24. Plans for financial year 23/24 were also reported to have commenced with divisional plans being reviewed at February Efficiency Group meetings. It was anticipated that further conversations relating to this would be discussed at Efficiency Group meetings scheduled for March 2023. Mr Hobbs concluded by alerting committee to the outlined total of 5.7% of 22/23 risk schemes reducing from 5.8% with further efforts being made to mitigate concerns and reduce the financial gap to the £6.3 million stretch target. Mr Hobbs concluded by informing committee that a 23/24 schemes had been identified at £8.23 million with £3.74 being budget extractable which was reported to be significantly below £16 million request for financial year 23/24. Mr Hobbs advised the task to increase CIP schemes was being monitored once budgets for 23/24 had been confirmed, with ambition to get above the Trust's elective recovery fund activity levels. Mrs Brathwaite commented on the difficulty to achieve CIP targets for the forthcoming financial year. Mr Hobbs stated that targeting a level of efficiency savings would contribute towards reducing the overall ICS deficit, but there would be a large difference between targeting and delivering them. He advised that at this point in the meeting that committee could not be assured there was a plan in place to deliver that particular level of CIP at that stage. Mrs Martin queried the process of signing off individual programme of potential cost savings and what potential impacts could affect patient care and experience. Mr Hobbs assured committee that an individual Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) was in place to monitor this, viewable by the Director of Nursing and Chief Medical Officer for scrutiny. Each Divisional scheme would also require Divisional triumvirate authorisation prior to implementation. Mrs Martin suggested that Quality and Patient Experience and Safety Committee monitor the Equality Impact Assessments and that it would be useful for all committee Chairs to meet once a year to discuss cross-committee challenges/suggestions. There were no further comments from members.

	RESOLVED That committee **note** the contents of the report for assurance.
172/23	**Performance and Constitutional Standards**
	Community Mr Dodd introduced the item and began by advising committee progressions made to the virtual ward service with 537 patients passing through the service up to 17th March 2023. Committee noted that approximately the service had achieved approximately 50% of the targets set by the Department of Health due to strict restrictions. Mr Dodd advised it was the ambition of the Division to expand the service and that discussions would take place with the ICB regarding funding elements. Mr Dodd informed committee of issues to discharge pathways that had increased by approximately 15% over the last quarter resulting in cost pressures of around £3 million. Mr Dodd assured committee that the issue was in hand and that the Local Authority were undertaking their annual renegotiation of rates but despite concerns being sent to members of the council, this is still within the authority's gift. As a result, Mr Dodd advised that contingencies were in place to minimise impact to patients, but this could result in an increase in patients medically fit for discharge. Mrs Martin thanked Mr Dodd for his presentation and made reference to the Health Visiting team anticipate to deliver all mandated contact face-to-face by Summer 2023. Mr Dodd responded to advise the service was now in a much healthier position with a total of 7 vacancies out, resulting in the service coming out of special measures. Mr Dodd advised that conversations were being held as to what investment figures would be required due to fears that caseloads and demand could remain high for the current level establishment within the service. **Acute – Including Restoration and Recovery** Mr Hobbs introduced the item and began sighting the committee on emergency care, cancer diagnostics and routine elective care for April 2023. Mr Hobbs assured committee that the overall national standard for ambulance handover standards remains extremely challenged due to operational pressures. Mrs Martin queried how the UECC had been impacted following handover challenges. Mr Hobbs advised that post handover figures were anticipated to reach 75% with no significant deterioration. Mr Hobbs assured committee that 63 day cancer targets remained positive with suspected breast cancer patients receiving a referral within 10 days. Mr Hobbs then advised members that a temporary issue skin cancer pathways within Dermatology had been experienced due to

	increased sickness absence, despite this, 'Tele dermo' had commenced within the last few weeks with little issues. Overall diagnostic rates were reported to be improving, with routine elective care figures decreasing to the low 70's yet were beginning to stabilise. A total of 9 spinal surgery patients were reported to be at risk of waiting over 78 weeks, including patients receiving treatment during weekend periods. Mr Hobbs alerted the committee that he could not assure members that these numbers would decrease to 0 should issues to patient treatment plans continue and evidenced this with some 600 outpatient appointments being cancelled due to industrial action by Junior Doctor colleagues. Dr Shehmar followed on from points raised by Mr Hobbs that these figures were also impacted by restrictions to clinical practice, with some clinicians still undergoing training. Mrs Martin raised the issue of high Did Not Attend (DNA) figures (11%). She had heard about various initiatives being developed within the Patient Relations department. Mr Hobbs advised he would liaise with Mr G. Perry to ascertain improvement methods and would endorse supporting this via charitable fund options. There were no further comments from members. **RESOLVED** That committee **note** the contents of the report for their assurance. **Urgent and Emergency Care Centre Update** Mr Hobbs assured committee that the Emergency Department had successfully opened on 2nd March 2023, with the Acute Medical Unit moving in on 9th March 2023. It was reported that the Paediatric Assessment Unit would transfer towards the end of April once workforce establishment issues had been resolved. Mr Hobbs concluded by assuring committee that any final building works would be supported by the Trust's Private Finance Initiative (PFI) and there were no significant risks outstanding.
173/23	**Board Assurance Framework & Corporate Risk Register**
	Mr Hobbs introduced the Corporate Risk Register as set out for information only and informed committee that a new Board Assurance Framework document would be made available within the coming weeks. **RESOLVED** That committee **note** the contents of the Corporate Risk Register and **note** the imminent circulation of the Board Assurance Framework.

174/23	**Annual Cycle of Business**
	RESOLVED That the Annual Cycle of Business be **approved** as set out.
175/23	**Any other Business**
	There were no additional items of business raised by members for discussion.
176/23	**Committee Escalations**
	RESOLVED That committee approved the below escalations for reference at Trust Board in March 2023. - Celebrate the successes of the new UECC Build. - Alert the Board that the auditors need to be kept updated balance sheet provision releases. - Medical agency spend was being reviewed by new governance process. - Alert we need to review non-pay pressures, particularly within the Division of Surgery. - Cash forecasting for the forthcoming 13 weeks show we have money to pay bills but impacts to budget may be an issue. - Increased challenges to Cost Improvement Plans. - Community alerts around Health Visiting successes. - Performance improvements are still required. - The new Board Assurance Framework will be shared with colleagues imminently.
177/23	**Committee Reflections**
	Mr Hobbs placed on record his thanks to colleagues who had stepped in to cover capacity. There were no further comments from members.
178/22	**Date and Time of the Next Meeting**
	Committee noted that the next meeting of the Performance and Finance committee would take place **in person** on **Wednesday 26th April 2023 at 15:00 in Room 9 of the Manor Learning and Conference Centre.**

Signed: 

Mrs Mary Martin
Designation – Chair of the Performance and Finance Committee – March 2023 only.

Date: 26/04/2023

Walsall Healthcare NHS Trust

MEETING OF THE PERFORMANCE AND FINANCE COMMITTEE HELD ON WEDNESDAY 26th April 2023 2023 AT 15:00 ROOM 9, MLCC

Members

Mr Paul Assinder	Non-Executive Director (Chair)
Mrs Mary Martin	Non-Executive Director
Ms Dawn Brathwaite	Non-Executive Director
Mr Ned Hobbs	Chief Operating Officer
Mr Dan Mortiboys	Operational Director of Finance
Dr Manjeet Shehmar	Chief Medical Officer
Mrs Lisa Carroll	Director of Nursing

In Attendance

Mr Tim Shayes	Deputy Chief Strategy Officer
Mr Stephen Jackson	Divisional Director of Operations- Community
Mr Nathan Joy-Johnson	Group Director of Procurement
Ms Katherine Geal	Executive Assistant (Minutes)
Mr Brad Allen	Executive Assistant

Apologies

Mr Keith Wilshere	Group Company Secretary
Mr Simon Evans	Group Chief Strategy Officer
Mr Kevin Stringer	Group Chief Finance Officer

01/2023	**Chair's welcome, apologies, and confirmation of quorum**
	Mr Assinder welcomed everyone to the meeting and introduced Ms Geal to the Committee as the new committee secretary. Mr Assinder also thanked Mr Allen for his interim support until Ms Geal commenced in post. The meeting was declared quorate, with necessary apologies being noted above.
02/2023	**Declarations of Interest**
	There were no declarations of interest raised by members for noting.
03/2023	**Minutes of Previous Meeting – 29th March 2023**
	Mr Hobbs requested that amendments be made to the penultimate paragraph on page 2 to state 'core standards' rather than 'constitutional standards'. Mr Hobbs also requested that, on page 5, that the funding to support recruitment initiatives should be £2.08 million, not £2.8 million. Finally, the penultimate paragraph on page 8 should read 'Mr Hobbs advised that post handover 4 hour figures were anticipated to reach 75% with no significant deterioration'

	rather than 'Mr Hobbs advised that handover figures were anticipated to reach 75% with no significant deterioration'. **RESOLVED** That, having incorporated the changes above, the minutes from 29th March 2023 be approved as a true and accurate record of discussions and decisions that took place.
04/2023	**Matters Arising and Action Log**
	Dr Shehmar updated the meeting on the agency usage process. It was noted that Dr Shemar, Mr Hobbs and Mr Creighton have met with divisions, and a governance structure and reporting systems are now in place through the Divisional Performance Meetings. Agency usage will be reported to the Medical Workforce Group going forward. It was agreed to provide a written report to the committee next month with some sight of divisional plans to reduce agency usage, and bi-monthly thereafter.
05/2023	**PFI Report Update**
	Mr Assinder informed the committee that Mr Watson was to attend the committee to provide a full report, but it was agreed that as a number of planned meetings with PFI provider colleagues had not yet taken place, the report would be deferred until next month, and a brief summary update would be provided at this committee meeting. The summary update was noted. Mrs Martin stated that a full paper would be welcomed at the next committee meeting to include an outline of the scope, timeframe, key facts and overlying finance of the contract. The committee agreed that it would be beneficial if a briefing paper was brought to the next committee to provide an update on the fire regulations claim, to include discussions already held with PFI provider. **ACTION** Mr Watson to provide full PFI paper to the May 2023 committee and a briefing paper on the fire regulations claim.
06/2023	**Procurement Report**
	Mr Joy-Johnson introduced the item and advised of 3 areas of detail. The final WHT 2022-23 Trust Procurement related bottom line savings position of £2.87 million with a variance of £1.93 million. Overall savings is 6.07%. 103 of 190 individual projects have been delivered. Mr Joy-Johnson advised that focus now continues on the 2023-24 financial delivery, with 94k identified; less than 2%, though early in the financial year. A large portion of the cost avoidance savings are expected later in the year. Mr Joy-Johnson updated the committee about the re-branding of the existing North Midlands & Black Country Procurement Group (NMBC) model with the University

	Hospitals of North Midlands NHS Trust (UHNM), The Royal Wolverhampton NHS Trust (RWT), Walsall Healthcare NHS Trust (WHT), North Staffordshire Combined Healthcare NHS Trust (NSCHC) and the Black Country Pathology Services (BCPS) organisation. The current model operates over two ICS's. The Pan ICS Procurement model will continue and include a midlands partnership, and will extend beyond the traditional remit on the procurement of goods and services, to a wider portfolio driven by the regional ICS transformation. Mr Joy-Johnson described the first stage of the development of the Pan ICS Category Cells. This will be a 'one stop shop' portfolio including Acute, Mental Health, Community, Pathology, GP Practices, CSU and Integrated Care Board (ICB) representation. The second stage of the model includes the review of the Black Country Procurement Target Operating Model (TOM). A paper was submitted to the Black Country Integrated Care Board (BC ICB) setting out the extensive collaborative work and vision for collaborative working across the Black Country ICS. The ICB requested a detailed options appraisal on A) Do nothing B) Merger of the Black Country Procurement Alliance (BCA) into the North Midlands & Black Country Procurement Group (NMBC) C) Creation of a dedicated Black Country ICS Procurement model, involving all existing Black Country trusts disbanding from the NMBC D) Remaining 'as is', but with further development of collaborative working/development of joint work plans/reporting and creating a new dedicated Black Country Procurement Board for the Black Country ICS. It was decided to go with option 2, the consolidation of all of the Black Country Procurement resources under the NMBC Plan ICS consolidation model. Mr Joy-Johnson outlined the phasing requirements for the merger to the committee. Ms Brathwaite queried the workforce challenges and financial pressures related. Mr Joy-Johnson advised that the new model aims to deliver and retain more senior posts, with investment into the senior structure, with an increased model and size. The committee is supportive of the development. The committee resolved to approve the report as set out.
07/2023	**Integrated Care System Update**
	Mr Shayes made a verbal report to the committee. The targeted operating model was signed off by the ICB on 31st March 2023 with the paper sent to Trust Board in April 2023. The reporting has been paused due to finances.
08/2023	**Financial Reports**
	Month 12 Mr Mortiboys presented the report to the committee and began by outlining that the Trust has delivered a pre-audit surplus of £0.049m at the year end. The Trust has a balanced capital plan with spend of £42.248m at the year end, £18k within the capital resource limit. The Trust is holding significant cash balances at close of period, with pressure expected in 2023-24 as per the NHSE Financial Sustainability review reported to the Audit Committee.

Mr Mortiboys continued to advise that the ICB Full Year position is £0.357m surplus against a break even forecast position. There is to be an expected allocation of £6.6m to the ICB for 2023-24.

Mr Mortiboys advised that temporary expenditure has increased across the Trust in month, in part due to the Junior Doctors strike in March 2023. Mr Mortiboys informed the group that there is not yet a complete financial picture of the cost of the strikes; this will be available following the April payroll. Mr Mortiboys advised that there is a nursing agency plan in place from 1 April 2023. A further report will be made available to the next Audit Committee.

Mr Mortiboys informed that Better Payment Practice performance remains below the national target. This primarily relates to 74.1% YTD agency invoices passed due to staffing shortfalls.

Mrs Martin asked Mr Mortiboys if the financial report could be reviewed to remove any repetition. Mr Mortiboys advised that a slide pack was under development in collaboration with RWT.

Mrs Martin requested information regarding the balance sheet. Mr Mortiboys advised that significant work was ongoing, with year-on-year comparison, and that this would be emailed to Non-Executive Directors.

Mrs Martin asked for an update on the Theatre Refurb. Mr Mortiboys advised that he had met with Mr Hobbs and Mr Watson. A funding conversation is required to replace the Plant Room; this wasn't part of the original project and will likely cost £4.5- £5 million. Support will be sought from NHSE to support the scheme into 2024-25. Mr Hobbs added that NHSE recognise that the Theatres require modernisation and future proofing.

