Bundle Trust Board Meeting to be held in Public 13 December 2023

7.1.1 10:21 - Pack B: Research and Education (Reading Room)
Enc 7.1.1 Research Development - Nov 23
7.4.1 10:36 - Pack B: Improvement and Research Group - Appendices
Enc 7.4.1 Appendix 1 - QI Board action plan and NHS Impact
Enc 7.4.1 Appendix 2 - Improvement & Research Group ToR updated 27-11-23
8.1.1 10:41 - Pack B: Board Level Metrics Datapack
Enc 8.1.1 PACK B Exception Pages Collaboration
9.1.1 10:51 - Pack B: Board Level Metrics
Enc 9.1.1 PACK B Exception Pages Communities
9.3.1 11:01 - Pack B: Operational Performance Pack (Reading Room)
Enc 9.3.1 Appendix Grp Dir Place Operational Performance Pack November 2023
10.2 11:21 - Pack B: Board Metrics Datapack
Enc 10.2 PACK B Exception Pages Care
Enc 10.2 PACK B Finance Slides Care
10.3.1 11:26 - Pack B: Month 7 Finance Report
Enc 10.3.1 Group CFO Report Public Board Dec 23
10.4.1 11:31 - Pack B: Black Country ICB Letter
Enc 10.4.1 Board Embedded Doc Dec 23
10.4.2 11:31 - Pack B: Infection Prevention and Control
Enc 10.4.2 IPC monthly report - Oct 23 FINAL
10.4.2 Winter training
10.4.3 11:31 - Pack B: Safeguarding Report
Enc 10.4.3 Q2 Safeguarding Report
10.4.4 11:31 - Pack B: SPARC
Enc 10.4.4 SPaRC Annual Report 22-23 v2
10.5.1 11:36 - Pack B: Final Maternity Peer Review Report
Enc 10.5.1 Final Maternity Peer Review Report WHT
10.6.1 11:41 - Pack B: Pharmacy and Medicines Optimisation
Enc 10.6.1 Chief Pharmacist Report Dec 23 - READING ROOM
10.6.2 11:41 - Pack B: Safe, High Quality Care Report
Enc 10.6.2 SHQC Report Dec 23 - READING ROOM
10.6.3 11:41 - Pack B: Clinical Fellowship Training Programme
Enc 10.6.3 Clinical Fellowship Annual Report Dec 23 - READING ROOM
10.8.1 11:51 - Pack B: Covid 19 National Inquiry
Enc 10.8.1 - Covid-19 National Inquiry
10.8.2 11:51 - Pack B: Annual Health & Safety Report 2022/23
Enc 10.8.2 APPROVED WHT Health and Safety Annual Report Front Sheet 2023-23 for Public Trust Board
Enc 10.8.2 APPROVED WHT HS Annual Report 2022-23 for Public Trust Board 13.12.2023
10.8.3 11:51 - Pack B: Patient Safety Incident Response Framework (PSIRF) Policy
Enc 10.8.3 WHT-OP1008 V1 Patient Safety Incident Response Plan
Enc 10.8.3 WHT-OP1008 V1 Patient Safety Incident Response Policy only
10.9.1 11:56 - Pack B: Estates Strategy
Enc 10.9.1 Estates Strategy Trust Board November 2023
10.10.1 12:01 - Pack B: EPRR Assurance 2023 Action Plan
Enc 10.10.1 EPRR Assurance 2023 Action Plan v3
11.1.1 12:06 - Pack B: Board Level Metrics Datapack
Enc 11.1.1 PACK B Exception Pages Colleagues
11.2.1 12:11 - Pack B: Workforce Metrics
Enc 11.2.1 Board Workforce Metrics Report
15.1 12:21 - Pack B: Finance and Productivity Committee

Enc 15.1 Finance and Productivity Committee (Extraordinary) Meeting Minutes September 2023 APPROVED AT COMMITTEE

3. MINUTES Finance and Productivity Committee October KG PA

Finance and Productivity Committee Meeting Minutes September 2023 APPROVED AT COMMITTEE

15.2 12:21 - Pack B: Quality Committee

Lead: Lisa Carroll, Director of Nursing & Dr Manjeet Shehmar, Chief Medical Officer Annual Report - April 2023

Enc 15.2 QC Minutes - September 2023 v3 JP - Group Approved

15.3 12:21 - Pack B: People Committee

Enc 15.3 Minutes - PODC, September 2023 - Approved

Enc 15.3 People Committee October 2023 - Approved Minutes

15.4 12:21 - Pack B: Trust Management Committee

Enc 15.4 Approved - October 2023 TMC Minutes

Enc 15.4 Approved September TMC Minutes

Paper for Trust Board Meeting to be held in Public 13 December 2023		
Title of Report:	Research & Development Report	Enc No:
Author:	Catherine Dexter	
Presenter/Exec Lead:	Pauline Boyle	

Action Required of the Committee

Decision	Approval	Discussion	Other
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐

Recommendations:

This report is for information and assurance to the Trust Board Meeting to be held in Public.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None associated with this paper		
Resource Implications:	None associated with this paper		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☒No☐	Details: Research to improve health and care
	Life Sciences Vision	Yes☒No☐	Details: Research to address the Country's health, wealth, and resilience
CQC Domains	Well-led		
Equality and Diversity Impact	None associated with this paper		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • Constant growth of Commercial research within the Trust, meeting the target set following the Lord O'Shaughnessy recommendation of doubling the number of commercial recruits. • Initial local analysis indicates that we are recruiting participants who reflect the population we serve although greater analysis is required. This work will be presented to the Clinical Research Network (CRN) to inform the wider Equality, Diversity and Inclusion work regionally. • Research was well represented at the recent Black Country Provider Collaborative Clinical Summit.
Advise. • The Compton Care (Palliative Care) Hybrid post will cease in December. Fundings not available to support the continuation of the post due to the lack of Palliative Care studies on the national portfolio. Conversations are ongoing to develop locally designed studies. • Aseptic pharmacy support for research studies currently on hold, working in collaboration with the Interim Director of Pharmacy to rectify this issue, non-aseptic pharmacy support has been rectified. • Additional resource is required to support our workforce to complete their own research. By pooling resource across the Black Country, we will become more efficient in support our staff. • We need to exploit the unique position we are in within the Black Country to promote the diverse and stable population we serve, to secure more research opportunities for our population to access trials, particularly commercial trials which offer our population access to new novel treatments. As part of Research's KPI one of the team is looking at Equality, Diversity and Inclusion into Research across Walsall. The KPI's also reflect: The patients experience, Feasibility/Commercial, Research within the Community Links, Patient experiences, Communication, Identifying new departments, Patient Safety, and training and Education. • Future finance reports will include drug cost savings as well as system wide savings due to less activity. Currently liaising with RHT to develop a parallel system. Please note this may take a couple of months to implement fully. • Successful in obtaining additional funding from the CRN to continue with the Hybrid Research Midwife post. This post has been extremely successful with excellent recruitment into non-commercial studies. The commercial portfolio in midwifery is very limited. • We have been approached by Wolverhampton University about a potential joint Associate Professor of Pharmacy post. • A follow-on meeting has been arranged for 15 November with Aston University to explore potential projects to take forward following our second collaboration meeting.
Alert • Sickness within the Governance team is impacting on the set up of studies, currently supported by the R&D Manager and Clinical Trials administrator. Have requested support from RWT.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • 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 overall staff engagement
Improve the Healthcare of our Communities	• Develop a health inequality strategy
Effective Collaboration	• Improve population health outcomes through provider collaborative • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Research & Development Report

Report to Trust Board Meeting to be held in Public – 13 December 2023

EXECUTIVE SUMMARY

This report is to inform the Trust Board of research activities at Walsall Healthcare NHS Trust.

The information provided will focus on:

- Number of Studies open, in Set up and in the Pipeline for October (Appendix 1-Graph 1)
- Number of Home-Grown Studies (Summary)
- Recruitment by Specialty (counted to the end of August) (Appendix 2-Table1)
- Recruitment over the previous 5 years (Appendix 3-Graph 2)
- Research Financial update -Commercial Income (As from April 2023)- (Appendix 4) Table 1, 2)
- Research Financial update - Non-Commercial (Cost savings to the NHS)- (Appendix 5)
- Research current investment into service support departments to support research activity (Appendix 6) Table 1
- Research publications 2022-23 (West Midland Repository) Appendix 7, Table1
- Appendix 8, Table 2- Main Journals used for publication at Walsall Healthcare NHS Trust

BACKGROUND INFORMATION & ADDITIONAL INFORMATION

- AZ Track study-Walsall best on a global level, and no other country is close to Walsall's achievements, 1st site in Europe to recruit into this study. PI Dr Rumi Jaumdally & Dr Huda Mahmoud (lead on the study) supported by Ben Jones- Clinical Research practitioner and Jessica Kane -Nursing Associate instrumental in recruiting and data entry and management.
- The CRN awards take place on the 30th of November. (Nominated for team and Governance award)
- Participant Research Celebration Event taking place on the 28th of November in Walsall's Learning Centre 2-5pm

RECOMMENDATIONS

There are no specific recommendations relating to approvals or decisions the report relates to information only on research activity.

Appendix 1

Graph 1-Reflects the number of studies open, in set up and in the pipeline for November

Number of Studies

	Open	Set Up	Pipeline
Number of Studies	23	10	9

Study Startup	Commercial	Non-commercial
Number of sites opened this financial year	0	9
Sites with first recruit in this financial year (even if opened in previous years)	1	6

Number of home-grown Studies

A sharp increase in staff contacting R&D regarding advice and support on ethics application, writing research proposal's, accessing data, requesting R&D approval. Since the 1st of November R&D have received 11 requests for support.

Appendix 2: Table 1 – Recruitment by Speciality

Recruitment by Specialty (counted to end of October)

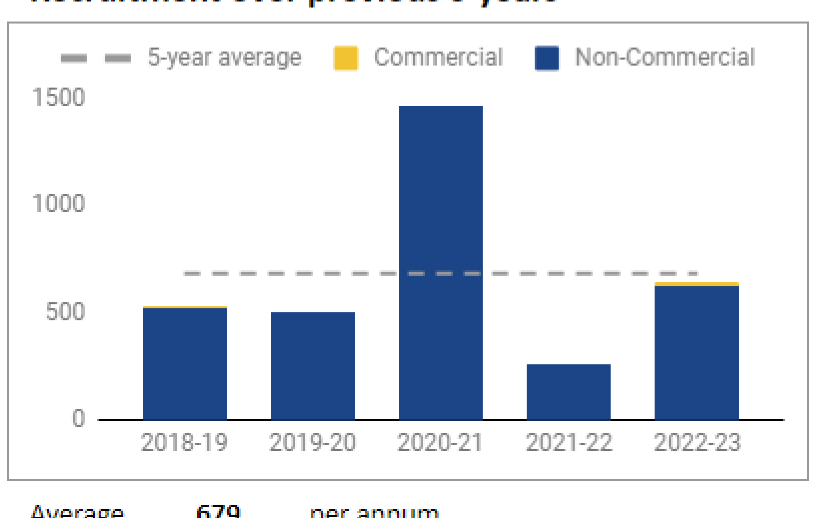
	Pro rata to end of month 7			2023-24 compared with	
	2018-19	5yr avg.	2023-24	2018-19	5yr avg.
Ageing	0	0	**0**		
Anaesthesia, Perioperative Medicine and Pain Management	0	3	**0**		-100%
Cancer	46	11	**9**	-80%	-18%
Cardiovascular Disease	0	6	**9**		50%
Children	36	8	**0**	-100%	-100%
Critical Care	0	6	**0**		-100%
Dementias and Neurodegeneration	0	0	**0**		
Dermatology	2	4	**21**	800%	425%
Diabetes	11	3	**2**	-81%	-33%

Ear, Nose and Throat	32	6	**0**	-100%	-100%
Gastroenterology	0	0	**0**		
Genetics	16	3	**0**	-100%	-100%
Haematology	0	0	**0**		
Health Services Research	87	17	**4**	-95%	-76%
Hepatology	0	0	**0**		
Infection	9	202	**0**	-100%	-100%
Mental Health	0	23	**0**		-100%
Metabolic and Endocrine Disorders	0	0	**0**		
Musculoskeletal Disorders	0	0	**14**		
Neurological Disorders	0	0	**0**		
Ophthalmology	0	0	**0**		
Oral and Dental Health	0	0	**0**		
Primary Care	1	0	**0**	-100%	
Public Health	0	0	**0**		
Renal Disorders	1	1	**16**	2643%	1500%
Reproductive Health and Childbirth	52	72	**34**	-35%	-53%
Respiratory Disorders	12	2	**3**	-76%	50%
Stroke	4	0	**0**	-100%	
Surgery	0	0	**0**		
Trauma and Emergency Care	0	19	**0**		-100%

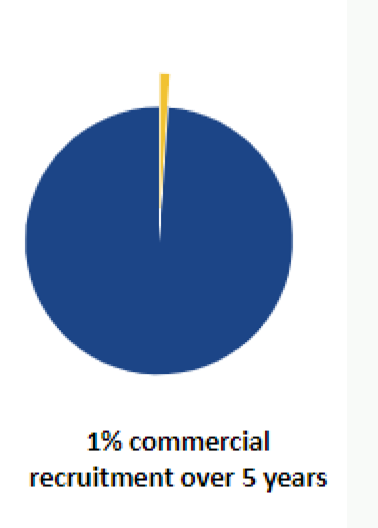
Table 1. Shows potential growth areas within the Trust, we know that some areas will have little research Nationally due to factors which are out of the control of the Trust or Walsall is a satellite service. We are currently scoping services to see where opportunities may lie. 1ST Rheumatology study.

Appendix 3: Graph 2- Recruitment over the previous 5 years

Recruitment over previous 5 years

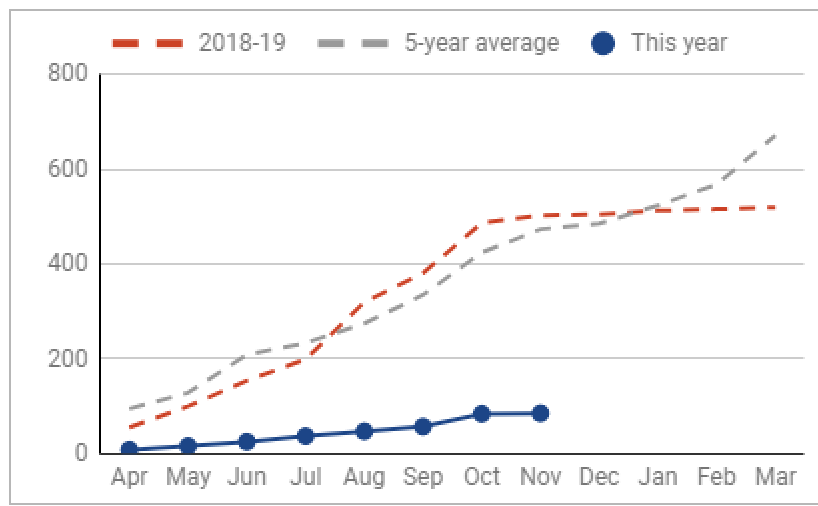


Average **679** per annum



1% commercial recruitment over 5 years

2023-24 Non-commercial **85 recruits**



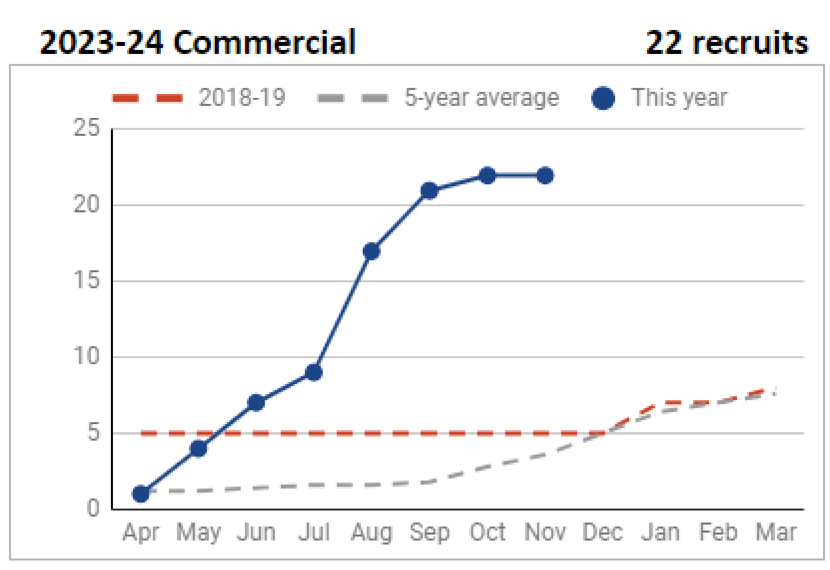
21% commercial recruitment so far this year