The committee discussed air exchange in Theatres; engineers have regularly been called to re-calibrate, meaning that there is significant Theatre downtime. Ms Brathwaite raised concerns regarding the financial risk if the Public Sector Decarbonisation Scheme (PSDS) do not support.

The committee resolved to approve the report as set out.

ACTION

Mr Mortiboys to email NEDs Balance Sheet report.

<u>2023/2024 Plan Update</u>

Mr Mortiboys presented the paper to the committee and began by advising that the planning guidance is to be re-submitted as the 30 March 2023 submission had too high a deficit. The submission is planned for 4th May 2023. The Black Country ICB intends to

	submit a deficit plan, of £73.9m. This level of deficit is being presented in a meeting on 26 April with CEO/CFO of Black Country ICB and NHS national leadership (Amanda Prichard (CEO), Julian Kelly (CFO) and David Sloman (COO)). There may be further iterations requested following that discussion or ramifications for the ICB for submitting a deficit plan. Mr Mortiboys referred colleagues to the Expenditure Reduction Options table in the paper and outlined the key findings. There was £31.3 million deficit in March 2023. Mr Mortiboys outlined the 5 lines affecting WHT: • ICB Contingency redistribution of £2.1 million • £3.0 million in Organisational Improvements with a number of items that the Trust can take risks on, including negotiations with Birmingham and Solihull for repayments of emergency activity which would improve position by c £0.750 million, and a plan for reduction in energy process of £0.750 million • Workforce Reduction of £1.8 million in line with a vacancy freeze approach or reduction in head count • Balance sheet growth £7.2 million. A plan will need to be developed • SDF Redesign (Across ICB) of £18.0 million Mr Mortiboys informed the committee that the Capital Plan has not changed significantly, and outlined that the Trust has secured Frontline Digitisation capital of £2.750m in 2023-24 and £4.249m in 2024-25. Mr Mortiboys referred the committee to Appendix 6 'Draft Workforce Bridge' which shows the change in workforce over the 3 years since the COVID-19 pandemic. Mr Mortiboys confirmed that a more granular breakdown is available from a Black Country perspective. Mr Assinder asked for clarity around the efficiency contribution expected. Mr Mortiboys confirmed that the Trust has been asked to find a further £7.2 million on top of the £17.2 million, which will be classed as a cost improvement. Mr Hobbs added that a £24.0 million CIP target is unachievable without adverse impact on patients and staff. Mr Hobbs also raised his concerns that the financial plan does not allocate an expenditure budget for the top prioritised patient risks, which are not income backed. This is a huge financial, clinical, and operational risk. Mrs Martin asked if there was an update on the funding of ICB commissioned services where full costs are not covered. Mr Mortiboys confirmed that the financial plan assumes that there is a fully funded service; discussions are being held with the ICB to discuss funding further. Dr Shehmar and Mrs Carroll confirmed that they have monthly meetings with the ICB CMO and Chief Nurse, who they will cite on the risk. **ACTION** Mr Mortiboys will prepare a further Financial Plan for Exceptional Trust Board.
09/2023	**Performance Constitutional Standards Report**
	Community

Mr Jackson presented the paper to the committee and began by informing that there has been an increase in demand on the service in March 2023. Community services saw a slight increase in referrals to teams. The virtual ward programme has been implemented, with the final virtual ward starting January 2023. The wards have accepted 569 referrals stepped down from the acute hospital since inception.

Mr Jackson advised that a 2-year plan was set out to continue to expand the number of virtual wards and their capacity, but the STF funding of £0.93m will not allow for the development that was planned. During February 2023 there was 40% utilisation of the virtual wards, with a mandated target for 70% expected for September 2023.

Mr Jackson outlined the Health Visiting workforce risk. There is a nationally recognised Health Visitor workforce recruitment issue. A prioritisation plan has been implemented to maintain a safe service, ensuring that children and families remain safe. The plan has been shared through the Governance process with partners in Local Authority Children's services and Public Health Commissioning.

Ms Brathwaite asked Mr Jackson to provide some assurance about the sustained growth in demand for complex discharges in the Intermediate Care Service. Mr Jackson advised that discussions are taking place with commissioners and advised that despite the levels of national discharge received, the Intermediate Care Service still ended in an overspend position. Mr Jackson assure the committee that work is ongoing with the commissioners to review the levels of funding that will come from the increase in the Better Care Fund (BCF) and further national discharge funding from councils and ICBs.

Ms Martin asked Mr Jackson what the scale of overspend was; Mr Jackson confirmed at £0.25 million. Mr Jackson advised that finances are run by Walsall Council. Mr Jackson advised the committee that there is good, open dialogue with the council regarding spend, and that a financial trajectory is being developed which will set out key finances in terms of BCF and spend profile.

ACTION
Mr Dodd to provide paper detailing modelling and financial risks to next committee meeting.

<u>Acute (Including R&R)</u>

Mr Hobbs introduced the item and began sighting the committee on emergency care. Mr Hobbs informed that in March 2023 the Trust remained in the upper quartile for four-hour emergency access standards (EAS) and continue to deliver good Ambulance Handover times.

Mr Hobbs continued by informing that, with the exception of one patient for patient choice, there were no patients who waited longer than 78 weeks for elective care as of the end of March 2023.

	Mr Hobbs informed the group that skin cancer patients have experienced longer waiting times due to an increase in Dermatology referrals, Consultant sickness and constrained ability to deploy additional clinics due to the Junior Doctor strikes. Mr Hobbs assured the committee that further outpatient slots have been made available over April and May 2023 and that waits returned to 2 weeks in April 2023. Mr Hobbs further outlined that 638 outpatient appointments and 76 elective surgical procedures were postponed during the April Junior Doctor strike, to release doctors to maintain safe inpatient and emergency care. Mrs Martin stated that these figures read better than expected; Mr Hobbs assured the committee that the Trust learnt from the first Junior Doctors strike, though anxiety remains regarding the lack of clarity regarding meaningful resolution in the dispute.
10/2023	**Efficiency Programme Update**
	Mr Hobbs presented the paper to the committee, outlining that 2023-24 schemes identified at £10.3 million, though only £4.1 million is currently budget extractable, significantly below the £17.2 million (4%) ask for the draft 2023-24 plan. Mr Hobbs assured the committee that a further £1.0 million of schemes have been identified since the paper was produced. The committee noted the programme update.
11/2023	**Operational Plan**
	Mr Shayes provided the committee with a verbal update, informing that a draft plan was submitted by the ICB in April 2023. There were three issues across the ICB: Ambulance Handover, 65 Week Assurance targets across all Trusts, and Bed Occupancy. Mr Shayes assured the committee that since the plan was submitted the financial position has become clearer, with a piece of work being led by the ICB to understand the changes. Mr Shayes informed the committee that WHT's plan submitted to the ICB was broadly compliant, with the exception of the ability to provide the 25% reduction in follow ups, and the delivery 92% bed occupancy requirements. Mr Shayes assured that no provider in the ICB has been able to deliver these targets. The committee noted the Operational Plan update.
12/2023	**Board Assurance Framework and Corporate Risk Register**
	<u>Board Assurance Framework</u> Mr Assinder introduced the new Board Assurance Framework (BAF). Mrs Martin raised that 'BAF SO 05 Use Resources Well' is scored at 25. Mr Hobbs advised that the Risk Management Group meeting did not take place in month, and that this would be reviewed for the next meeting. The committee recommended increasing the risk score to 25 due to challenges in setting a balanced 2023-24 budget.

	Corporate Risk Register Mr Assinder noted that Risk 3058 'Enforcement with Undertakings from NHSE' will not be scored at '6' going forward following the outcome of the undertakings review by NHSE. The committee recommended increasing the risk score to 20. Mr Hobbs noted that Risk 25 'Failure to achieve 18 Week RTT constitutional standards in the Division of Surgery' has been transferred from divisional level to the Corporate Risk Register due to poor performance. Mrs Martin raised her surprise that Risk 665 'Cyber Attack' had not scored higher. The committee noted that the risk score would likely change due to ongoing work.
13/2023	**Terms of Reference**
	The changes made to the Terms of Reference suggested at the previous committee were noted.
14/2023	**Any Other Business**
	Mr Hobbs informed the committee that the Paediatric Assessment Unit had moved in to the new UECC today, 26th April 2023.
15/2023	**Escalations to Trust Board**
	RESOLVED The committee approved the below escalations for reference at Trust Board in April 2023: Procurement • Risks of inflationary pressures, lack of freight capacity in the logistics system and long-term vacancy issues • Positive performance report for 2022-23 (Cashable benefit of £0.6m) Theatre Upgrade • Reduced capital funding for 2023-24 jeopardising the urgent upgrade of Manor Operating Theatres Finance • Financial Budget 2023/24- Loss of revenue this year for WHT is greater than peers. ICB deficit plan would require the achievement of cash releasing efficiency savings of c6.8%

	• Financial Performance 2022/23 - Pre-audited accounts show a revenue surplus of £49,000 and a (capital) surplus against CRL of £18,000. Year end cash is £38m and the Black Country ICS in total is reporting a c£357m surplus Industrial Action • Adverse impact on services is noted PFI Update • Background briefing on structure of Walsall PFI to contextualise future updates on contract performance monitoring and negotiations 2 Week Wait for suspected skin cancers • Staff sickness issues resulting in failure to meet target in March and April 2023 Activity & Waiting Times • Contribution of community-based services to care outside hospital, avoidance of inappropriate hospital admissions and timely appropriate hospital discharge remains impressive • Hospital based urgent and emergency care remains firmly in the top quartile of national performance • The Prime Minister's 78 week elective treatment guarantee by 31st March was achieved in Walsall
16/2023	**Reflections of the Meeting**
	The committee agreed that it was beneficial to continue face to face meetings.
17/2023	**Date and Time of the Next Meeting**
	Committee noted that the next committee meeting will take place on 31st May 2023 at 15:00. The meeting is provisionally booked as a Teams meeting, but Ms Geal will endeavour to source a room for a face to face meeting.

Signed:

Committee Chair:

Date:

Walsall Healthcare NHS Trust

MEETING OF PATIENT EXPERIENCE & SAFETY COMMITTEE

HELD ON FRIDAY 24 DAY OF MARCH 2023
HELD VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Dr Julian Parkes	Non-Executive Director (Chair)
Mrs Lisa Carroll	Director of Nursing
Mr Mathew Dodd	Interim Director of Integration
Mr Ned Hobbs	Chief Operating Officer
Professor Louise Toner	Non-Executive Director
Professor Anne-Marie Cannaby	Group Chief Nurse & Deputy Chief Executive
Dr Manjeet Shehmar	Chief Medical Officer
Mrs Ofrah Muflahi	Associate Non-Executive Director

In Attendance

Mrs Carol King-Stephens	Equality and Inequality Lead Midwife
Mrs Michelle Metcalf	Deputy Director of Assurance for WHT & RWH
Mrs Alison Mitchell	Executive Assistant (Minutes)

Apologies

Mr Kevin Bostock	Group Director of Assurance

404/23	Chair's welcome, apologies, and confirmation of quorum
	Dr Parkes welcomed all members and attendees to the meeting and declared the meeting to be Quorate. Formal apologies received and noted as above. The meeting was recorded.
405/23	**Declarations of Interest**
	There were no declarations of interest raised.

406/23	**Minutes of Previous Meeting – Friday 24th February 2023**
	There were no comments or amendments from members therefore committee approve the minutes of the meeting that took place on Friday 24th February 2023 as a true and accurate record of decisions and discussions that took place.
407/23	**Items for Redaction**
	There were no items for redaction and minutes were approved for publication.
408/23	**Matters Arising and Action Log**
	There were no matters arising and no outstanding actions on the action log.
409/23	**CQC Action Plan Update & Section 29A Notice Response**
	Report taken as read and Mrs M Metcalfe highlighted key points. Good progress has been made. All relevant submissions have been forwarded to the CQC and we await further notification/feedback. Mrs Cannaby asked if there were any specific areas of concern. Mrs Metcalfe advised continual progress is being made. Outcome from the Medicines Management Group meeting earlier in the week highlighted core actions which are in hand. Dr Shehmer also stated training and audits have improved within the Trust.
410/23	**Constitutional Standards & Acute Service Restoration & Recovery Report**
	Report taken as read and Mr N Hobbs highlighted key points. Emergency care continues with positive assurances. The Trust has been recognised for providing the best ambulance handover in the West Midlands for a total of 24 out of a possible 25 months. The Trust is also currently 10th place across the country for performance in February. Quality risk will continue to be monitored over the coming year. Cancer care timelines for treatment remain strong compared to other Trusts in the region. This Trust is currently providing 2 out of 3 patients treatment within 62 days compared to 44% in the West Midlands and 54% nationally. Breast care practitioners capacity has also seen an increase with bookings at 14 days. Challenges were experienced within dermatology with suspected skin cancer due to consultant absences and the reduction of routine clinics during the strike period.

	Tele dermatology is now gone live with the first 10 practices. This will significantly increase the Trusts capacity to assess suspected skin cancer patients. Mutual aid from Wolverhampton will also provide 84 slots for Walsall based patients. Slight improvements have been made with the 18 week performance. During the first junior Doctor industrial action in March 600 outpatient appointments and 56 elective surgical procedures were cancelled. The 92 and 72 week wait has also been challenging. Ongoing work to reduce waiting times continues. The national wait for 78 weeks as of 31st March will be 11,000 patients. The ICS has predicted 100 patients across the Black Country. Good progress has been made particularly with the recovery of cardiac Physiology and imaging. Mrs Toner asked has there been any impact with the new service? Mr Hobbs advised capital build for the dermatologists and plastic surgeons are already to undertake the procedures, this will roll out over the next couple of months. Mrs Toner referred to the old emergency department being used for patients with mental health and asked if there is likely be an increase in capacity once this extra step is in place. Mr Hobbs confirmed approximately 40% of patients attending ED with mental health issues would be likely to be clinically suitable to be treated in the mental health assessment hub. Patient with more significant physical conditions or potentially significant self-harm risks will continue to be seen in the main emergency department. The new Mental Health Assessment Hub will be staffed by the Mental Health Trust, Black Country Healthcare. Dr Parkes asked for confirmation of the dermatology increase. Mr Hobbs advised that the increase is a short term issue with a combination of increased referrals, reduction in capacity due to sickness absence and the doctors strike. All those factors together have resulted in a 31 day wait however, with the implementation of Tele dermatology this will reduce overtime.
411/23	**Performance Constitutional Standards Report Community**
	Report taken as read and Mr M Dodd highlighted key points. 437 patients have been seen through the virtual wards. This has reduced the need for beds within the Trust. Ongoing work continues. Commissioners acknowledge progress is good however, the need still outweighs the service. Work continues around discharge. Financial pressure across the whole of the borough currently around £2.5 to £3 million and likely to continue into next year. Ongoing work

	towards this with Walsall councillors announcing the uplift to rates for providers. Over the past 6 months the Urgent Treatment Centre has been open through the night. There is a concern that the current ICB financial arrangements could lead to that getting reversed which will have a massive impact on the service. Ongoing work to try and resolve this as soon as possible. Dr Parkes asked how is the service likely to be funded? Mrs Toner asked how much the cost for wound care will increase as a result of delayed referrals? Mrs Carroll advised there is continued work toward this especially with community services and community teams. This involves mattresses and products and also assessing the length of time patients spend in ED and whether it has an impact on pressure care. Mrs Muflahi asked if the Trust is confident that there is enough resourcing in order to deliver? Mr Dodd advised there is a national shortage of health visitors. Ongoing work towards skill mix and what alternative ways and reconfiguration can be undertaken. Funding however is the major issue. Mrs Muflahi asked if the safety aspect will be maintained? Mr Dodd stated there has been an increase in demand. Pathways have been managed, over the last quarter the referrals into those pathways increased by 20%. The services have been working exceptionally hard and kept the level stable. There will be an impact over the next financial year, ongoing work regarding efficiency and evaluating the benefits of discharging and treating in the community. Dr Parkes enquired how many health visitors had been appointed? Mr Dodd advised a lot of skill mixing has been implemented to help the gap in the service. There are currently 9 vacancies for health visiting. Mrs Muflahi stated the Trust must also look into retention of staff providing the option of career progression and developments. Mrs Carroll confirmed there is work across the organisation regarding retention from legacy mentoring, courses. Mr Dodd confirmed review of recent levers highlighted factors that were unavoidable for example, retiring, moving out of area.

412/23	**Safe High Quality Care Oversight Report (to include the Board Assurance Framework, Corporate Risk Register and Performance Dashboard**
	Report taken as read and Mrs L Carroll highlighted key points. There has been a slight increase from April to December from a tissue viability perspective. Hybrid mattresses and the education program are set to be implemented week commencing the 17th of April across the Trust. Sepsis compliance continues to improve. A business case has been developed to look at expanding the sepsis team to 24 hours a day. Weighing scales are now in use within the Trust. All patients attending the hospital via ambulance are weighed at the entrance to the emergency department. The Trust has seen an increase in mental health patients and elderly care population. A total of 3 C-diffs in the month. Two Qi projects around community has been implemented. Pharmacist micro guide has also been updated. Weekly ward rounds have commenced to focus on antibiotic use and educating doctors. This has shown a positive effect with less antibiotic use. An educational training event around C diff was also attended by a significant number of nursing and AHP staff. Further events are being arranged. Level 3 safeguarding training document is in the final stages of completion. Mrs Carroll confirmed she is currently working on a detailed safeguarding paper which will be presented at the next meeting. Dr Shehmar advised a lot of work has been completed around the Medicines Management Group and in particularly around the way that the divisions respond and take accountability for their medicines management. Pharmacy team provide divisions with current data which allows divisions to respond with actions/assurance. The outcomes are shared with the Quality Improvement Group. Mrs Carroll confirmed improvement continues. Audits are being undertaken with a view to target key areas. Mrs Muflahi referred to the safeguarding level three child and adults strategies that have been implemented and asked if the strategies are enough as there is an ongoing issue and numbers are increasing. Mrs Carroll advised training will be provided in bite size pieces making it more accessible for staff to attend. It is expected all divisions will be compliant by the end of the summer.

	Mrs Muflahi asked for clarification on poor compliance with nursing record keeping. Mrs Carroll confirmed nursing documentation has been updated and rolled out across the organisation from November. Audits have seen an improvement.
413/23	**Maternity Services Update**
	Report taken as read and Mrs C Jones-Charles highlighted key points. Continued pressures around staffing. 18 international midwifes have been recruited. Improvements are expected from June onwards. Triage is high on the agenda from the CQC perspective although good progress is being made on mortality and supporting patients. There were no serious incidences in February. Dr Shehmar commended the maternity services for continued improvement. Mrs Muflahi asked how many clinical fellows are in post at the Trust? Mrs Jones-Charles confirmed there was a total of 18 in post for the period July to November. There were also 2 midwifes supporting and positive feedback was gained.
414/23	**Serious Incident Update**
	Report taken as read and Mrs Metcalfe highlighted key points. There are a number of unmanaged incidents that are still in the system and a plan has been implemented to address these working in partnership with the divisions and the insurance team. There has been a slight delay with the unforeseen cyber attack . Dr Parkes asked what the timeframe is? Mrs Metcalfe advised this would be 1st July which includes the risk management module, running alongside the incident modules.
415/23	**Clinical Audit and Effectiveness Update**
	Report taken as read and Dr M Shehmar highlighted key points. Information provided from the divisional groups to the Clinical Effectiveness Group has enabled more focused improvements. Currently MSK group and rheumatology require more work. A meeting has been arranged to discuss what steps could be put in place to increase data submissions. Rheumatologists are in the process of talks/visits to other organisations to gather intel. Contracts/job descriptions will need to be amended to include allocated time to complete these tasks.

	The data collected will also enable our clinical teams to look at where their benchmarks are and where their quality prevent programs should focus. Over the next month care groups with focus on clinical audits. An update will be provided at the next meeting. The Trust continues to be in a good position with safety alerts. Loccips have also improved. Only one care group needs extra focus and this will be monitored through Patient Safety Group through the Divisional Quality Board reports.
	ITEMS FOR INFORMATION
416/23	**Infection Control and Control Update**
	Report taken as read and Mrs L Carroll highlighted key points. Blood culture contaminant rate has reduced. There has been a big push towards education throughout the Trust with a focus particularly with junior doctors. A QI project has been implemented with the emergency department and there is evidence the rate is reducing. A business case for 24/7 phlebotomy service has been approved in principle at the investment group this month. However, due to the current pressures this depends on the next financial year. C-diff de-camp programme to be arranged.
417/23	**Sepsis Compliance**
	Report taken as read and Mrs L Carroll highlighted key points. RSM audit and the action plan is currently ongoing. Paediatrics currently use both manual and device for recording information. Audit information is gathered on individual components currently after sepsis 6 bundle with overall compliance within 60 minutes of antibiotics. 19 maternity patients in 2022 that had been identified as having sepsis. Each one of those notes have been reviewed and confirmed compliant with sepsis 6 bundle. 5 paediatric cases identified as having sepsis. Sepsis team conducted a snapshot audit and again all five of those patients received all elements of sepsis 6 within 60 minutes. A case is currently being worked on to provide a 24 hour sepsis team. IT are also working towards full electronic systems which will provide more accurate and timely information.

418/23	**Patient Experience Quarter 4 Update**
	Report taken as read.
419/23	**104 Day Harm Update**
	Report taken as read and Dr M Shehmar highlighted points. 104 day harms are now reviewed with case notes and a report presents on a monthly basis. The process is working extremely well with Lead Cancer Nurse, CCG Primary Care Nurse and Cancer Lead within the Trust. Actions have been assessed and an improvement program is currently ongoing regarding urology. Delays with the business case for endoscopy has also been noted.
420/23	**New Terms of Reference**
	Chair asked if Committee thought the meetings are running more efficient and the committee agreed. The New Terms of Reference were read and agreed by the committee.
421/23	**Exception Reports from any subgroup reporting to the committee**
	No exception reports were received for discussion.
422/23	**Matters for escalation to the Trust Board**
	No comments or questions raised.
423/23	**Any Other Business**
	There was no other business to discuss.
424/23	**Reflections on Meeting**
	The meeting finished at 1.05pm.
425/23	**Date and Time of the Next Meeting**
	The next committee meeting will take place on 28th April 2023.

Signed:

Committee Chair:

Date:

Walsall Healthcare NHS
NHS Trust

MEETING OF PATIENT EXPERIENCE & SAFETY COMMITTEE

HELD ON FRIDAY 28 DAY OF APRIL 2023
HELD VIRTUALLY VIA MICROSOFT TEAMS

Members

Dr Julian Parkes	Non-Executive Director (Chair)
Mr Kevin Bostock	Group Director of Assurance
Mrs Lisa Carroll	Director of Nursing
Mr Ned Hobbs	Chief Operating Officer
Professor Louise Toner	Non-Executive Director
Dr Manjeet Shehmar	Chief Medical Officer
Mrs Ofrah Muflahi	Associate Non-Executive Director
Mrs Michelle Metcalf	Deputy Group Director of Assurance
Mr S Jackson	Director of Operations
Mrs M Arthur	Deputy Group Director of Assurance

In Attendance

Mrs A Boden	Head of Infection Control
Mrs J Wright	Head of Midwifery, Gynaecology, Sexual Health
Mrs Jas Toor	Senior Operational Corodinator
Mrs A Mitchell	Executive Assistant (minutes)

Apologies

Mrs Carol King-Stephens	Equality and Inequality Lead Midwife
Mr Mathew Dodd	Interim Director of Integration
Professor Anne-Marie Cannaby	Group Chief Nurse & Deputy Chief Executive

426/23	Chair's welcome, apologies, and confirmation of quorum
	Dr Parkes welcomed all members and attendees to the meeting and declared the meeting to be Quorate. Formal apologies received and noted as above. The meeting was recorded.
427/23	**Declarations of Interest**
	There were no declarations of interest raised.

428/23	**Minutes of Previous Meeting – Friday 24th March 2023**
	Minor discrepancies noted from Mrs O Muflahi, Mrs L Carroll and Mr N Hobbs. Minutes amended and updated.
429/23	**Items for Redaction**
	There were no items for redaction and minutes were approved for publication.
430/23	**Matters Arising and Action Log**
	There were no matters arising and no outstanding actions on the action log.
431/23	**CQC Action Plan Update & Section 29A Notice Response**
	Verbal report provided by Mrs Metcalfe and key points highlighted. Mrs Metcalfe advised the CQC report was issued in January. The previous action plan has been retired. All actions have been closed and recorded. The report will be submitted to QPES in May followed by board in June.
432/23	**Constitutional Standards & Acute Service Restoration & Recovery Report**
	Report taken as read and Mr N Hobbs highlighted key points. Mr Hobbs advised the Trust has maintained upper quartile for emergency access standard performance. The Trust continues to improve with achieving the second best for ambulance handover times within the West Midlands. The transition into the new emergency care building has gone well. Two risk areas have been identified. The Trust has seen an increase of referrals with suspected skin cancer with a waiting time of around 4 weeks rather than the 2 week wait. There has also been a temporary reduction with consultant absence, bank holidays and junior doctor industrial action which has also had an effect. The Trust has also experienced an increase in demand for adult medical beds during the month of March. April has showed an improvement. Mrs Carroll noted around 6% of the Trust attendances are spending more than 12 hours from time of arrival. The Midlands average is currently around 10 or 11% which reflects the extent of pressure in urgent and emergency care. Mrs Carroll asked if there had been a significant impact with the junior doctor strike.

	Mr Hobbs advised the periods of the junior doctor industrial action has had a significant impact on the Trust and indeed on all Acute Trusts. The Trust lost 600 outpatient appointments and 56 elective procedures in the March industrial action. April industrial action with a four day period, the Trust lost 638 outpatient appointments and 76 elective procedures.
433/23	**Performance Constitutional Standards Report Community**
	Report taken as read and Mr M Dodd highlighted key points. The Trust saw an increase in demand across community services for the month of March. Reduced sickness absence within the team, allowed more staff capacity to handle the delivery and prevented patients from experiencing delays into Community pathways. Rapid response referrals had 100% compliant with the two hour response target. The total of patients medically fit for discharge was 42 with an average length of stay of 2.6 days. Virtual wards pathways had over 990 patients referred. The Trusts funding is still an ongoing concern. A financial and performance plan is in progress.
434/23	**Safe High Quality Care Oversight Report (to include the Board Assurance Framework, Corporate Risk Register and Performance Dashboard**
	Report taken as read and Mrs L Carroll highlighted key points. The Trust reports 59 falls for the month of March across the organisation. The total sits well below the standard and the Trust has been consecutively lower for a total of 31 months. Mrs Carroll confirmed there is ongoing work around falls and falls prevention. A total of 35 patients with pressure ulcers noted for the month of March. There has been a slow increase in the last couple of months. Hybrid mattresses were rolled out within the Trust on the 17th April. The next step is to look at trolley mattresses. Medicines management audits have been carried out. A new approved drug chart will be rolled out within the Trust from the beginning of June. A 12 minute training video has been agreed at the Medicines Management Group for all members of staff that are involved in medicines prescribing or administration. Improvement has been made with divisions achieving safeguarding Level 3 training.

	The Trust carried out a Cdiff educational event in March with another planned for May. Staff weekly training updates are provided throughout the Trust. The current regional campaign is "Gloves Off". The deep clean plan is currently being arranged. The old AMU will be utilised for the decamp. The quality framework was launched in April, which the nursing, midwifery, health history and AHP. This includes the strategy for the next two years. The Trust has also launched the Ward Accreditation Program. Mrs Carroll stated the Trust drives good quality care by having substantive staff imposed. The current vacancy rate is just over 2%, which is extremely low. There has been a reduction in agency staff with a view to only utilise in exceptional circumstances. ED and PAU are the principal areas at present. Mrs L Toner advised there is a meeting taking place next week across Birmingham and the Black Country in relation to developing a shortened course for adult nurses to become children's nurses. Dr Shehmar advised the Medicines Management Improvement Group will provide updates of improvements going forward. Funding has already ben agreed for the business case for the electronic patient record. Dr Shemar also advised there was a slight increase in error incidents. This has been investigated and the findings are admin rather than prescription errors. Work has gone into supporting staff with key role and responsibilities to reduce these types of errors going forward.
435/23	**Serious Incident Update**
	Report taken as read and Mrs Metcalfe highlighted key points. Mrs Metcalfe advised there had been an increased in instant reporting around medication incidents, tissue viability and falls, all of which have education and awareness raising programs in place. The Trust currently has 48 SI's. 32 are being reviewed with the ICB. Tissue viability, pressure ulcers and medication all being included. Ongoing work towards closing the remaining incidents is in progress. All actions that have gone beyond their review date are being reviewed with the support of the ICB quality team. Mrs Muflahi thanked the team for a clear and concise report.