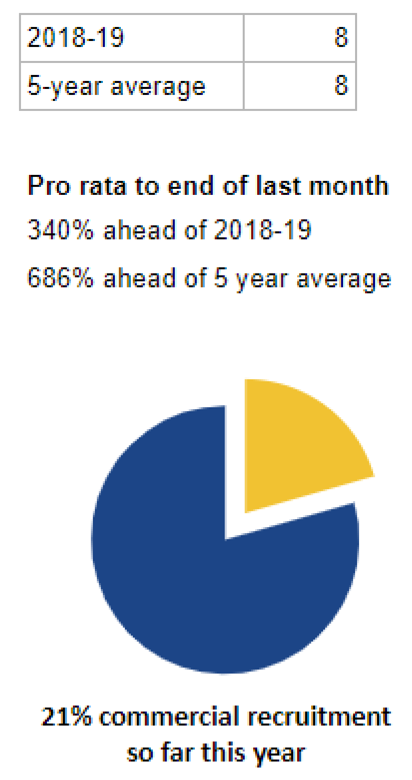
2018-19	520
5-year average	672

Pro rata to end of last month

83% behind 2018-19

80% behind 5 year average





Appendix 4 Commercial Research Financial update

Table 1 - Commercial Income for active studies

DIVISION	Specialty	CURRENT TRIAL	RECRUITS TO DATE	AVG. INCOME PER RECRUIT	TOTAL
Medicine	Cardiovascular	**AstraZeneca total (AZ TRACK)**	25	£1,226.77	£28,215.71
		Labs/Pharmacy/Imaging		n/a	£0
Medicine	Dermatology	**AD-REAL (OBSERV)**	10	£4,598.00	£32,186.00
		Labs/Pharmacy/imaging		n/a	£0
Medicine	Cancer	**KEYNOTE 905EV-303 total**	0	£5,803.00	£0
		Labs/Pharmacy/Imaging		tbc	£0
Medicine	Dermatology	**Delta Teen total**	2	£4,050	£8,100.00
		Labs		£191	£382.00
		Pharmacy		£1,755.5	£3,511.00
		Imaging		n/a	£0
Medicine	Dermatology	**Victor-MK-1242-0345 total**	3	£11,242.65	£33.727.95
		Labs		£157.19	£314.39
		Pharmacy		£1,477.8	£2,955.60
		Imaging		n/a	£0
Medicine	Tissue Viability/Diabetics	**BISIL**	0	£2,085.21	£0

		Labs/Pharmacy/Imaging		n/a	£0

Footnote: please note-this table refers to the income stages across multiple financial years,

Table 2 – Pending Commercial Income expected to be received.

DIVISION	Speciality	PENDING TRIAL	PREDICTED RECRUITMENT 23/24	AVE.INCOME PER RECRUIT	PREDICTED TOTAL 23/24
Surgery	Orthopaedics	**GORE**	10-15	£2,111.21	
		Labs/Pharmacy/Imaging			
Medicine	Dermatology	**Vitiligo**	3	£12,194.21	
		Labs/Pharmacy/Imaging			
Medicine	Cardiovascular	**MK-0616-01**	20	TBC	
		Labs/Pharmacy/Imaging			
Medicine	Dermatology	**LP0145-2240**	5	£11,251.98	
		Labs/Pharmacy/Imaging			
Medicine	Dermatology	**IST-07**	2	£9,373.49	
		Labs/Pharmacy/Imaging			
Medicine	Dermatology	**TRAPEDS 2**	TBC	TBC	
		Labs/Pharmacy/Imaging			
Medicine	Renal	**FINE-ONE**		£3,957.21	
		Labs/Pharmacy/Imaging			

Appendix 5- Non-Commercial Income -expected to be received.

Division	Speciality	Study (Opened)	Finance associated with this study	Target	Recruited	Actual	Predicted
Medicine	Dermatology	A-Star	£224 per patient, plus after Year 1, each visit (every 3-6 months) £35.00	20	11	£2,464 (excludes income post year 1)	£4,480 (excludes income post year 1)
Medicine	Dermatology	Badbir	£120 per patient, £30 per follow up (1-3 yr)	1-2 per month	21	£2,520 (excludes follow up)	£2,520
Surgery	O&T	PASHiON	£400 per patient plus non reported CT-Scan	2	1	£400	£800
Medicine	Respiratory	MucACT COPD	£2,400-includes pharmacy set up, archiving, Participation Identification Centre (PIC), R&D set up. **Extra per participant**	10	1	£2,647.24	£4,872.4

			£100-Randomisation £94-Follow up LAB-£46.27 Sputum kits-£6.97 Per pt £247.24				
Surgery	O&T	RACIER Hip	Per Patient payments -£779, plus one-off payment for SIV & R&D set up £1,631.80	25	7	£7,084.8	£21,106.8
Surgery	O&T	RACIER Knee	Per Patient payments-£829, plus R&D set up £500	25	7	£6,303	£21,225
Surgery		Sapphire	£4.00 per patient	(no target as agreed with sponsor)	61	£244	£244
Women's & Childrens		SNAP	£33.00 per patient	1-3 per month	9	£297	£297
Medicine		Easy-AS	£300.00	5	1	£300	£1,500
Medicine		Sphere	£120.00	(no target as agreed with sponsor)	16	£1,920	£1,920
Medicine		VENUS 6	Per Patient payments-£469.00. Other-Archiving £500 Nurse travel- £22.20	(no target as agreed with sponsor)	7	£3,805.2	£3,805.2
Total						£27,985	£62,770.4

Appendix 6- Current investment into service support department to support research activity.

Table 1

Support service	Band	WTE
Pharmacy (technician support)	5	1
Radiology	7	0.2
Labs	4	0.8

R&D also have the support of a named pharmacist who is instrumental in signing off research related documents as supported by the Director of Pharmacy .

Appendix 7.

Table 1- Research Activity -Walsall Healthcare NHS Trust -Publications 2022-23

West Midlands Evidence Repository
Research Activity by Trust Department

Department	Count
Paediatrics	13
Obstetrics and Gynaecology	3
Imaging	9
Genito-Urinary	3
Urology	4
Pathology	28
Corporate	3
Trauma and Orthopaedics	22
Operating Theatres	1
Oncology/Cancer Services	1
General Surgery	18
Ear, Nose and Throat	4
Anaesthetics	6
Nephrology	2
General Medicine	1
Gastroenterology	3
Endocrinology and Diabetes	3
Elderly Care	5
Dermatology	36
Cardiology	3
Accident and Emergency	4
Education	4
Psychology	1
Palliative Care	1

0 5 10 15 20 25 30 35 40

New publication: Dr Amy Boswell has co-authored an article titled 'Clinical emergencies in inpatient hospice: simulation-based training to improve nursing confidence' that has recently been published in the BMJ Supportive & Palliative Care!
You can find it here: ['Clinical emergencies in inpatient hospice: simulation-based training to improve nursing confidence' (bmj.com)](),

Appendix 8: Table 2: Main Journals used for publication.