436/23	**Mortality**
	Report taken as read and Dr M Shehmar highlighted key points. Dr Shemar advised there had been 100% review of eligible deaths. The roll out of the community medical examiner process has been postponed. The delay has been raised at ICS level and the ICB have agreed for this to be added to the risk register. HSMR is continuing to drop within the trust. Improvements have been made in documentation and working alongside coding. The electronic patient record will increase results further. COVID-19 pattern remains the same. A project is currently being carried out for the Trust to improve on data for ethnicities. Discussions with the bereavement team is ongoing. The ICS have implemented an improvement program around. testing for colorectal. The Trust have employed new staff and ongoing projects are in hand to improve the current pathways. Meetings have taken place with the ICB around respiratory support as the Trust is the only one currently that does not have respiratory support unit. The Trust gold standard framework programme commenced October 2022 for end of life. Two pilots that commenced on Wards 2 and 11 are going well with a further program to roll out across all wards by the end of October. The perinatal mortality improvement in pathway and just the actions percentage of avoidable deaths in this quarter was 1.2% which is. Perinatal mortality percentage rate for this quarter is 1.2%. This is has not changed, however improvement pathways have been implemented.
437/23	**CQUIN UPDATE Q3**
	Report taken as read and Mrs highlighted key points. The Trust currently has 12 schemes applicable, all being compliant on each of the quarters. Discussions with ICS is currently ongoing to look at means of submitting data more efficiently.
438/23	**ITEMS FOR INFORMATION**
439/23	**Infection Control and Control Update**
	Report taken as read and Mrs A Boden highlighted key points.

	Mrs Boden advised an educational event had taken place on the 1st of March. The Trust had three acute acquired C diff cases. All three of those followed on from experience in norovirus in February. Mrs Boden highlighted the great work that the antimicrobial stewardship team have been undertaken in the last month in particular, consultant, microbiologist and pharmacist with the IPC team with the antibiotic timeout sessions within targeted areas. Review of patient's information has produced thorough actions and educational benefits. This month's focus has been engaging with staff to push from IV to oral switch as the benefits from a recent study that was identified at UHB on reducing nursing time of one hour every shift. This extra time will have a significant impact on the Trust with the current workforce pressures. The change from PCR to LFT testing continues to make a difference with the ongoing management of COVID. Mrs Boden advised the business case for the mouth care team has been submitted to the investment group. Mrs Boden confirmed an associate position had been filled and dental nurse had been appointed. There has been considerable progress with mouth care education within the Trust. Dr Shehmar advised the Trust now has compliance with the national standard for Lock sips. Continued improvement work within this area is required. Dr Shehmar advised the Trust has received a letter from the Royal College of Surgeons which confirms they are now satisfied with the evidence provided on the two reviews carried out in trauma and orthopaedics and the practice of a single practitioner. The Trust provided evidence and lessons learnt and the Investigation has now concluded.
440/23	**Patient Experience Quarter 4 Update**
	Report taken as read and Mrs L Carroll highlighted key points. No further update with the annual report as all quarterly reports have been previous seen updates. The report will go to board next month. Mrs Muflahi thanked Gary and his team for the immense work they do.
441/23	**104 Day Harm Update**
	Report taken as read and Dr M Shehmar highlighted points.

	Dr Shemar advised that Urology is the Trust main focussed pathway at present. Urology has now moved over to Royal Wolverhampton Hospitals NHS Trust. Dr Shehmar reports directly to Wolverhampton providing information on all the 104 day breaches and the handover of documents. Urology will no longer be in the report going forward. The Trust team will work across both sites and will still be involved in the pathway.
442/23	**7 Day Services Report**
	Report taken as read and Dr M Shehmar highlighted key points. Dr Shemar advised improvement of the Trust compliance with target standard two and eight. This is around the consultant review at 14 hours and the ongoing consultant review. All targets in the seven-day audit have now been met. This was carried out through education and more attention to good documentation.
443/23	**Maternity Update**
	Report taken as read and Mrs J Watts highlighted key points. Mrs Watts advised the Trust is fully compliant with saving babies lives. A latest version will be available soon. One SI has been declared around a 26-year-old lady who unfortunately had a maternal mortality at around 10 weeks in her pregnancy. The patient was known early at around 8 weeks and the booking process was commenced. The patient was a known asthmatic from 18 months old. Mr Bostock noted this was not a serious incident for this trust. Mrs Muflahi thanked Mrs J Watts and team for their hard work and asked if the Maternity Voices Partnership could also be added to the report. The Trust need to be able to demonstrate patient engagement improvements that are being made as a direct result of feedback.
444/23	**New Terms of Reference**
	Mrs Arthur confirmed updates have been made to the New Terms of Reference that were highlighted in the previous meeting. Mrs Arthur advised there are some further groups proposed to report.

	directly interview QPES, namely the information Governance Steering Group and the health and Safety Steering Group. A total of six groups will be reporting to QPES PSG, Patient Experience Group, I PCG, IG, health, and safety if agreeable to the members. Mrs Arthur will complete updates and forward to Dr Parkes.
445/23	**Exception Reports from any subgroup reporting to the committee**
	No exception reports were received for discussion.
446/23	**Matters for escalation to the Trust Board**
	No comments or questions raised.
447/23	**Any Other Business**
	Mr Bostock advised the group The Trust experienced a Cyber Attack. Some staff and patient data may have been accessed. The Trust is currently working with the National Crime Agency. It is still unknown if the data has been taken or just accessed. An Incident Response Group has been created within the Trust. Decisions have already been made to manage the situation and further discussions are planned with the Caldicott Guardian today. Once all relevant information has been gathered the Group will decide what approach to take when informing staff and patients. Dr Shehmar advised a meeting had taken place with the Data Protection Officer. Consultation with the UK Council of CALDICOTT Guardians will also take place to ensure the Trust is taking the appropriate action.
448/23	**Reflections on Meeting**
	The meeting finished at 1.05pm.
449/23	**Date and Time of the Next Meeting**
	The next committee meeting will take place on 26th May 2023 at 11.30am.

Signed:

Committee Chair:

Walsall Healthcare NHS Trust

MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

HELD ON MONDAY 27TH DAY OF MARCH 2023 AT 10:00 VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mrs Dawn Brathwaite **(Chair)**	Non-Executive Director
Mrs Fiona Allinson	Non-Executive Director
Ms Catherine Griffiths	Chief People Officer
Mrs Lisa Carroll	Director of Nursing
Mrs Louise Nickell	Group Director of Education and Development
Mr Alan Duffell	Group Chief People Officer

In Attendance

Mrs Catherine Wilson	Deputy Director of Nursing – The Royal Wolverhampton NHS Trust
Ms Catherine Lisseman	Group Head of Corporate Learning Services
Mr Ravi Kainth	TBC
Dr Liam Manely	Chair – LGBTQ+ Ally Network
Dr Anjan Bhaduri	Associate Medical Director – Workforce
Mrs Jane Wilson	Joint Staff Side Representative – Unison
Mr Brad Allen **(Minutes)**	Executive Assistant

Apologies

Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead
Mr Junior Hemans	Non-Executive Director
Mr Paul Assinder	Non-Executive Director

182/23	**Chair's welcome, apologies, and confirmation of quorum**
	Mrs Brathwaite welcomed all members to the meeting and thanked them for their attendance. The meeting was declared quorate in line with terms of reference and apologies were noted as recorded above.
183/23	**Declarations of Interest**
	There were no declarations of interest raised by members.
184/23	**Minutes of Previous Meeting – 27th February 2023**
	There were no comments or amendments from members therefore committee **resolved** to **approve** the minutes of the meeting that took

	place on 27th February 2023 as a true and accurate record of decisions and discussions that took place.
185/23	**Matters Arising and Action Log**
	There were no actions outstanding for discussion on the action log.
186/23	**Integrated Care Board Update**
	Ms Griffiths referred members to the report enclosed for information. There were no comments or questions from members. **RESOLVED** That committee **note** the contents of the report for information.
187/23	**Workforce Safeguards Report**
	Mrs Carroll introduced the report as read and advised committee that this was an annual paper for committee oversight to assess national safeguard requirements issued by National Health Service England & Improvement (NHSEI). A total of fourteen recommendations had been issued to develop the action log, in which the Trust was reported to be fully compliant in seven and partially complaint in five and was tabled for committee information. **RESOLVED** That committee note the contents for the report for their information.
187/23	**Safe Staffing Report**
	Mrs Carroll introduced the report as read and highlighted the following points for committee reference: • Registered General Nurse establishment figures were reported to be outstanding 3% staffing Trust Wide following the recruitment of an additional 302 International Nurses. • Paediatric Nursing vacancy rates were reported at 50% with the main reason for colleagues leaving the Trust being promotion at other organisations. Despite this, vacant positions had successfully been recruited to therefore establishment figures were expected to improve. • Cessation of agency usage continued to decrease with only necessary usage being approved by Executive leads to ensure patient safety.

	• Recruitment into Maternity vacancies were proving successful, with all Board Assurance Framework targets being achieved despite high parental leave rates. • Health Visiting establishment figures had improved following skill mix pathway. • Cessation of agency usage will be fully implemented on 1st April 2023. There were some areas that may still require agency support to ensure patient safety, but this would require Director or Deputy Director of Nursing authorisation. During out of hours periods, this responsibility would fall to the Director on Call. Mrs Brathwaite thanked members for their efforts in dramatically reducing agency usage but queried utilisation in maternity services given their high parental leave figures. Mrs Carroll responded to advise agency usage was rarely utilised due to a recently approved business model and support from Bank capacity. Mrs Brathwaite referenced Bank worker mandatory training compliance and expressed her support for actions put in place to improve figures. There were no further comments from members. **RESOLVED** That committee note the contents of the report for assurance.
188/23	**Trust Workforce Metrics**
	Ms Bond introduced the report as read and referenced new formatting for committee reference and then sighted the committee on the below points for their information: • Sickness absence figures were beginning to stabilise at 5.3%, down from 5.7% with a third of these relating to seasonal issues. • Vaccination figures for Influenza were reported at 31% and Covid-19 at 24%. • Mandatory Training figures were reported at a total of 87%, with further support being required within the Medicine Division. • Annual appraisal figures were stood at an overall 84%, with administrative and clerical roles requiring improvement. • A summary of workforce parameters was provided for committee with two key performance indicators requiring alteration. These were sickness absence with a recommendation to be brought in line with Royal Wolverhampton target rates of 5% as well as retention measures reducing from 24 months to twelve raising the overall target to 88%.

	Mr Duffell expressed his support for the overall direction of travel and queried the overall vacancy rate as set out at 0%. Ms Bond advised this was an administrative error and would confirm following the meeting. Mrs Allinson queried what supportive elements had been introduced for the Division of Medicine to improve their mandatory training figures. Ms Bond replied to advise direct conversations would be held with the Divisional Team, as necessary. Ms Bond advised that despite exit interview data being positive, further conversations would be required to determine what additional methods could be implemented to retain more staff and gave examples of Healthcare Assistant retention levels. It had been identified that the vast majority of staff who had left the organisation were employed for some four years, with work-life balance and promotional opportunities being the main reasons for departure. Committee noted that evidence had been obtained following a years' worth of data collation therefore additional trends could be identified to improve figures. Mr Duffell queried whether there were any elements in which the committee would need to address immediately. Ms Bond responded to state a total of 50% of Nursing and Midwifery colleagues had been appointed in to other organisations, therefore a new Band 5 Transfer process for internal colleagues being recruited into other areas had been introduced to improve retention. Mrs Allinson referred colleagues to the figure of 65 colleagues who had left the organisation but remained in the NHS and queried whether they were moving across the Black Country or further afield. Ms Bond advised that this data was obtainable and could be returned to committee for reference. Mr Duffell added that colleagues moving within the NHS was not particularly negative, but should they be leaving the Health Service altogether, further efforts as an organisation would be needed. Mrs Allinson referenced a recent Non-Executive area walkabout where staff had shared their positive experiences in wards describing them more as 'communities' therefore providing evidence that supporting staff with their flexible requests is working. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
189/23	**Corporate Risk Register**
	Ms Bond introduced the item and advised that no Board Assurance Framework had yet been received.

	Ms Bond then went on to summarise the four Corporate Risks within the Committee's remit, two of which will be transferred to the Quality Patient Experience and Safety Committee relating to Nursing and Midwifery staffing figures. Ms Bond and Mr Duffell referenced the Trust's staff survey sighting divisional responses would be explored by the committee as well as stressed the need to monitor other survey starts dates at other organisations. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
190/23	**Health and Wellbeing Assurance Report**
	Ms Griffiths gave an overview of the report advising that the framework had been introduced to identify supportive methods to promote the health and wellbeing of colleagues in the workplace. Elements of compassionate leadership had been identified from recent staff survey figures which evidenced that plans were proving successful, with the Division of Women's, Children's and Clinical Support Services piloting a talent management programme across all areas. There were no comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
191/23	**LGBTQ+ Inclusion Report**
	Mr Manley introduced the report and gave an overview of highlights for committee information, they were as follows: • Action plans have been developed to include improvements to overall education and inclusion. • A review of all policies to ensure their inclusivity is scheduled to take place within the coming months. • Conversations are being held with colleagues to promote the Trust at Gay Pride, Birmingham 2023. • The re-launch of the staff network is scheduled to take place in the coming months, with all colleagues being reminded to encourage members to join. • Meeting with executive leads have taken place to update on progress and showcase success stories.

	• Trans and LGBTQ+ awareness training sessions had recently been introduced for colleagues to attend to improve colleague awareness, with the first session taking place within the outpatients' department following concerns in some areas. A total of seventy-eight people had undertaken the training to date. • A guidance document to support colleagues in difficulty had been developed for circulation. • Posters to promote the organisation's 'Rainbow Badge' initiative had been developed and would soon be displayed in all areas across the organisation. Miss Nickell thanked Mr Manley for his work and suggested the report feature as part of the Trust's Schwartz Rounds. Mr Duffell also thanked Mr Manley for his work and queried whether he required any support from the Trust Board improve awareness. Mrs Brathwaite and Mrs Allison joined colleagues in thanking Mr Manley for his work, praising efforts made to trans awareness and suggested it would be welcomed should colleagues wish to discuss their experiences when working at the Trust. There were no further comments from colleagues. **RESOLVED** That committee note the contents of the report for their assurance.
192/23	**Staff Survey Update**
	Ms Bond introduced the report and began by giving a brief overview of areas identified for priority support to reduce concerns. Details of the survey results had been released following the last meeting in February 2023, but more efforts were required to showcase the positive elements. Improvements had been recorded in all nine categories, with only two areas being below national averages. Ms Bond stated that a total response rate of 47% had been achieved, with a total improvement rating of 83% being recorded across all areas, with discrimination being the main cause for improvement within the Trust. Ms Bond advised that conversations were being held to undertake a stability and respect programme across the organisation, with advocacy being quite a way from target. Improvements to colleagues recommending the Trust as a place for Treatment remained a concern, placing us 14% behind national figures. Despite this, figures for colleagues recommending the Trust have a place of work were positive due to development opportunities being offered to staff.

	Mr Duffell suggested that figures evidencing the organisation as a good place to work be published at the earliest opportunity. Ms Griffiths recommended figures that showcase the Trust as caring and dedicated be published at the earliest opportunity. Mr Duffell suggested that reducing vacancy levels will improve survey rates, sighting that their reduction evidences that we are investing in colleagues as an organisation. There were no further comments from colleagues. **RESOLVED** That committee note the contents of the report for their assurance.
193/23	**Board Pledge Assurance Report**
	Ms Bond introduced the report, advising members on updated figures from September 2022 and highlighted the below updates for committee reference: • Overall turnover rates had reduced. • Harassment and bullying grievance figures had increased to forty-seven from thirty-five on the previous year. • A successful programme of events for Black History Month and Freedom to Speak Up month had taken place over. • A joint Trust anti-racist statement had been developed in partnership with staff across both Walsall and Wolverhampton Trusts. • A Board development session had been delivered in January 2023 by utilising the feedback and outcomes from the workshops with a view to agreeing the joint to vision statement. • The national WRES team had reviewed the action plan and rated it as an overall score of 3 which aligning to the CQC award system and is therefore outstanding. • The Dispute Resolution Policy had been approved and implemented across the Trust. Mr Duffell referred members to the EDI (Equality, Diversity and Inclusion) agenda figures not reaching target and suggested committee consider adding this as Board Assurance Framework risk. Ms Bond advised that the Trust already had a specific risk badged against EDI. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.

194/23	**Terms of Reference**
	Committee **resolved** to approve the terms of reference as set out subject to the inclusion of retention target discussion.
195/23	**Cycle of Business – 23/24**
	Committee noted the Business Cycle as set out and **resolved** to approve subject to the following amendments: • Inclusion of the Annual Workforce Safeguards report due to be tabled in March 2024. • Annual Education and Skills report due to be tabled in March 2024. • Inclusion of the Agenda Pay Gap report due for discussion in March 2024. • Inclusion of the Annual Health and Wellbeing report for discussion in March 2024.
196/23	**Annual Education and Training Report**
	Mrs Nickell introduced the report as read and highlighted the following points for committee oversight: • Positive progress had been made to the collaborative training approach. • Positive feedback had been ascertained following a Health Education England visit sighting no patient safety concerns, with an action plan being submitted ahead of another visit in November 2023. • Overall NET Survey data had improved. • The Speech and Language Therapy had been awarded the blue flag, as well the post-graduate paediatric team. • Aston Medical School were reported to be integrated under the graduate medical team. Ms Brathwaite queried the figures for BAME (Black and Minority Ethnic) Midwives and queried why no colleagues had been successful during the process. Ms Wilson and Carroll responded to advise no colleagues were successful in their bids. There were no further comments from members. **RESOLVED** That colleagues note the contents of the report for their assurance.

197/23	Annual Education and Training – Collaborative Approach Report

Mrs Nickell introduced the report as read and highlighted the following points for committee oversight:

- Committee noted that apprenticeship job offers were different across both organisations, with Walsall offering employment at the end of each course and Wolverhampton not.
- Education Informatics were included in in revised learning management systems, My Academy, which allows all training is centrally available.
- Plans were in place to harmonise people leadership across both organisations, with conversations being held to host these at Walsall to support with staff retention efforts.

Ms Nickell queried what supportive elements could be introduced to provide a like-for-like leadership education service across both sites. Ms Griffiths suggested that should Walsall identify opportunities; a review of educational resources would be required to ensure no organisation is overwhelmed with requests.

Mr Duffell advised that committee could endorse the direction of travel for this initiative, but not the financing as this would initially require discussion and approval with the Executive team.

Mr Kainth reported the following points for the reference of the committee:

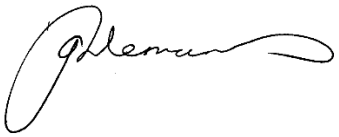
- A Robust Education action plan had been devised to ensure supportive elements are introduced for staff.
- Health Education England (HEE) had visited to review organisational progress and what challenges were still in place. Therefore, another November 2022 visit took place where no A&E culture concerns were identified.
- In terms of NETS feedback, double respondents allowing further detailed feedback were scheduled to take place to improve overall figures meaning the organisation was placed above national average.
- Contract funds were increased to £1.5 million overall.
- A full review of the Induction and Study Leave policies has been completed.

There were no further comments from members.

RESOLVED
That committee approve the report as set out.

198/23	**Workforce Strategy**
	Committee noted the report for their assurance. Mr Duffell advised that there had previously been individual strategies in place, but a revised set of shared strategic objectives had been adopted by both organisations. There were no further comments from members.
199/23	**Workforce Plan**
	Ms Griffiths gave a brief verbal overview of the draft report contents and advised the final version would be circulated for reference. Mr Duffell concluded by advising members that the report was on target for completion.
200/23	**Items for Information**
	Committee **resolved** to **note** all items tabled for their assurance.
201/23	**Escalations to Trust Board**
	Committee **resolved** to escalate the following points to the Trust Board: • ICB Update Details. • Assurances to Trust Strategic approach. • Support for additional leadership requirements. • Efforts of the LGBTQ+ Inclusion Group
202/23	**Any other Business**
	Mrs Brathwaite suggested that there had been some disconnection between report recommendations and the agenda and requested that colleagues review this before submitting reports in line with agenda recommendations. There were no further items of business raised by members for consideration.
203/23	**Date and Time of the Next Meeting**
	The next meeting of the People and Organisational Development Committee is due to take place at 13:30 on Monday 22nd May 2023.

Signed:



Committee Chair: Mr Junior Hemans

Date: 22nd May 2023

Walsall Healthcare NHS
NHS Trust

MEETING OF THE AUDIT COMMITTEE
HELD ON MONDAY 6th FEBRUARY 2023 AT 09:00
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mrs M Martin	Non-Executive Director **(Chair)**
Mr P Assinder	Non-Executive Director
Dr J Parkes	Non-Executive Director
Mr J Hemans	Non-Executive Director

In Attendance

Mr K Stringer	Group Chief Financial Officer
Mr D Mortiboys	Interim Director of Finance
Mr K Bostock	Group Director of Assurance
Mr K Wilshere	Group Company Secretary
Miss B Edwards	Executive Assistant **(Minutes)**
M A Hussain	RSM
Ms E Sims	RSM
Mr M Gennard	RSM
Ms L Gough	RSM
Mr M Surridge	Mazars
Mr G Garg	Mazars
Ms L Parsons	Mazars

Apologies

Mr R Caldicott	Chief Financial Officer
Mr P Smith	Head of Security

87/22	**Chair's Welcome, Apologies & Confirmation of Quorum**
	Mrs Martin welcomed everyone to the meeting. The apologies are noted above.
88/22	**Declarations of Interest**
	There were no declarations of interest raised.
89/22	**Minutes of previous meeting - Monday 5th December 2022**
	The minutes of the previous meeting were approved.
90/22	**Matters Arising and Action Log**
	Action 622: Mrs Martin requested assurance of the level on overpayments caused by late notification of leaving dates of staff. Mr Mortiboys confirmed managers would be reminded how to terminate staff correctly and in sufficient time to prevent overpayment. Mr Hemans questioned if other organisations experienced this issue. Mr Stringer confirmed the issue happened across the NHS but stated some managers were more proactive than others. Mr Stringer agreed to do further work with Mr Mortiboys on comparison between Walsall

	and Wolverhampton and bring back an update and to review if the process could be strengthened. Action 451: Mr Stringer presented the report to members. It was highlighted it was a cultural issue of staff not keeping their email account live due to becoming suspended and deleted following inactivity. The deadline and process for closure was a nationally mandated issue and not a Trust issue. Members requested the Trust Management Committee approved the mandate that all permanent and fixed term staff must maintain an active NHS email account. **Action:** - **Mr Stringer and Mr Mortiboys to perform a comparison between Walsall and Wolverhampton overpayments to staff leavers and to review if the process could be strengthened.**
91/22	**Items for Escalation from Board Committee Chairs**
	Performance and Finance Committee Mr Assinder raised to members concerns had been raised in relation to cash flow management. It was highlighted the Trust had £40m cash but had an ambitious capital programme for 23/24 and with a deficit budget forecasted for 23/24 would present pressure on cash flow management. Due to this the Committee requested Internal Audit to explore and test the management process. Quality Patient Experience and Safety Committee There was nothing highlighted from the Committee. People and Organisational Development Committee There was nothing highlighted from the Committee. Trust Management Committee There was nothing highlighted from the Committee. Charitable Funds Committee Mr Assinder raised concern in relation to the League of Friends. Mrs Martin and Mr Assinder agreed to have an offline discussion. Walsall Together There was nothing highlighted from the Committee. It was agreed moving forward Mr Assinder would provide updates to members.
92/22	**Single Tender Actions**
	Mr Mortiboys provided members with an update on the Medinet waiver and expressed there was a requirement to spend the funds by the end of June 2023. A report will be submitted to Trust Board August 2023. Members were informed FJ limited was a long standing supplier of the Trust but had no contract in place but work was underway to ensure it was captured on the procurement system. Mrs Martin requested an update on the contract in 6 months. **Action:** - **Mr Mortiboys to update the Committee on FJ Limited's contract with the organisation in August.**

93/22	**Suspension Breaches**
	Members noted there were no breaches recorded.
94/22	**Review of Losses and Special Payments**
	Mr Mortiboys presented to members. It was highlighted a crime number had been created for the incident where £690 was stolen from a patient but no further internal action had been taken. Mr Mortiboys added the process for losses and special payments had been outlined within the report and stated the proposal would be to tighten the process and link in The Royal Wolverhampton NHS Trust to make it best practice. Mr Bostock advised the cash was locked in the control drugs cupboard for a period of 22 hours before it disappeared and added there would be a record of every staff member that had the keys. Mr Bostock advised the crime was below police interest threshold due to committing resource to investigate and expressed this should be investigated internally. Mrs Martin requested the investigator was made aware. Mr Jones joined the meeting at 09:29. Mr Hemans questioned if the Trust advised patients not to bring in valuable items or large cash sums. Mr Bostock advised all patients are advised through a policy not to bring in valuables or excessive amounts of cash and staff tend to pass these back to relatives.
95/22	**Security Progress Reports**
	Mr Jones presented to members and highlighted there was issues with patient and visitor car parking with the barriers allowing entry even when the carpark was at maximum capacity. Mr Jones added previously the barrier would not lift once it reached maximum capacity but had resulted in queues forming and suggested a one way system around the site but expressed this would need further work. Mrs Martin requested Mr Jones held a discussion with Mr Hobbs to agree a way forward. Mrs Martin expressed the CCTV equipment had come under a lot of pressure and questioned if there was a clear route for the concerns. Mr Jones highlighted there was Capital funding available to be able to fix the issue but not future proof the CCTV system and added this would require further funding. Mr Jones left the meeting at 09:36. **Action: Mr Jones and Mr Hobbs to discuss car park control**
96/22	**Cyber Security Update**
	Mr Stringer presented to members. It was highlighted there was a delay in the multifactor authentication (MFA) for VPN users across the Trust due to resource having to be diverted to the new Emergency Department. It was advised there was now 1 cyber team across both WHT and RWT and the team had business case approval for additional investment which would provide increased protection against cyber related issues. Mr Assinder expressed he was disappointed to hear the MFA would be delayed to the end of 2023. Mr Stringer advised the high priority staff such as Executives, Finance and Procurement departments had received the required change but agreed to find out if the implementation for the wider Trust could be brought forward. Mr Assinder added if the date could not be brought forward if more promotion of ? and improving staff knowledge could be done. Mr Stringer agreed.

	Ms Sims advised it was suggested a quarterly cyber workshop be held as part of the proposed workplan. Mr Wilshere advised the first version of the cyber, Board Assurance Framework (BAF) risk would be shared following the addition of mitigations, controls and assurance. **Action:** - **Mr Stringer to check if the date for the implementation of MFA could be brought forward from December 23.**
	Internal Audits Progress Reports
	Mr Hussain presented the update report to members. It was highlighted there was an additional advisory review on theatres. This was requested following business cases being created. He stated the review had been led by clinical consultants and a number of significant actions identified. Mr Hussain added the action tracker was in place and work was ongoing with Mr Mortiboys and Mr Lakin to ensure prompt closure of actions or updates provided. The action tracker was presented to members. Mrs Martin requested owners of the risks that are overdue in May 23 should attend the Committee.
97/22	**Internal Audit Completed Reports**
	<u>COVID recovery</u> Ms Gough presented to members. It was noted there were 2 high priority actions following the report. Mr Bostock stated the ICB and CQC had been sharply focused on the harm caused following the wait delay. Mr Assinder stated with the new PAS system, if more patients were on the new system, it could be indicative of waiters not previously being registered and kept on the auxiliary list. Mr Assinder requested this was followed up to review what had happened and report back to the Committee. Mr Bostock stated there was a plan that Mr Hobbs was leading on and noted the ICB was asking for monthly updates. Mrs Martin enquired about the completion dates for key actions. Ms Gough agreed to check but expressed it would be November 2023. Mrs Martin requested the report was circulated to Quality Patient Experience and Safety Committee members and an update to be brought back to the Committee from Trust Management Committee in 3 months. <u>Rostering</u> Ms Gough presented to members. It was highlighted there was 3 high priority actions. Mrs Martin questioned if the issues were down to areas still using a paper-based system. Ms Gough raised she did not think it was down to the use of paper records as predominately areas would be using Allocate. Mr Bostock stated the importance of renewing the focus on rostering due to the Trust's drive to reduce agency and the greater reliance on bank staff. Mrs Martin requested assurance on how this would be taken forward. The Committee agreed the Director of