Number of publications	Journal title
25	Clinical and Experimental Dermatology
20	Cureus
7	International Journal of Clinical Practice
6	Radiography
5	Cardiovascular Endocrinology & Metabolism
5	The British journal of dermatology
4	British Journal of Nursing
4	Journal of Diabetes Science and Technology
3	Bone & Joint Open
3	British Dental Journal

2	Acta paediatrica (Oslo, Norway : 1992)
2	Acta Paediatrica: Nurturing the Child
2	Advances in medical education and practice
2	American journal of ophthalmology
2	Archives of Disease in Childhood
2	BJPsych Open
2	BMJ Case Reports
2	Burns
2	Clinical Medicine
2	The journal of knee surgery
2	The Journal of Laryngology and Otology
1	Annals of cardiac anaesthesia
1	Annals of Clinical Biochemistry
1	Annals of surgery open: perspectives of surgical history, education, and clinical approaches
1	Applied Neuropsychology: Adult
1	Avicenna journal of medical biotechnology
1	BJA Open
1	BMJ Open
1	BMJ Open Gastroenterology
1	British journal of cancer
1	British Journal of Community Nursing
1	British Journal of Dermatology
1	British journal of hospital medicine (London, England: 2005)
1	British Medical Journal (BMJ)
1	Clinical Chimica Acta; International Journal of Clinical Chemistry
1	Clinical case Reports
1	Clinical Paediatrics
1	Cochrane Database of Systematic Reviews
1	Cornea
1	Current Problems in Cardiology
1	Dermatologic Surgery
1	Diabetes Research and Clinical Practice
1	Diabetes therapy: research, treatment and education of diabetes and related disorders
1	Diabetic medicine: a journal of the British Diabetic Association
1	Endocrine Connections
1	Endocrinology, diabetes & metabolism
1	Endocrinology, diabetes & metabolism case reports
1	European Journal of Neurology
1	European Journal of Ophthalmology
1	Experimental and Clinical Endocrinology and Diabetes
1	Future healthcare journal
1	Health policy (Amsterdam, Netherlands)
1	Indian Journal of Anaesthesia
1	Indian Journal of Tuberculosis
1	Indian paediatrics
1	International emergency nursing

1	International journal of stroke : official journal of the International Stroke Society
1	International ophthalmology
1	Irish Journal of Medical Science
1	Journal of bone and joint surgery
1	Journal of computer assisted tomography
1	Journal of endourology
1	Journal of family medicine and primary care
1	Journal of Global Health
1	Journal of Investigative Dermatology
1	Journal of Minimally Invasive Gynaecology
1	Journal of orthopaedics and traumatology: official journal of the Italian Society of Orthopaedics and Traumatology
1	Journal of Plastic, Reconstructive and Aesthetic Surgery
1	Journal of the American Academy of Orthopaedic Surgeons. Global research & reviews
1	Neurourology and urodynamics
1	Nursing open
1	Ocular Immunology and Inflammation
1	Paediatrics and neonatology
1	Photo dermatology, Photo immunology & Photomedicine
1	Phytotherapy Research
1	PLoS One
1	Primary care diabetes
1	Radiology Case Reports
1	Renal failure
1	Saudi Journal of Anaesthesia
1	Saudi journal of ophthalmology: official journal of the Saudi Ophthalmological Society
1	Sexually transmitted infections
1	Sultan Qaboos University medical journal
1	Surgical Endoscopy
1	The American Surgeon
1	The British Journal of Surgery
1	The Cochrane Database of Systematic Reviews
1	The journal of obstetrics and gynaecology research
1	The Knee
1	The Medico-legal journal
1	The Primary Care Companion for CNS Disorders
1	The World Journal of Men's Health
1	Urology Annals
1	World Journal of Methodology
1	World journal of orthopaedics

Q. Data: NHS Impact Self-assessment Levels across 22 Categories from National Survey

Q.	Category	1 Starting	2 Developing	3 Progressing	4 Spreading	5 Improving & Sustaining	WHT
	Building a Shared purpose and Vision					Average score	2.5
7	Board and executives setting the vision and shared purpose	Starting: We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.	Developing: Our board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Progressing: Our board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (e.g. Operations, Quality, Financial and People / workforce).	Spreading: Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.	Improving & sustaining: Our vision and shared purpose is well embedded and often referred to by the board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.	3
8	Improvement work aligned to organisational priorities	Starting: Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.	Developing: Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.	Progressing: Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	Spreading: Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Improving & sustaining: Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.	3
9	Co-design and collaborate - celebrate and share successes	Starting: We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.	Developing: The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Progressing: Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.	Spreading: We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Improving & sustaining: Our leaders and managers model collaborative working as part of the organisation's continuous improvement approac h. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.	3
10	Lived experience driving this work	Starting: There is an aspiration or stated commitment to engage patients, carers, staff and public in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.	Developing: Patients, carers, staff and public are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities.	Progressing: Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Spreading: Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.	Improving & sustaining: Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at board level, including setting the strategic direction of the organisation and wider system.	1

	Category	1 Starting	2 Developing	3 Progressing	4 Spreading	5 Improving & Sustaining	WHT
	Investing in People and Culture					**Average score**	**2.25**
11	Pay attention to the culture of improvement	Starting: There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.	Developing: Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement.	Progressing: Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of patient care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	Spreading: Leaders and managers at all levels understanding their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are 'walking the floor' (e.g., during 'go & see' visits).	Improving & sustaining: We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g., NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits patients and users. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.	2
12	What matters to staff, patients and carers	Starting: Our ways of understanding what matters most to staff, patients and carers tend to be reliant on formal mechanisms (e.g., surveys) and the link to improvement is not strong or systematic.	Developing: We understand well as an organisation what matters most to staff, patients and carers (e.g., through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Progressing: Most of our services and functions have a good understanding of what matters most to staff, patients and carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g., through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient sand carers into improvement priorities or goals.	Spreading: Most of our teams have a good understanding of what matters most to staff, patients and carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. Patients and service users have a role in the development, prioritisation and monitoring of delivery of improvement goals.	Improving & sustaining: Most of our staff can describe what matters most to them, patients and carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for patients, which is energising. Patients and service users often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.	2
13	Enabling staff through a coaching style of leadership	Starting: There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	Developing: There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g., through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.	Progressing: A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g., to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered.	Spreading: Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers and clinicians participate in improvement, celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.	Improving & sustaining: A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.	2
14	Enabling staff to make improvements	Starting: Improvement activity is limited and may be centralised (e.g., led by a discrete 'improvement team' with relevant skills operating independently). Staff do not generally feel able to make improvements in their own area of work.	Developing: Some staff and teams feel able to make improvements (e.g., if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.	Progressing: The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	Spreading: The majority of teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative), and can solve problems effectively.	Improving & sustaining: Staff and teams are systematically engaged in improvement activity as part of their day to day work and are proactive in sharing the learning, and in looking for ways to collaborate with other teams and organisations in improvement programmes.	3

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
	Developing Leadership behaviours					**Average score**	**2.2**
15	Leadership development strategy	Starting: Our board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.	Developing: Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role.	Progressing: Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.	Spreading: Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	Improving & sustaining: Our board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our board are visibly linked to future planning at a system level.	2
16	Leadership Values and behaviours	Starting: Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach.	Developing: Leadership values and behaviours are agreed across our organisation.	Progressing: Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation.	Spreading: Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to.	Improving & sustaining: A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.	2
17	Leadership acting in partnership	Starting: Our Leadership works to competing and misaligned goals lacking in clarity.	Developing: Most of our leaders work in partnership with their fellow leaders and managers.	Progressing: Our leadership team have shared goals with commissioners and work effectively with systems partners.	Spreading: Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.	Improving & sustaining: Our board and system focus on constancy of purpose through multi-year journey with improvement at its core.	2
18	Board development to empower collective QI leadership	Starting: Our board discusses improvement at board meetings, but it is not a regular occurrence.	Developing: Our board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every board meeting.	Progressing: Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement.	Spreading: Our leadership and management teams actively enable staff to own improvement as part of their everyday work.	Improving & sustaining: Our leaders and managers - CEO through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done.	3
19	Go and see visits	Starting: Some senior leaders spend time on the ‘shop floor’ from time to time to engage directly with staff and teams but it is not routine or widely practiced.	Developing: Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement tools.	Progressing: Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management.	Spreading: All levels of leadership and management 'walk the floor'/'go & see’ as a matter of routine and the insights they gain informs decision making and problem solving to support improvement.	Improving & sustaining: Leaders undertake 'walk the floor'/'go & see’ visits for external bodies to visit their site and to observe different ways of working.	2