	People and Culture and Interim Director of Finance would need to produce a presentation at the next Audit Committee in response. Mr Hemans agreed and questioned if Communications needed to be involved to ensure the message was shared across the Trust. Mr Hussain expressed he had met with Mrs Carroll, Director of Nursing and that he was pleased with action that was to be taken. Mrs Martin confirmed for the next meeting for Mrs Carroll to attend to provide a presentation following the findings of the report and to be supported by Interim Director of Finance and Director of People and Culture. <u>Data quality – Sepsis</u> Ms Gough presented to members and highlighted there was 1 high priority action. Mrs Martin expressed that she had spoken to Mrs Carroll ahead of the meeting and stated an action plan was required. Mr Parkes expressed his concern that paediatrics, gynaecology and maternity are not included. Mrs Martin requested the report was circulated to members of the Quality, Patient Experience and Safety Committee and requested Mrs Carroll and Dr Shehmar's attendance at the next meeting to present the plan of addressing the issues raised. **Actions:** - **Mr Hobbs to provide an update on patient numbers on the PAS system.** - **COVID recovery report to be shared with Quality, Patient Experience and Safety Committee Members.** - **An update from Trust Management Committee on the COVID Recovery report to be brought back in 3 months.** - **Mrs Carroll to be invited to the next meeting to present the findings following the report on Rostering.** - **Data Quality – Sepsis to be shared with Quality, Patient Experience and Safety Committee members.** - **Mrs Carroll and Dr Shehmar to be invited to the next meeting to present plans to address the issues raised around Sepsis.**
98/22	**Head of Internal Audit Opinion**
	Mr Gennard presented to members. It was highlighted there was outstanding work to be completed but that would be unlikely to change the opinion presented. Weaknesses were highlighted across governance and risk management control resulting in it becoming inadequate and ineffective. Members were informed the report was set out in draft. Mr Stringer questioned if it was clear what needed to happen before the end of March 23 to change the opinion. Mr Gennard stated it was unlikely the opinion would change due to the partial assurance and minimal assurance work would not be completed prior to formal sign off. Mr Bostock questioned who had been engaged in reviewing the weaknesses in framework governance and risk management control. Mr Gennard expressed his opinion was based on the work undertaken throughout the year and nobody had been engaged with. Mrs Martin questioned if the remaining work would be completed in time of the next meeting due to be held in May 23 and questioned where the extra work on theatres came in. Mr Gennard agreed and Mr Hussain added the extra work on theatres was advisory but

	expressed the opinion was brought to the Committee in draft to ensure members had early sight of the report. Mr Assinder questioned where the organisation sat against other NHS organisations in regard to the Internal Audit Opinion. Mr Assinder further questioned how the Internal Audit team would work with the organisation to ensure the weaknesses are addressed. Mr Gennard advised there was a road map of management actions and members would be kept updated on transparently by Internal Audit with a follow up at Audit Committee. Mr Gennard expressed only a few opinions had been issued so far but stated opinions that had been issued were rated higher than the Trusts.
99/22	**Internal Audit Plan**
	Mr Hussain presented to members. It was noted for the next financial year he would meet with the Executive Directors as the plan had not been shared collectively. It was highlighted the Internal Audit Team had been budgeted to do 125 days a year but with pre-agreed work in data security protection toolkit and key financial controls equated to 63 days being utilised. The proposed work and the revisit of areas has equalled 82 days, totalling 145 days. Mr Hussain highlighted that previously additional audits had been purchased. Mrs Martin questioned how to review the number of days procured. Mr Stringer advised there was a defined number of days for the contract for next year but with the Executive team and Trust Management Committee approval, additional days could be purchased but would need to be included in the prioritised list of investment. Mr Stringer advised a conclusion would be reached by the end of March 23 latest. Mrs Martin requested Mr Hussain and Mr Stringer meet to draft what is supported by the Executive team and email it round to members for approval. Mr Assinder urged members to look at the Internal Audit work systematically before reviewing the budgetary implications. **Action:** - **Mr Hussain and Mr Stringer to meet to agree the audit topics and number of associated days for 2023/24 and to send it to Committee members for approval by email.**
100/22	**Local Counter Fraud Progress Report**
	Ms Sims presented to members. It was highlighted work was progressing and was on track to deliver by year end with a focus on ensuring the risks identified within the fraud and bribery risk assessment are considered by the relevant risk owners in line with the counter fraud functional standard. It was confirmed there were 6 new referrals. Ms Sims advised the mandate fraud case was still on going with liaison with NHS Fraud and updates would be provided.
101/22	**Annual Local Counter Fraud Work Plan**
	Ms Sims presented to members. It was highlighted that awareness sessions would be held with People and Culture colleagues to ensure they are equipped to continue to identify and pursue parallel sanctions as well as quarterly recruitment training and ID workshop. Members noted there were also be cyber workshops.
102/22	**External Audit Plan Progress Report**
	Ms Parsons presented to members and stated in-depth planning would start within the next week. It was noted the internal risk of the financial reporting framework required a risk identification assessment and members would be updated at the May 23 meeting following further testing.

	Mrs Martin questioned if the Committee normally reviewed the Audit Strategy Memorandum at the May 23 meeting. Ms Parsons agreed and explained it would be prepared in March 23. Mrs Martin requested it was shared with members as soon as it was available. Mrs Martin requested assurance on how external and internal audit work together to ensure there was no duplication of work. Ms Parsons expressed there were discussions with Internal Audit but expressed they would not rely on the work of Internal Audit. Mrs Martin questioned if the timetable had been agreed. Mr Mortiboys expressed he and Mr Surridge had agreed a date for the final order report to come to Audit Committee and agreed to confirm a date in June 23 as soon as possible. **Action:** - **Audit Strategy Memorandum to be shared with members as soon as it was available.** - **June 23 date to be confirmed as soon as possible.**
103/22	**Board Assurance Framework and Risk Register**
	Mr Bostock presented to members. Members were informed at the next meeting, the new Board Assurance Framework (BAF) and Corporate Risk Register (CRR) with the new strategic objectives would be used. Mrs Martin requested an update on the delay on the implementation of the Datix system. Mr Bostock advised the implementation was agreed from January 23 but due to issues including training the volume of staff and the connection to the active directory it was agreed it would be pushed back to the start of the new financial year. It was confirmed the new system was being populated with the new strategic risks and cleansing what is transferring from the old system into the new one. It was noted that a number of the current risks were over measured but would be cleansed as they transferred over to the new system. Mr Wilshere advised for the new BAF there are 6 risks and expressed it would be shared to members in draft form if requested. The 6 risks were identified as: - Cyber - Cultural and behaviour change - Staffing, Recruitment and retention - Patient Safety Standards - Financial Resource - Equality and inclusion
104/22	**Cyber Risk Management**
	Mr Wilshere advised members he had been in discussions with Mr Pearson, Chief Information Officer and Mr Bruce, Associate Chief Technology Officer, around the creation of Cyber BAF and aligning the risk and some of the common mitigations with Wolverhampton NHS trust.
105/22	**External Visits and Inspections**
	Mr Bostock presented to members. It was highlighted the Trust's overall CQC rating remained as requires improvement but had moved towards the good rating. Mr Bostock added there was justification to write to NHSE to come out of undertakings. It was added

	following receipt of the Section 29a warning notice, a consultant Chief Pharmacist had been engaged to review pharmacy services until April 23. Dr Parkes questioned when the Trust was likely to be re inspected. Mr Bostock advised the inspection regime was due to change on the 1st April 23 allowing the CQC to have a dynamic remote monitoring and only performing deep dive into areas of concern allowing ratings to become more dynamic. However, this had been pushed back until April 24 but the Trust did not anticipate being inspected again for the foreseeable future. Mr Assinder stated it was more beneficial for Committee members to review the big independent reports and it was good practice to have them reviewed and debated at the Committee. Mrs Martin questioned if the tracking system following reviews was monitored by the Quality, Patient Experience and Safety Committee on a regular basis. Mr Bostock advised work was underway to pull together a framework that will be registered in a central location to allow sufficient tracking of action reports. Members discussed the Committee oversight of External Reviews and it was agreed as external reviews covered both clinical and non-clinical, the Audit Committee would continue to have oversight. It was agreed Audit Committee would continue to have oversight of external reviews due to covering clinical and non-clinical areas.
106/22	**Committee Self Assessment**
	Members were reminded to complete the Audit Committee Effectiveness Review survey ahead of the deadline of Thursday 16th February 23.
107/22	**Terms of Reference**
	Members requested the addition of External Reviews. The changes outline on the Terms of Reference were agreed.
108/22	**Any Other Business**
	Mrs Martin passed on her thanks to Miss Edwards ahead of her departure from the Trust at the start of March 23.
109/22	**Matters for escalation to the Trust Board**
	It was agreed the following would be included within the Trust Board Committee Highlight report. - Internal Audit work programme was on track to be complete at the end of the financial year. - The outcomes of the three detailed audits. - The expectation that the Head of Internal Audit opinion would be "There are weaknesses in the framework of governance, risk management and controls such that it could become inadequate and ineffective. - Cyber security continued to strengthen following the addition of a joint cyber team across Walsall and Wolverhampton NHS Trusts. - The Outstanding actions tracker has now been set up. - TMC to consider a request for further days on the Internal Audit Work plan. - Counter Fraud work continued to be on track.
110/22	**Date and Time of the Next Meeting: Thursday 4th May 2023 at 09:00**

Signed:

Committee Chair – Mrs Mary Martin

Date:

Walsall Healthcare NHS Trust

MEETING OF THE CHARITABLE FUND COMMITTEE HELD ON FRIDAY 16th DECEMBER 2022 AT 14:00 HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members	
Mr P Assinder	Non-Executive Director **(Chair)**
Mr R Virdee	Non-Executive Director
Mrs S Evans	Group Director of Communications and Stakeholder Engagement
Mr D Mortiboys	Interim Director of Finance
In Attendance	
Mrs G Westley	Fundraising Manager
Miss B Edwards	Executive Assistant **(Minutes)**
Mr G Perry	Associate Director - Patient Relations & Experience
Ms K Aplin	Fundraising Support Officer
Ms L Perager	Management Accounts Assistant
Mr T Baker	Chief Financial Accountant
Apologies	
Mr R Caldicott	Chief Financial Officer

38/22	**Welcome, Apologies and confirmation of quorum**
	Mr Assinder welcomed everyone to the meeting. The meeting was declared quorate and the apologies are noted above.
39/22	**Declarations of Interest**
	There were no declarations of Interest raised.
40/22	**Minutes of the previous meeting: 12th September 2022**
	The minutes of the previous meetings were approved.
41/22	**Matters Arising and Action Log**
	Action 490- Uncommitted Grant Funds Mrs Westley advised that a meeting had been arranged to discuss spending plans but had subsequently cancelled. However, she stated that (covered in a report later on the agenda) some requests for funding for a user-friendly patient waiting area for ENT and breast feeding locations across the Trust. Members noted a large amount was already committed. Mrs Westley advised that, for the COVID-19 fund, it would be beneficial to ask staff what they would want after being allocated some money.

	Mr Perry advised the Trust was looking to complete an entertainment survey to see what patients would want but common feedback was more televisions to be installed on wards. Mr Virdee expressed the importance of staff health and wellbeing. Mrs Westley agreed and advised the Trust had won a £100k bid from an NHS charities that could be used to support the health and wellbeing of staff. Mrs Westley highlighted that modular block wards did not have televisions and suggested the funds donated by Mr Patel were utilised. Members discussed a scoping exercise being performed with Mrs Longden, Divisional Director of Estates and Facilities, to establish which wards did not have functioning televisions. Mrs Evans agreed to look into it. **Actions** - **Mrs Evans to work with Mrs Longden to review which wards had functioning televisions.**
42/22	**League of Friends Update**
	Mr Perry provided members with an update. It was highlighted in December 2020 the League of Friends (LoF) had requested full autonomy for its operations within the organisation, through a memorandum of understanding (MOU) in line with the Trust policies, procedures and insurances. However, the MOU was not signed. It was confirmed the LoF were no longer operating in the Trust and the Trust was running and administering the full volunteer services. It was highlighted that there were a number of volunteers that used to work for the LoF who now purely work for the Trust. Mr Assinder raised that Dr Shehmar had been in conversation around purchasing equipment for Pharmacy through the League of Friends. Mr Perry agreed and advised an invitation had been shared for the LoF treasurer to meet with Dr Shehmar, Ms Whyte and Mr Caldicott but added the meeting was cancelled and not yet rearranged. Mrs Evans questioned the level of LoF funds. Mr Perry advised it was around £300,000. Mr Perry advised that further information and support could be accessed through the Charities Commission to understand the level of funding and if it could be accessed by the Trust. In addition, there could be reputational issues if the Trust were to make this enquiry Mr Perry made members aware the LoF Chair had been in the organisation to meet with Mr Andrew Rice, Patient Experience & Voluntary Services Manager, where the Trust was asked to return the wheelchairs that had been donated to the organisation by LoF. Mr Mortiboys advised Pyxis machines for Pharmacy had been ordered due to approval gained from LoF. Mr Mortiboys questioned who he would need to take this forward to ensure the funds were received. Mr Assinder stated he was not aware of the purchase but stated the paperwork and the LoF approval would need to be reviewed ahead of the funds being requested from LoF.

	Mr Perry advised a LoF Annual General Meetings (AGM) had taken place to try and move forward. He also stated some LoF members had walked away from the organisation due to behaviours from colleagues. Mr Assinder requested Mr Mortiboys to meet with Mr David Guttridge to discuss the order of the Pharmacy Pyxis machines. Mr Perry left the meeting at 14:36.
43/22	**Quarterly Review of Expenditure Below 5k Authorised by Fund Managers**
	All requests below £5k were approved.
44/22	**Expenditure Requests £5k to £99,999**
	Mr Mortiboys advised that Ms Sindy Dhallu, Professional Lead for Palliative & End of Life Care, had agreed to fund the Trust Gold Standard Palliative Care training out of the Palliative Care Funds. Mrs Westley advised she had held a conversation with Mr Caldicott in relation to the Stroke Garden and he had advised for work to commence as funds were available. Mrs Evans agreed this would be the best way forward. The 3 requests were approved.
45/22	**Expenditure Requests over £100k**
	There were no requests presented.
46/22	**Quarterly Review of Income & Expenditure**
	Mr Mortiboys presented to members. It was highlighted the overall level of money in the fund had increased from March 2022 but said that the Trust was below the reserve threshold of £0.5m, once the committed and restricted funds are taken into account. Mr Mortiboys expressed that members could look into revisiting the reserve policy as the reserve level appeared high but he expressed that caution would need to be taken. Mr Virdee questioned why the reserve was apparently so high in the Reserves Policy and if it was reduced, what would the risk be. Mr Mortiboys advised the Fundraising Manager role was part funded by the Charity but there were no other commitments and expressed the view that a £0.5m amount was a very cautious and appropriate approach but could be revisited. Mrs Westley expressed members would need to be careful as fund managers can now view in real time what funds they have in their account and this could result in more spend. Mrs Evans agreed and questioned if any benchmarking or research had been performed on other

	organisations reserve policy. Mr Mortiboys confirmed he had not but agreed to speak to colleagues at the Royal Wolverhampton. Mr Assinder expressed that it would be good practice to review the reserves policy on a regular basis and requested a paper was pulled together for the next meeting. **Action:** - **Mr Mortiboys to find out RWT reserves and produce a paper for the next meeting.**
47/22	**Annual Report and Accounts Review**
	Mr Assinder informed members the Trust Board had delegated powers to the Committee to review and approve the Annual Report and Accounts. Mr Mortiboys presented the Annual Report and 2022/23 Accounts to members. It was highlighted that Mr Mark Surridge from Mazars was unable to join the meeting but members were encouraged to share any concerns that could be passed on to him. It was added that the accounts had been shared with Mazars. The Accounts had been subject to independent examination and Mazars were comfortable that all was as expected. Mark Surridge from Mazars had e-mailed to support that summary. Mr Virdee questioned the Trustee membership. Mr Mortiboys advised he had spoken to Mr Keith Wilshere, Group Company Secretary around the membership. Mrs Evans requested that moving forward, greater narrative on the Charity be included alongside the Accounts to demonstrate the activity that has gone on over 12 months. Mr Assinder questioned the possibility of having the narrative produced for the latest Annual Report. Mrs Evans agreed and added it would accompany the recent Annual Report when it is presented to Trust Board in February 2023. Mrs Westley confirmed and advised there was a template available to use. The Committee approved the Annual Report and Accounts.
48/22	**Report from External Auditors**
	The Committee approved the letter provided to Mazars. Mr Mortiboys agreed to share Mr Surridge's email of supportive points with members.
49/22	**Report on Investment Portfolio Year to Date**
	Mr Mortiboys presented to members. It was noted 2022/23 had been a challenging year for investment markets generally, due to surging inflation and increasing interest rates. It was added the portfolio had increased by £10k but there were fluctuations.

	Mr Virdee stated that inflation nationally had peaked at 11% and that this had further impacted investment performance into the new year. Mr Assinder stated that the Trust was 'heavy in cash' and suggested a conversation with Brewin Dolphin in relation to recent interest rate increases and liquid investment opportunities.
50/22	**Fundraising Update**
	Mrs Westley presented to members. Members noted it was a positive year for the Charity with it becoming more well known in the local area. Members welcomed Ms Kimberly Aplin, Fundraising Support Officer, who was a new starter within the Fundraising team. Mrs Evans echoed Mrs Westley's comments and passed on her thanks to Mrs Westley for her hard work for the charity. The Committee agreed and passed on their thanks to Mrs Westley's hard work over the last 12 months.
51/22	**Fundraising Policy**
	Mrs Evans advised members the policy was being re-written but agreed it would be available for the next meeting. Mr Virdee questioned if the Trust had a relationship with Freemasons. Mrs Westley confirmed the charity did have regular donations. **Action:** - **Fundraising Policy to be on the March 2023 agenda.**
52/22	**Annual Cycle of Business**
	The annual cycle of business was approved for 2023.
53/22	**Any Other Business**
	There was no other business raised.
54/22	**Matters for Escalation to the Trust Board**
	Mr Assinder highlighted the following points to be included within the highlight report. - £28k of Expenditure noted over quarter 2. - 3 requests over £5k were approved. - Debate and agreement on a review of the reserve policy. - Discussed potential usage of Captain Tom, COVID-19 and NHS charity money. - Delegated Authority used to approve the Annual Report and Accounts for 2021/22 including the Annual Audit Letter. Mr Baker joined the meeting at 15:04.

	Mrs Evans provided Mr Baker with an update on League of Friends. Mr Baker advised members he had been in discussions with Mr Ivan Westley from LoF and stated their confirmed contribution was around £135k.
55/22	**Date of Next Meeting - Monday 13th March 2023 at 10:00**

Signed: P. Assinder

Mr Paul Assinder – Designation – Chair of the Charitable Funds Committee

Date: 13th March 2023

Walsall Healthcare NHS Trust

Trust Management Committee

Date/time: Thursday 27th April 2023
Venue: Via Microsoft Teams
Quorate: Yes
Chair: Prof. A-M Cannaby on behalf of Prof. D Loughton

Prof A-M Cannaby	Group Chief Nursing Officer/Deputy Chief Executive
Mr N Hobbs	Chief Operating Officer
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Mr S Mirza	Deputy Chief Medical Officer
Ms L Carroll	Director of Nursing
Ms C Whyte	Deputy Director of Nursing
Mr C Ward	Deputy Director of Nursing
Mr R Pearson	Chief Information Officer, Digital Services
Ms R Joshi	Clinical Director for Emergency Department/Deputy Director for Medicine and Long-Term Conditions
Ms R Virk	Divisional Director of Nursing – Medicine and Long-Term Conditions
Mr S Jackson	Director of Operations – Community
Mr M Ncube	Divisional Director of Clinical Support Services
Ms K Geffen	Divisional Director of Nursing – Community
Mr W Goude	Divisional Director of Surgery
Ms K Rawlings	Divisional Director of Nursing – Surgery
Ms C Jones-Charles	Divisional Director of Midwifery, Gynaecology and Sexual Health
Ms J Longden	Divisional Director of Estates and Facilities
Ms C Bond	Deputy Director of People and Culture
Ms P Boyle	Director of Research & Development RWT and WHT
Ms C Long	Group Deputy Director of Assurance
Ms M Metcalfe	Group Deputy Director of Assurance
Ms R Tomkins	Deputy Divisional Director of Nursing – Medicine and Long-Term Conditions
Ms L Nickell	Group Director of Education and Training
Ms M Arthur	Group Deputy Director of Assurance
Ms K Salmon	Deputy Chief Strategy Officer
Ms C Matthews	Deputy Director Clinical Support Services
Ms L Ibbs-George	Divisional Manager – Estates and Facilities
Ms S Webley	Divisional Director of Operations – Surgery
Ms J Wright	Head of Midwifery, Gynaecology and Sexual Health

In Attendance:

Ms S Rowe	Associate Non-Executive Director WHT/ Executive Director Children's Services - Walsall Council
Ms J Sembi	Walsall Council (for Item 525/23 only)
Mr D Morris	Head of Contracting
Mr F Botfield	Head of Digital Strategy, Walsall Together
Mr S Jeewa	Freedom to Speak Up Guardian
Ms D White	Interim Deputy Divisional Director – Medicine/ Senior Project Manager for UECC
Ms P Usher	Joint Staff Side Lead
Ms I Pathirage	International Medical Leadership Fellow
Ms S Chand	Deputy Director Pharmacy
Ms E Stokes	Senior Administrator for Group Company Secretary
Ms J Toor	Senior Operational Coordinator for Group Company Secretary

Apologies:

Prof D Loughton	Group Chief Executive
Mr K Wilshere	Group Company Secretary
Ms C Griffiths	Chief People Officer
Mr S Evans	Group Chief Strategy Officer
Mr K Stringer	Group Chief Financial Officer

Mr K Bostock	Group Director of Assurance
Mr D Mortiboys	Operational Director of Finance
Mr G Perry	Associate Director of Patient Relations and Experience
Mr G Fletcher	Director of Pharmacy
Dr M Shehmar	Chief Medical Officer
Mr N Bruce	Associate Chief Technology Officer
Dr J Odum	Group Chief Medical Officer
Mr A Duffell	Group Chief People Officer
Ms C Yale	Divisional Director of Nursing – Paediatrics and Neonates
Dr N Usman	Divisional Director of Medicine and Long-Term Conditions
Ms A Boden	Head of Infection Prevention and Control
Mr M Dodd	Director of Transformation
Mr F Ghazal	Divisional Director of Women's, Children's & Clinical Support Services
Ms T Adeniji	Deputy Divisional Director of Women's, Children's & Clinical Support Services
Mr W Roberts	Deputy Chief Operating Officer/Director of Operations, Medicines, and Long-Term Conditions

524/23	**Welcome and Apologies**
	Prof. Cannaby welcomed everyone to the meeting and apologies were noted.
525/23	**Fostering Friendly Discussion – Walsall Council**
	Ms Rowe and Ms Sembi attended from Walsall Council and presented details on the Fostering Friendly Scheme within Walsall. Ms Rowe advised that Walsall Council had become an accredited Fostering Friendly organisation and said that they were encouraging other public sectors to join the Scheme. Ms Bond reported that the Trust had updated the family friendly policy in March 23 to include additional supplementary guidance surrounding foster parents. She said she would work with Ms Rowe to encourage fostering within the Trust and support staff through the process. **Resolved: that the Fostering Friendly Discussion – Walsall Council be received and noted.**
526/23	**Minutes of Trust Management Committee held on 23 March 23**
	Prof Cannaby confirmed the minutes of the meeting held 23 March 2023 and approved them as an accurate record. **Resolved: The minutes of the last meeting held on 23 March 2023 were received and APPROVED.**
527/23	**Matters Arising and Action Log**
	Prof Cannaby received the action log and updates were noted as follows. **Action 627** – Mr Mirza to review and update the smoking cessation and smoking policy. **Ms Carroll confirmed that a draft smoking cessation and smoking policy was under completion.** This action was closed. **Action 643** – Ms Carroll to discuss with Ms Hickman and Ms Boden and provide data of vaccine uptake versus influenza admissions and compare with previous data recorded. **Ms Carroll confirmed that the data collated would be included in the upcoming 2023 Flu Campaign.** This action was closed. **Action 644** – Ms Carroll and Ms Griffiths to set up a focus group of staff refusing vaccination to explore motivation behind refusal. **Ms Carroll confirmed that the data collated would be included in the upcoming 2023 Flu Campaign.** This action was closed. **Resolved: The Action Log was reviewed, and updates received and noted.**
528/23	**Policies, procedures for approval and information**
	Ms Metcalfe provided a summary of the policies report and asked that the listed policies be reviewed and approved. 1. WHT-IP975 V3 Middle East Respiratory Syndrome (MERS-COV) Policy 2. WHT- CP931 V4 HIV Post Exposure Prophylaxis Policy 3. Genital Injuries in Children Trust Wide Guideline V4 (previously known as the Accidental genital injuries in children guideline)

	4. Emergency Marriage Trust wide sop V2 5. WHT-OP980 V6 Security Policy 6. WHT-OP979 V3 Management of External Agency Visits, Inspections, Accreditations and External Reports Policy **Resolved: that the above listed policies be received and APPROVED.**
529/23	**Director Of Nursing Report**
	Ms Carroll reported on the Trust's improved vacancy rate and advised that the Trust had ceased agency use across all Wards from 1 April 23 other than in exceptional circumstances. She reported the Trust's registered nurse vacancy position as 16WTE and said that this was a strong position for the Trust. Ms Carroll reported that the Trust would continue to focus on retaining staff through quality away days and continuing with the recruitment to the Legacy Mentor Programme. She encouraged staff to attend the Healthcare Support Worker event 22 May 23. Ms Carroll advised that the Trust had implemented new hybrid mattresses across wards and staff would monitor the effect of these on reported pressure ulcers. Ms Carroll reported that the Trust had launched the Quality Dashboard which reported from Floor to Board and had been shared with all Ward managers. She said this would allow the Trust visibility of data at all levels. **Resolved: that the Director of Nursing Report be received and noted.**
530/23	**Midwifery Service Report**
	Ms Wright advised that the Trust had reached 80% of the target to recruit 24 fellowship midwives for 2023 with the Trust having 18 midwives currently in post to help support the Maternity Department. Ms Wright reported that 75% of shifts within Maternity were fully staffed with 24% of shifts having a shortfall of 2 midwives. She said this shortfall had not impacted safety within the department and no incidents had been reported. She advised that the Trust had 1 Maternity Serious Incident following a maternal death of a patient from respiratory problems. She advised that the case had been referred to the Serious Incident Committee for information. **Resolved: that the Midwifery Service Report be received and noted.**
531/23	**Infection Prevention Report**
	Ms Carroll advised that blood culture contaminant rates had decreased following significant focus on training and education within the Emergency Department. She advised that work within the Trust was ongoing to continue to reduce blood culture contaminant rates with the business case for a 24/7 Phlebotomist ongoing. Ms Carroll reported 10 *C-Difficile* cases for March 23 which gave the Trust a total of 50 *C-Difficile* cases for 2022/23 against a trajectory of 27. Ms Carroll advised that the Trust had identified the time for taking samples as avoidable and the inappropriate use of antibiotics and they would continue to focus on these actions. Ms Carroll advised that the Trust had implemented several changes to improve antimicrobial prescribing and the lead antimicrobial pharmacist would continue with weekly ward rounds to focus on this. She reported that MicroGuide had been updated to reflect these changes. Ms Carroll reported that UK Health Security Agency (UKHSA) joined the Trust's Infection Prevention Committee meetings every month and the Trust had been assured around the actions being taken. She reported that Ms Virk and the Estates Team had begun work to deep clean the Modular Block with the old Acute Medical Unit to be used as decant for the deep clean to begin as this had been a long-outstanding action. Ms Carroll advised all staff to be vigilant around the appropriate cleaning of clinical areas. Ms Carroll advised the importance of reporting lateral flow results of patients being discharged to Nursing Homes as this was a legal requirement of the Trust. **Resolved: that the Infection Prevention Report be received and noted.**

532/23	**Learning from Deaths Update**
	Mr Mirza reported that the Trust's Summary Hospital-level Mortality Indicator (SHIMI) value was within the expected range and the Medical Examiner had reviewed 100% of all inpatient deaths. He reported that the Trust had 20 outstanding Structured Judgement Reviews and work with speciality leads continued to address those. Mr Mirza reported on the Trust's continued work with colleagues at The Royal Wolverhampton NHS Trust to look at how Same Day Emergency Care (SDEC) activity affected the Trusts SHIMI value. Mr Mirza advised of 16.5% of patient cases where ethnicity for Covid-19 positive deaths was undetermined. He said he would continue to work with the Medical Examiner and Bereavement Team to capture the data accurately. Mr Mirza advised that the quarterly Perinatal Mortality review report had demonstrated 5 themes for improvement which were now in progress and said it would take 6 months to embed the improvements within the Trust. He said a working group would continue to look at improving care provided to patients locally, aligned with the local Maternity Neonatal services with a thematic review to be presented at Mortality Surveillance Group in May 23. Ms Virk asked how the learning and recommendations from Learning Disability and Autistic People (LeDer) reviews was disseminated across the Trust. Mr Mirza advised that the LeDer lead for the Trust would share the learning at the Mortality Surveillance Group and this would subsequently be shared with the relevant Divisions. **Resolved: that the Learning from Deaths Update Report be received and noted.**
533/23	**7 Day Service Report**
	Mr Mirza reported on the 4-priority standards required of the Trust to meet the 7 day service standard, Consultant Review within 14 hours, Availability of Diagnostics, Consultant led interventions and Consultant review every 24 hours. Mr Mirza advised there had been improvement on previous audits across all divisions with Medicines and Long-Term Conditions and Women, Childrens and Clinical Support Services meeting the standard and the Trust's overall compliance was 91%. Mr Mirza reported on the ongoing alert of missing patient records and said temporary patient records continued to not be attached with the original patient record which resulted in serious patient safety concerns. He said that once the Electronic Patient Records system was in place this would resolve this concern. **Resolved: that the 7 Day Service Report be received and noted.**
534/23	**Divisional Quality and Governance Report – Medicines and Long-Term Conditions**
	Ms Joshi advised on the Trust's Emergency Access Standards and said the Trust had ranked as number 2 for ambulance handover times in the West Midlands in March 23. She noted this had been affected due to the move to the new Emergency Department building and staff adjusting to a new way of working. Ms Joshi advised that the Trust had maintained safe and effective response times for Duty of Candour and the Trust was at 80% for stage 1 Duty of Candour levels and had an 86% complaint response rate within agreed timeframes. Ms Joshi reported that Sepsis 6 compliance for paediatric patients attending the Emergency Department (ED) with sepsis had improved and following the relocation of the Paediatrics Assessment Unit into the new ED and there would be opportunity for closer working and collaboration between the ED and Paediatric Team. Ms Joshi advised that timely observations were below the Trusts 90% target and there had been a reduction from 86% to 84% in March 23. She said the Trust had a plan to improve timely observations working with care groups and the different clinical teams. She reported that fortnightly Medicine Management meetings continued following the Section 29A Medicines Management warning notice.