	Category	1 Starting	2 Developing	3 Progressing	4 Spreading	5 Improving & Sustaining	WHT
	Building Improvement Capability and Capacity					Average score	2.25
20	Improvement capacity and capability building strategy	Starting: We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (e.g. Academic Health Science Networks and Institute for Healthcare Improvement Open School).	Developing: Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around quality improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.	Progressing: Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing QI capability.	Spreading: Sustainability is addressed via 'in-house' training and development approaches including train the trainer models. Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.	Improving & sustaining: There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage. Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally.	3
21	Clear improvement methodology training and support	Starting: No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	Developing: There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS Impact components, alongside a dosing formula and skills escalator to support capability building ambitions.	Progressing: Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.	Spreading: Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, patients, service users and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.	Improving & sustaining: Learning from improvement activity is driving continuous improvement There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.	2
22	Improvements measured with data and feedback	Starting: Our organisational approach to reviewing and tracking progress against goals has yet to be defined, At present Improvement doesn't feature in whole organisational measures.	Developing: We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to deliver.	Progressing: We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.	Spreading: Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required.	Improving & sustaining: Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer term sustainability are reviewed regularly at organisational level.	2
23	Co-production	Starting: We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors.	Developing: Learning is captured when doing improvements, but this is rarely shared across departments.	Progressing: Users and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, patients, service users and other stakeholders have access to improvement capability development.	Spreading: Stakeholders are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively.	Improving & sustaining: Stakeholders are both supported and challenged to ensure success. Users and wider stakeholders are embedded within teams and are an integral part of the capability building process.	2
24	Staff attend daily huddles	Starting: Any huddles are only traditional shift change clinical handovers.	Developing: There is a plan in place for team huddle to focus on continuous improvements in all clinical frontline areas with clinical and operational staff in attendance.	Progressing: All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all operational/support/corporate areas.	Spreading: All operational/support/corporate areas have continuous improvement team huddles established.	Improving & sustaining: There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a standardised format and process.	2

	1	2	3	4	5	
Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
Embedding improvement into management systems and processes					**Average score**	**2.25**
25 Aligned goals	Starting: Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at board and senior leadership level but executives' and functions goals are often not well aligned with each other.	Developing: Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Progressing: Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Spreading: Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Improving & sustaining: Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.	2
26 Using the management system for planning and understanding	Starting: Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Developing: Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.	Progressing: Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. HR, Finance, Comms, Informatics) are also aligned to our improvement priorities.	Spreading: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff and assets from enabling services (e.g. HR, Finance, Comms, Informatics) are also aligned to improvement priorities and are shared across the system in an agile way.	Improving & sustaining: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.	3
27 Using the management system to respond to local, system, and national priorities	Starting: We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting.	Developing: Across the organisation, we believe having a management method (e.g., Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.	Progressing: Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.	Spreading: Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.	Improving & sustaining: All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g., SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.	2
28 Using the management system to integrate QI into everything we do	Starting: Improvement/QI is seen as separate to the day to day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply, and may be sending conflicting signals within the organisation.	Developing: Improvement/QI is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some front-line clinical areas.	Progressing: Improvement/QI is starting generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas and supporting clinical functions.	Spreading: As part of our management system, all parts of the organisation are using improvement/QI methods, and learning occurs between areas (e.g., to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not just month-to-month variation.	Improving & sustaining: The way we understand, manage and improve performance across the organisation – including how we use and report data – is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation.	2

Q. Data: NHS Impact Self-assessment Levels across 22 Categories from National Survey

	Domains	Action	Action2	Action3	Action4	WHT
	Building a Shared purpose and Vision					2.5
7	Board and executives setting the vision and shared purpose	Define strategic priorities that link to the vision and engage with the Board. Discuss mechanism, potentially a series of board development sessions. Ensure alignment				3
8	Improvement work aligned to organisational priorities					3
9	Co-design and collaborate - celebrate and share successes	QI Quarterly Star - agree timing eg. monthly/quarterly to be presented to individual departments/wards (by NED/Executive) which is then shared in the Daily Dose/RWT Comms (ensure included with QI launch in New Year).	Sharing and learning events (Report outs). Design our equivalent where MDT's present their QI projects aligned with Trust priorities.			3
10	Lived experience driving this work	Agree a process that ensures patients/carers and staff and public have input (a voice) into our organisational priorities.				1
	Investing in People and Culture					2.25
11	Pay attention to the culture of improvement	To establish a method for assessing cultural readiness for teams doing improvement work, and link to an OD resource to support improving the cultural readiness. (Amend project brief to include - is the team culturally ready for this change).	Values - when these are revisited - to ensure QI contribute eg. Encouraging improvement ideas and supporting individuals, learning from others, this is how we do things here.	Include expectations about improvement being part of the appointment process inc job descriptions and asking about improvement at interview. (Standard questions similar to equality - part of BCIS work).		2
12	What matters to staff, patients and carers					2
13	Enabling staff through a coaching style of leadership	Board development session around a coaching style of leadership to seek agreement on developing as the default leadership style.				2
14	Enabling staff to make improvements	Encourages visiting and learning from others. Describe the support available for teams wishing to visit other services	Consider the Inclusion of QI within Appraisal documentation asking about involvement in Improvement projects, focus on personal development and objective setting (part of BCIS work)			3
	Developing Leadership behaviours					2.2
15	Leadership development strategy	Undertake board development session focussing on Developing leadership behaviours as part of the Maturity matrix.	It is proposed QI skills and knowledge form part of Essential or Desirable criteria for Personal Specifications. Part of BCIS work looking at JD's and individuals with line management responsbilities. From Band 4 upwards.			2
16	Leadership Values and behaviours					2
17	Leadership acting in partnership					2
18	Board development to empower collective QI leadership	NED or Executive to sponsor QI programmes in priority areas	Consider the concept of a monthly QI Forum (quarterly initially) chaired by Chief Nurse and CMO to share successes and learning from QI projects. Similar to Schwarz rounds - a safe space to talk about successes, failures, barriers, networking and shared learning. On Teams, open to both Trusts, rotating chair between CNO and CMO. 'Lesson of the month'			3
19	Go and see visits	Schedule NED and Executive walkabouts on a rolling basis to specialties, ward areas, departments where they should take every opportunity to engage with staff about their QI ambitions, achievements, recognising and celebrating successes	Board to consider % of Exec time spent on the frontline, connecting with staff	Proposed all managers do walkabouts in their areas (similar to Gemba) and not just Execs and NEDs and incorporated into JD's and 'the way we do things around here'		2
	Building Improvement Capability and Capacity					2.25
20	Improvement capacity and capability building strategy	Proposed, as a minimum, Divisional triumvirates and Care Group/Directorate triumvirates attend one day QSIR fundamentals or bespoke training.	Every area needs a defined leader for Improvement. (Agree what protected time would look like for this). For the individual and within the department.			3
21	Clear improvement methodology training and support	Identify the roles that have leadership and managerial responsibilities - and recommend Leadership for Improvement training.	QI presentation (video - 15 mins) at Trust induction - introducing the teams, huddle boards, this is what we do around here, how to register a project etc. All staff inductions including junior doctors.			2
22	Improvements measured with data and feedback					2
23	Co-production					2
24	Staff attend daily huddles					2
	Embedding improvement into management systems and processes					2.25
25	Aligned goals	Agree 2 way process for agreement of improvement priorities between execs and divisions and then divisions and directorates/departments				2
26	Using the management system for planning and understanding	To consider as part of the Board development session to how data is presented and reported eg. alignment to the CQC domains	Trust board and Divisional meetings should have QI on the agendas and discussed.	Agree process for reporting against improvement priorities at all levels	Set out how resources are aligned and prioritised to support improvement work (information, HR, Comms, finance)	3
27	Using the management system to respond to local, system, and national priorities					2
28	Using the management system to integrate QI into everything we do					2

Document Title	
Improvement & Research Group	
Document Description	
Document type	Terms of Reference
Version	1.2

Lead Author(s)	
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Change History				
Version	Date	Comments	Review Date	Ratification Date
1.0	22-11-22	Draft for review at IIR Group 02-12-22	02-12-22	
1.1	28-11-22	Comments from KW prior to circulation	02-12-22	
1.2	28-11-23	Amendment to reporting arrangements for Digital Innovation. Name change of the Group. Addition – CD R&D to membership.	17-11-23	TBC

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TERMS OF REFERENCE: Improvement & Research Group

RATIFIED BY: Trust Board

NEXT REVIEW DUE: 17-11-24

1. CONSTITUTION

Both Trust Boards approved a new reporting structure through the Joint Committee ((JC) shared Executive and Non-Executive Directors) to keep them fully appraised on common and shared issues and to monitor the implementation of the trusts' joint 5-year Strategy. There are several JC working groups that will report into a JC Steering Group; the Improvement & Research Group (IRG) is one of these groups, chaired by a Non-Executive Director.

2. PURPOSE

The IRG will provide a formal platform for reporting progress against the trusts Strategic Aims and Objectives involving Improvement and Research activities. It informs and supports the JC in delivering the Strategic Objectives of the trusts.
IRG will consider and address cross Trust and cross Divisional issues and risks.
The IRG will review performance of the three separate activities against any agreed action plans and where necessary, agree remedial actions. The IRG can delegate responsibility for specific aspects related to Improvement and Research to other subgroups and working groups.

3. MEMBERSHIP

The Membership of IRG will be (But not limited to):

- Non-Executive Director (Chair)
- Non-Executive Director – Digital (Deputy)
- Chief Strategy Officer
- Deputy Chief Executive/Group Chief Nursing Officer
- Associate Medical Director – QI Team
- Managing Director, Research & Development
- Clinical Director, Research & Development
- Medical Director or Deputy Medical Director RWT & WHT
- Deputy Chief Strategy Officer – Improvement & Collaboration
- Associate Director of Digital Innovation

4. ATTENDEES

If necessary, deputies can be nominated to attend prior to the meeting and identify themselves as such. Deputies are expected to attend briefed, read-in and ready to contribute.
The IRG may request the presence of any senior manager/clinician/member of staff to present or comment (with notice).
For the purpose of leadership development occasional shadowing at this meeting will be allowed following prior discussion and agreement with the Chair.

5. QUORUM

The Committee will be quorate when a minimum of four members with two from:
Chair/Deputy Chair
Chief Strategy Officer/Deputy Chief Strategy Officer
Medical Director or Deputy

6. FREQUENCY OF MEETINGS

IRG will meet on an approximately bi-monthly basis. Meetings will be expected to last no more than 1.5 hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of IRG may be called by any member of IRG, with the consent of the Chair.
IRG will meet as a minimum six times per year.

7. ESTABLISHMENT OF SUBGROUPS

IRG may establish Task and Finish Groups made up wholly or partly or lead by members of the IRG to support its work. IRG may delegate work to such groups in accordance with an agreed terms of reference and timeframe. The Chair of each group will be expected to provide a report to the IRG on a frequency agreed with the Chair.

8. ADMINISTRATIVE ARRANGEMENTS

The IRG is chaired by a nominated Non-Executive Director. The Chair and/or Deputy Chair of the IRG will agree the agenda for each meeting with the Deputy Chief Strategy Officer – Improvement & Collaboration. IRG shall be supported administratively by the Quality Improvement Team Administrator. Agenda and papers will be published at least five working days prior to the meeting.

8 ANNUAL CYCLE OF BUSINESS

The IRG will develop an annual cycle of business for approval by the Chair and Executive at the start of each financial year. The IRG work plans informs the standing agenda items as described within the terms of reference.

9 REPORTING ARRANGEMENTS

The approved actions and, where deemed necessary, brief topic/issues notes of each meeting shall be provided to the JC Steering Group for information, supported by an executive summary. The Chairman of the IRG shall provide a report of each meeting drawing to the attention of the JC Steering Group the actions agreed and any issues that require disclosure to the JC or require executive action.
The IRG shall receive and review reports of its subgroups.

10 RESPONSIBILITIES

Seek opinions on potential improvement and research opportunities.
The IRG will advise on and be responsible to the JC Steering Group on all matters relating to Improvement and Research. This will include the following activities:

- Provide direction to and monitor progress of the implementation of key strategic aims and objectives within scope
- Recommend to the JC Steering Group schemes and projects for the trusts to consider.
- Receive updates from the Quality Improvement Team Action plan and Research Plans and collate efforts where appropriate.
- Advise on any issues relating to the Joint Committee governance, risk management and compliance.

Receive regular updates and advice from the leads for Quality Improvement and Research including but not limited to:

- Policy development
- Strategy development and implementation
- Other developments
- National & local strategies, policies, and developments
- Legal issues

Review reports to the IRG with a view to advise the JC on any potential prospective strategic risks to inform the Board Assurance Framework (BAF), Trust Risk registers & Divisional risk registers.
Ensure the IRG undertakes an effectiveness self-assessment at least every 2 years (as a minimum and if still in existence).

11 AUTHORITY AND ACCOUNTABILITY

The IRG is authorised by the JC to investigate any activity within the scope of its terms of reference at either Trust on behalf of the Joint Committee including information and co-operation in its endeavours. The IRG shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01).

12 STANDARDS

As with any group within either organisation, it operates with due diligence and reference where appropriate to:

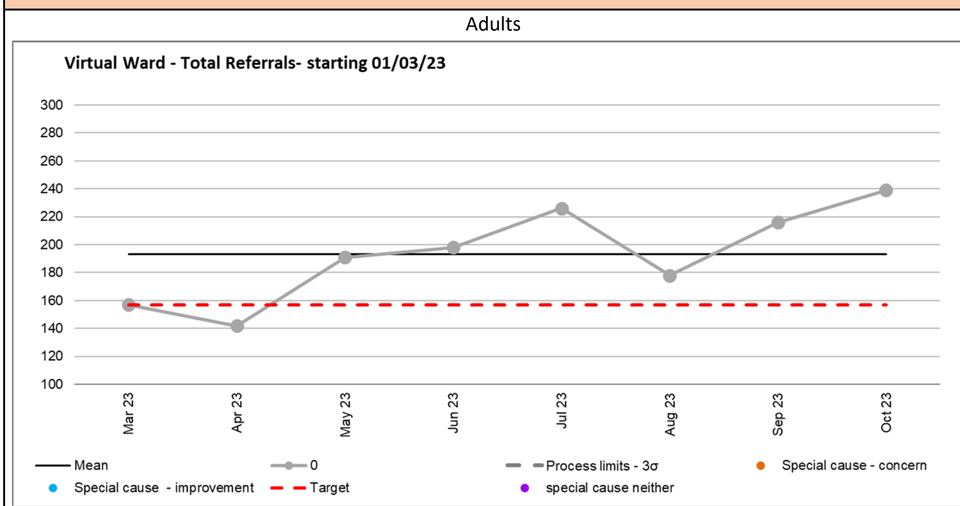
- Risk Assessment Framework
- Well-Led Framework
- CQC Essential Standards of Quality and Safety
- Risk Management Standards

Strategic Aim: COLLABORATION

Strategic Objective: **Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital**

Board Level Metric(s): **Increase from March 23 in the number of patients being cared for in virtual wards by March 2024**

Adults



Virtual wards (also known as hospital at home) allow patients to get the care they need at home safely and conveniently, rather than being in hospital. The NHS is increasingly introducing virtual wards to support people at the place they call home, including care homes.