	She said improvements continued and there had been an increase in awareness of the actions required within the Division. Ms Joshi reported that the Trust had submitted a Venous Thromboembolism (VTE) improvement programme action plan to acquire the right data to help improve VTE performance. She said work within the improvement programme also continued focusing on *C-Difficile* cases within the Division and new guidance had been shared following lead care group meetings. Prof Cannaby asked how staff had settled into the new Emergency Department (ED) Building. Ms Joshi advised that staff had settled well and were achieving good results. She said that signage within the ED to Pharmacy was not yet in place and Ms Longden was working to rectify this. **Resolved: that the Divisional Quality and Governance Report – Medicines and Long-Term Conditions be received and noted.**
535/23	**Divisional Quality and Governance Report – Community Services**
	Ms Geffen reported that the Community Division had gaps in Mortality Reporting and the Division would continue to carry out audits and oversight to monitor and report though clinical effectiveness and patient safety to mirror other divisions within the Trust. Ms Geffen advised that the Trust had attended the Safeguarding Executive Partnership Board in March 23 to present the Trust's Health Visiting and Prioritisation Plan positive feedback had been received. Ms Geffen advised that medicines management within the Division had commenced with standard monthly meetings to provide assurance and oversight and no concerns had been raised. She reported that overall mandatory training within the division remained over 95%. Ms Geffen highlighted that the Trust had 5 active Virtual Wards with capacity available, and utilisation remaining relatively low and the Trust would continue to encourage use of the Wards. Mr Jackson reported that current utilisation of the Virtual Wards was 35-40% of available Virtual Ward beds and work would continue to engage with acute wards to help achieve the 70% mandated target by September 23. **Resolved: that the Divisional Quality and Governance Report – Community Services be received and noted.**
536/23	**Divisional Quality and Governance Report – Surgery**
	Mr Goude advised that 14 patients had breached 104 days in cancer waiting times and all cases had been reviewed by the lead cancer nurse. He reported on consistent themes which included wait for oncology appointments, histology delays and waiting for biopsies and first treatment. He said that the Trust had appointed oncology specialist nurses to manage the backlog. Mr Goude reported that Duty of Candour compliance was 88% and the complaint response rate was 73% within agreed timeframes. He advised that the Trust had dealt with a rise in complaints over December 22 and January 23 and work was ongoing to review complaint management to decrease complaints to informal concerns. Mr Goude advised that there had been no serious incidents within the Division of Surgery since November 22. He said that Venous Thromboembolism (VTE) data had improved and was recorded at 91% and work continued to meet the 95% target. Mr Goude thanked his colleagues across the Trust for their support and hard work during the junior doctor strikes. Mr Mirza advised that the Division of Surgery had 15 guidelines within intensive care and 6 guidelines in anaesthetics that required updates. He asked Mr Goude to provide a position slide on this within the next report to TMC. **ACTION: Mr Goude to provide a position slide on guidelines within the Division of Surgery.** **Resolved: that the Divisional Quality and Governance Report – Surgery be received and noted.**
537/23	**Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services**

	Mr Ncube highlighted that complaint compliance within the division remained at 100% within agreed timeframes. Mr Ncube reported that the Trust had launched the Single Pregnancy Record (SPR) on 22 March 23 which would enable patients to have a seamless record wherever they are booked with other Trusts who are part of the SPR. Mr Ncube advised that phase 2 of the Ockenden Business Case had been approved with some sections still requiring completion. Mr Ncube reported that the Division continued monthly meetings with the Pharmacy team surrounding medicine management and compliance. He advised that the Paediatric Assessment Unit (PAU) had relocated on 26 April 23 to the new Emergency Department building and thanked his colleagues for supporting the Division with the relocation. Mr Ncube advised on the discontinuation of the Andrology service from Black Country Pathology Services (BCPS) and said that that Birmingham Women and Childrens Hospital would offer the service moving forward. He said the Trust would inform the Integrated Care Board (ICB) of this change. Mr Ncube reported that the Human Tissue Authority (HTA) would be conducting an inspection on 19 June 23 to ensure the Trust was compliant with the relevant legislation and codes of practice. Mr Hobbs asked that the Division of Surgery and Division of Women's, Children's and Support Services provide assurance of the preparations underway for the Surgery in Children Peer Review scheduled for June 23. **ACTION: Division of Surgery and Division of Women's, Children's and Support Services to provide assurance of preparations underway for the Surgery in Children Peer Review scheduled for June 23.** **Resolved: that the Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services be received and noted.**
538/23	**Integrated Performance and Quality Report**
	Resolved: that the Integrated Performance and Quality Report be received and noted.
539/23	**Trust Financial Position - Month 12**
	Mr Morris advised that the month 12 financial position report was draft and pre audit and the Trust would be submitting final accounts 27 April 23. He said the Trust had delivered a pre-audit surplus of £0.049M for the year end 2022/23. Mr Morris reported that the Trust had achieved a capital break even position £18K below the capital resource limit of £42.3M. He said the break-even position had been delivered through balance sheets, support from commissioners and several technical adjustments. **Resolved: that the Trust Financial Position – Month 12 be received and noted.**
540/23	**Contracting and Business Development Update – Verbal**
	Mr Morris reported that discussions were ongoing with regional and national regulators following the Trust's initial submission at the end of March 23 and advised that the Trust would be re-submitting on 4 May 23. Mr Hobbs advised that the financial outlook for 2023/24 would be extremely challenging and that the Trust would struggle to reach a break-even position for 2023/24. He advised that the Trust needed to focus on utilising resources that it already had and how these resources could be utilised better. He said senior leaders within clinical and non-clinical operational divisions needed be sighted on providing services that were as effective and as productive as other Trusts – targeting upper quartile performance on operational productivity metrics, as the bulk of the expenditure sat within these divisions. **Resolved: that the Contracting and Business Development Update – Verbal be received and noted.**

541/23	**Walsall Together**
	Mr Botfield advised that progress had been made with setting smart objectives for the Transformation Programme and the Clinical Professional Leadership Group (CPLG) for 2023/24. He said these would be set for all projects and used to evaluate progress and provide assurance as part of the outcomes framework. Mr Botfield reported that a Service Development Improvement Plan (SDIP) was under draft for Walsall Healthcare NHS Trust community services with work continuing to embed the contract agreement for 2024/25. **Resolved: that the Walsall Together report be received and noted.**
542/23	**PLACE Scores**
	Ms Ibbs-George reported on the Patient Led Assessment of Care Environment (PLACE) scores the Trust had received following the PLACE assessment undertaken by the Trust in November and December 22. Ms Ibbs-George advised that the Trust had maintained the same results and had been rated as 6 on the domain as the process had been paused for 2 years during the Covid-19 pandemic. She said that the assessment tool had looked at cleanliness, food and hydration, privacy, dignity and well-being, condition, appearance and maintenance, dementia and disability. She reported that the assessment had been carried out prior to the move of the new Emergency Department and Acute Medical Unit and said the Environment Group would begin developing an action plan of what was required for the Trust to be in a better position for the next assessment. **ACTION: Ms Ibbs-George to provide a PLACE light assessment in 6 months and update Trust Management Committee of the results at the Trust Management Committee Meeting 26 October 23.** **Resolved: that the PLACE Scores report be received and noted.**
543/23	**Workforce Summary**
	Ms Bond reported that following discussions at the Workforce and Organisational Development Committee in March 23, the Trust had changed its' Key Performance Indicators (KPI) for sickness absence for Walsall Healthcare NHS Trust from a target of 4.5% to a target of 5%. She advised that the Primary Retention KPI had been changed from 24 months to 12 months which had been due to staff leaving the Trust between 12-14 months. **Resolved: that the Workforce Summary Report be received and noted.**
544/23	**Learning Management System**
	Ms Bond reported on the progress of the new Learning Management System portal with preparations underway to launch on 15 May 23. She said the system would allow staff access to all mandatory and statutory training from one platform. She advised that any training completed by staff before the launch of the new system would be captured and the data implemented into the new system once operational. **Resolved: that the Learning Management System Report be received and noted.**
545/23	**Business Case (All Business Cases reviewed by Investment Group during December 22, March 23 and April 23).**
	Ms Salmon asked that the business cases be received for information and said that these had been approved in principle by the Investment Group meetings in December 22, January 23 and March 23 meetings and were subject to final financial agreement. Ms Salmon reported that the business cases had been through prioritisation exercises and had been grouped into the relevant high, medium and low priority group. She encouraged divisional leads to continue with the submission of business cases in the upcoming financial year 2023/24. **Resolved: that the Business Cases reviewed by Investment Group be received and noted.**
546/23	**ICS Development**
	Ms Salmon advised that the report had been written by the Integrated Care Services (ICS) and would be submitted for approval by the Integrated Care Board (ICB). She said that the report implemented the national mandated structure for the ICB, Provider Collaboratives and Place Based Partnerships within the Black Country. **Resolved: that the ICS Development report be received and noted.**

547/23	**Quarterly Pharmacy and Medicines Optimisation Pharmacy**
	Mr Mirza reported on the weekly audits for medicines management and prescribing quality and said that feedback continued to be shared with the relevant divisions. He said the Trust had responded to the Care Quality Commission (CQC) following the Trusts Section 29A Warning Notice. Mr Mirza advised that electronic drug storage units were in operation within Wards 16, 17 and the Urgent Emergency Care Centre. He said that further electronic drug storage units had been purchased for refurbs on Ward 5/6, 14/15, Maternity and Ward 24/25. Mr Mirza reported that a Home Office inspection visit on Controlled Drugs Management had been scheduled for May 23 and all pre-visit documents had been completed and submitted. Mr Mirza advised that following a group project in the Emergency Department the Trust had identified and introduced the Eight Rights of Medication Administration and said that prompt cards had been issued to all divisions to disseminate to drug prescribing colleagues. **Resolved: that the Quarterly and Medicines Optimisation Pharmacy report be received and noted.**
548/23	**Research and Development**
	Ms Boyle advised on the Trust's Strategy Development Day planned for 4 May 23 and said work would continue to develop a 3-5 year plan for Research and Development that was aligned to the Joint Trust Strategy. Ms Boyle reported that the Trust was looking to appoint Research Fellows in collaboration with pharmaceutical companies and had approved to appoint 5 joint Professors in Nursing, Midwifery and Allied Health Professionals in 2022 with joint funding being confirmed from University of Wolverhampton and Birmingham City University. Ms Boyle reported that the Trust had received a letter from Ms Chappell, Chief Executive of the National Institute for Health Research (NIHR), asking Trusts to prioritise commercial research as this had decreased in activity following the Covid-19 pandemic. Ms Boyle advised that there had been delays with aseptic support in oncology which would impact the clinical trials available to offer to patients under the research cancer portfolio. **Resolved: that the Research and Development report be received and noted.**
549/23	**Digital Including Digital Improvement**
	Mr Pearson advised that the Trust was implementing a Group Lead for health records across Walsall Healthcare NHS Trust (WHT) and the Royal Wolverhampton Trust (RWT). He said this would strengthen the Health Records team and help prioritise the actions that had been identified within the service review. Mr Pearson reported that the Trust would continue the rollout of the Electronic Document Management Solution from 1 May 23 which would enable the process for the Trust to cease the use of paper patient notes. He said the Trust had raised an order for a new Health Records Library to provide a better working environment for staff with improved modern facilities. Mr Pearson advised that the Trust had successfully procured through national capital in 2022/23 the new Patient Engagement Portal system. He said the Trust had applied for additional revenue funding that had been made available to support the implementation of the system. Mr Pearson reported that the system would allow patients to access their correspondence electronically and provide the Trust with cost saving initiatives with the reduction in postage. Mr Pearson reported that Graphnet One Health Care System went live within the Trust on 19 April 23. He said the system included data from over 250 GP practices and acute activity from RWT and WHT. Mr Pearson advised that advised that multi factor authentication had been mandated for all staff across WHT using Virtual Private Network (VPN) connection. He said the Trust continued to work on implementing multi factor authentication for nhs.net email accounts and this had been nationally

	mandated to improve cyber security and make it more difficult for cyber threat actors to gain access to systems. Mr Pearson reported that immediate technical response and recovery work had been completed following the recent cyber incident the Trust had incurred. He said additional audits would continue to gather additional assurance for the Trust with action plans formed from data received through the audit process. He said the Trust continued to work closely with the Information Governance Team on the data investigation phase following the incident. Prof Cannaby thanked Mr Pearson and his colleagues for their hard work and support following the cyber security incident. **Resolved: that the Digital Including Digital Improvement report be received and noted.**
550/23	**Corporate Risk Register/ Board Assurance Framework Heat Map**
	Ms Long advised that Board Assurance Framework (BAF) improvements were continuing and meetings had been scheduled with individual BAF owners to review improvements. **Resolved: that the Corporate Risk Register/ Board Assurance Framework Heat Map be received and noted.**
551/23	**Any Other Business**
	Prof Cannaby confirmed that no other business was raised.
552/23	**Date of next meeting**
	Thursday, 25 May 2023 – 09.00-11.00