Wards	Planned Go Live	Actual Go Live	Beds Plan	Actual Beds Open	Actual Admissions Oct 23	% Of Capacity Used	Step down vs Step up	Av. LOS (days)	% Face to Face contacts	No. of Readmissions
Acute Respiratory Infections	Jul 2022	Jul 2022	25	20	42	31.4%	37/5	4.6	92%	2
Palliative Care	Jul 2022	Nov 2022	15	15	30	58%	10/20	9.2	N/A	0
Hospital @ Home	Sep 2022	Dec 2022	20	20	36	39.5%	34/2	7	91%	6
Frailty	Jul 2022	Jan 2023	40	20	44	51%	43/1	5.4	92%	4

Analyst Narrative:

The adult virtual wards continued to offer 75 virtual beds covering respiratory, palliative care, hospital at home and frailty pathways during October. Referrals into the service remained below the service capacity.
Paediatrics currently have 10 virtual beds covering 6 different pathways to prevent / reduce hospital bed admissions . The majority of referrals have been for respiratory conditions (65%).
Baseline data for referrals into the virtual wards for March 2023 was: 103 for adults and 54 paediatrics.
October 2023 reported 160 referrals adults and 79 paediatrics.

Virtual wards have been launched utilising funding from the national program.
The wards operate mainly on a step-down approach for patients following an acute admission. The number of patients admitted has grown significantly since their inception providing a safe MDT led discharge pathway for patients making a positive impact on discharge pathways during Winter.
Funding of the Virtual Wards for 2023/24 has been confirmed at a reduced level.
The Virtual Wards are currently operating around 50% of their capacity. Work continues with other Divisions in order to improve the utilisation of the wards to maximise their benefit

Executive Narrative:

A virtual ward summit took place in November 2023, this will bring together community and acute team with the aim of increasing the number of referrals onto the virtual wards thus increasing the occupancy. In addition, there is a plan to enhance Ask Earl functionality such that patients meeting inclusion criteria for respective virtual wards (driven by physiological clinical observations as well as demographic information) are auto-prompted for consideration of placing on VW pathway
The Paediatric VW has recorded several successes since its launch. The Team are now looking to increase utilisation with the introduction of additional pathways such as home oxygen which is currently not being utilised due to insufficient staffing. A further pathway for home phototherapy (in collaboration with NCOT) is also going through governance with an expected start date of January 2024. The Virtual Ward Team is pleased to share an example of an eating disorder patient that was managed via the VW and prevented hospital admission for 52 days. Excellent feedback and engagement with the Eating Disorder team avoiding a long term admission on to ward 21. A great example of the right collaboration where everyone kept the young person and the family at the heart of every decision making.

Strategic Aim: COLLABORATION

Strategic Objective: **Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital**

Board Level Metric(s): **Increase from March 23 in the number of patients being cared for in virtual wards by March 2024**

	ACTION	BY WHO	BY WHEN
	Virtual Ward Summit	Community VW Teams	Nov-23
	Home phototherapy pathway	Paeds VW Team	Jan-24

Strategic Aim: COLLABORATION

Strategic Objective: **Facilitate research that establishes new knowledge and improves the quality of care of patients**

Board Level Metric(s): **Increase the number of researchers and participant numbers beyond the level of achieved in 2019/20 by March 24**

Graph 1

Analyst Narrative:

The number of active researchers (AHP's, Midwives, Nurses, and Consultants) within the Trust is approximately 33, with the number of recruits into Commercial and Non-Commercial studies currently at 105 (refer to Graph 2&3). An increase year by year starting from the baseline of 2019/2020 (refer to Graph1). Growth of Commercial research within the Trust is meeting the target set following the Lord O'Shaughnessy recommendation of doubling the number of commercial recruits. Research activity continues to increase, with Commercial research (clinical trials) contributing most to this growth. Home grown research (research undertaken by staff) has also seen a sharp rise with more colleagues requesting support from R&D through their research journey, the number of staff undertaking potential home-grown trials has seen a sharp rise this year with 37 members of staff requesting advice and support on undertaking research .

-Pharmacy support now in place to support clinical Trials (Aseptic support is still an ongoing issue, raised with the Director of Pharmacy .

-1st Rheumatology study opened at Walsall -MS-MOOSE Study.

-1st Pharmacist/Antibacterial Study identified (UKAR Study).

-1st Midwife PI identified for the CHAPTER Study.

-Chief investigator for the HEALS Study (early stages)-Skin/Cancer.

-Nominated and shortlisted for the CRN WM Awards-Category-Trust Governance Teams (RWT & WHT) working in collaboration on the Vitiligo Dermatology Study.

-Nominated and shortlisted for the CRN WM Awards-Category -R&D Team (Commercial Trials growth).

-R&D Manager new Chair of the WM R&D Forum

-Participant Research Celebration Event taking place on the 28th of November in Walsall's Learning Centre 2-5pm

-Successful in obtaining additional funding from the CRN, this will enable FORCE to continue with the Maternity Hybrid post

Strategic Aim: COLLABORATION

Strategic Objective: **Facilitate research that establishes new knowledge and improves the quality of care of patients**

Board Level Metric(s): **Increase the number of researchers and participant numbers beyond the level of achieved in 2019/20 by March 24**

SUPPORTING INFORMATION

In February 2023, the government commissioned an independent review (by Lord O'Shaughnessy) to offer recommendations on how to resolve key challenges in conducting commercial clinical trials in the UK and transform the UK commercial clinical trial environment. The review sets out 27 recommendations, including both priority actions to progress in 2023 and longer-term ambitions for UK commercial clinical trials.

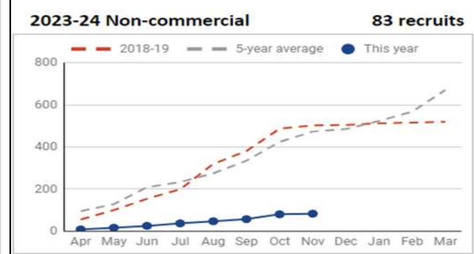
Graph 2

2023-24 Commercial 22 recruits

2018-19 5-year average This year

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Graph 3



Executive Narrative:

The Maternity Hybrid role will finish in December 2023. There is a risk due to lack of funding the role will cease. The link role has been pivotal in contributing to the growth and development of Maternity research, it has also helped promote and engage Maternity staff in becoming more involved in research. If the link role is unstainable due to funding this will impact on research within this division. Applied for CRN additional funding in the hope of sustaining this post, await outcome

Continued holdups with MHRA approvals which is impacting on the opening of Commercial Trials in particular. This is outside of our control.

Walsall continues to explore collaborations with local and regional research partners (meeting took place with CRN Primary Care team on the 10th October).

The NIHR have announced an additional £30 million per year to increase opportunities for healthcare professionals to include research in their careers

Number of Studies

Open 24, Set Up 10, Pipeline 8

ACTION	BY WHO	BY WHEN
Publicise the support available across both organisations such as courses and access to experienced personnel. Introduction to Research training programme -Delivered across the Trust September 2023,Course content to be reviewed the week of the 20th of November, new dates to be set for 2024	Catherine Dexter	Completed
CRN additional funding application (for the maternity hybrid role)	Catherine Dexter	Completed - funding agreed

Strategic Aim: COMMUNITIES

Strategic Objective: **Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025**

Board Level Metric(s): **Achieve a 5% reduction in the carbon footprint at WHT by the end of March 24 compared to 2020/21**

Carbon Footprint Update. The table below shows the Trust carbon footprint baseline and the reductions delivered from 1st April 2022 to 31 March 2023.

Category	2020/21 (Baseline tCO2e)	2022/23 (tCO2e)	2022/23 Reductions (tCO2e)
Scope 1			
Gas	5,354	4,714	640
Desflurane	427*	64	363
Nitrous Oxide	688*	453	235
Entonox	803*	1,432	-629
Scope 2			
Electricity	4,846	2,892	1,954
Scope 3	47,734	47,724	10
Total Carbon Emissions	59,852	57,279	2,573

Analyst Narrative:

Carbon Footprint Update. The table on the left shows the Trust carbon footprint baseline and the reductions delivered from 1st April 2022 to 31 March 2023.

The Trust has achieved a reduction of 4.3% reduction of its overall carbon footprint within 12 months of Green Plan implementation.

Executive Narrative:

Actions: see below. These priorities will require both revenue and capital funding as well as other resources such as staffing.

A meeting is scheduled with the Maternity Team to do a deep dive on the usage of Entonox, staff risks, current practices and reduction ideas which will include destruction technology.

Strategic Aim: COMMUNITIES

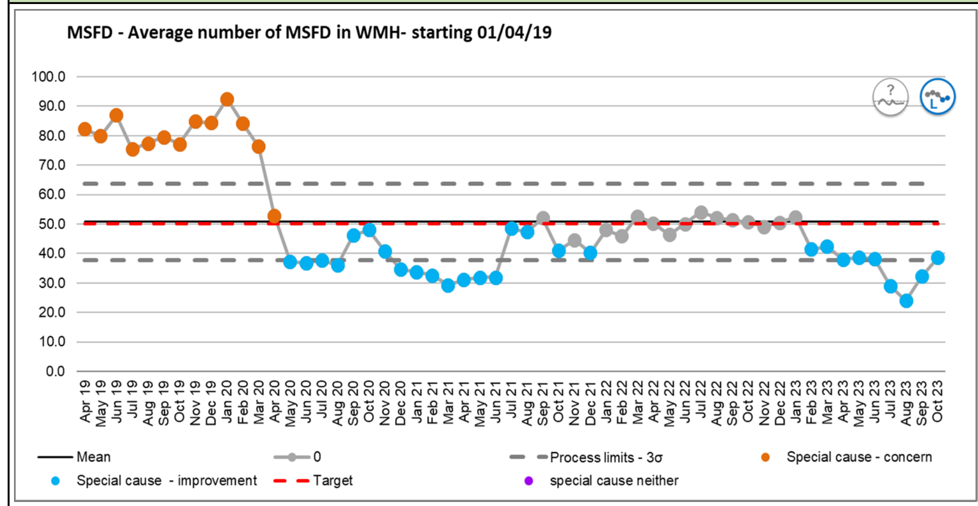
Strategic Objective: **Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025**
Board Level Metric(s): **Achieve a 5% reduction in the carbon footprint at WHT by the end of March 24 compared to 2020/21**

SUPPORTING METRICS	ACTION	BY WHO	BY WHEN
2023/24 Greener NHS National and Regional Priorities and Deliverables NHS England-Midlands circulated the draft 2023/24 Greener NHS Midlands Systems Ambition document which was discussed and commented on by the Black Country ICS Sustainability Network. A final document is expected to be issued at the end of September. Out of 19 deliverables, seven has been delivered. Three of the deliverables are unlikely to be delivered. These are: - 1. 19-23% Entonox carbon emissions reduction - 2. Ensuring that the region's owned and leased fleet is made up of at least 90% Low Emission Vehicles by March 2024. Including 11% of the fleet being made up of Ultra-Low Emissions (ULEV) and Zero Emission Vehicles (ZEV) by March 2024 - 3. 25% reduction of inhaler carbon footprint Green Plan implementation: Reduction of the proportion of desflurane used in surgery to less than 2% of overall volatile anaesthetic gases by volume by 31 March 2024. As of 30 June 2023, the proportion of desflurane used in surgery is at 0% below the 2% national target Greening Services Scheme. Sustainability initiatives implemented by the greening services teams are still ongoing. Some are expected to deliver both carbon reduction and cost improvement by 31st March 2024 Clinical Waste Strategy The Trust recently appointed a waste manager who will manage the implementation of the Trust Waste Strategy as well as ensuring the Trust waste management systems and practices are inline with the national strategy.	Update Green Plan carbon reduction targets and action plan to reflect results of sustainability initiatives	Sustainability Group/Head of Sustainability	June 2024
	Provide progress on the carbon reduction delivered by sustainability initiatives	As Above	Monthly
	Recruit clinical and non-clinical services in "Greening Services Scheme".	As Above	Monthly
	Roll out furniture, medical devices and equipment reuse scheme	As Above	March 2024
	Roll out mixed recycling and waste segregation	Waste and Recycling Manager	March 2024
	Develop an options appraisal for nitrous oxide/Entonox destruction technology	Medical Gas Group/Clinical Lead for Sustainability	January 2024

Strategic Aim: COMMUNITIES

Strategic Objective: **Work together with PLACE based partners to deliver improvements to the health of our immediate communities**

Board Level Metric(s): **Maintain the number of medically stable fit for discharge patients from 2022/23**



Analyst Narrative:

This reports the number of medically stable for discharge patients (month average). These are patients who do not need hospital bed for their acute management (Intermediate Care Services pathways 1-4).

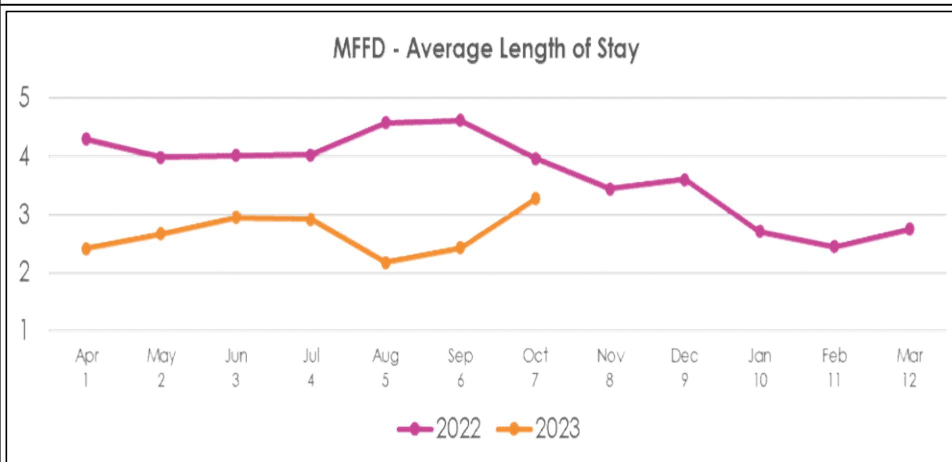
The Service delivered a strong performance in October, with the number of MSFD patients at 38 continuing the statistical improvement.

Average length of stay maintained at an average of 3 days demonstrating good flow. (2nd chart)

The number of referrals has grown significantly since the start of 2023. Despite the increase in the number of referrals the number of patients who are on the list has not risen at the same rate.

Over the past 12-18 months the complexity of patients that are being managed through Intermediate Care has increased requiring more time for discharge planning and complex placements. Additionally, the ICS team have managed an increased number of out of area patients that have dispositioned to Walsall as a result of the performance of ED and the discharge pathways in Walsall. Working with other parts of the system builds in delays to patients discharge as the performance of our ICS is dependent on our partners.

SUPPORTING METRICS



Executive Narrative:

Issue:

Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients. This includes working collaboratively with partner organisations within the system to address the repatriation of patients.

The Intermediate Care Service has also started to pilot a light touch assessments of patients meeting specific criteria in pathway one to enable a full supported assessment in their own home. This enables a more accurate assessment of their needs.

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.

In response to these challenges, the Division has increased the Nursing and Facilitator capacity within the ICS and the team have built strong links with our partners within the region to ensure a smooth transitions of care.

An activity and financial trajectory has been produced with commissioners to monitor the activity versus spend for the current financial year. Inclusive of national discharge funding a £1.7m deficit has been forecast. This is predominately being driven by the cost of care.

Strategic Aim: COMMUNITIES

Strategic Objective: **Work together with PLACE based partners to deliver improvements to the health of our immediate communities**
Board Level Metric(s): **Maintain the number of medically stable fit for discharge patients from 2022/23**

	ACTION	BY WHO	BY WHEN

Enc 9.3.1

Walsall Together Partnership Operational Update: November 2023

Stephen Jackson

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 1

Tier	Activity in-month	Thresholds			Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services																	
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	5784.25	6005	5957.75	6321	5589	6281.25	6608	5837.25	5739.5	5814.25	5561.5	5219.3	6014.7
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	1043.25	622.75	643.25	377.25	370.25	390.25	188.00	106.25	282.75	279.75	207.00	290.25	290.25
	% of hours demand unmet	>23%	20%-23%	<20%	15.28%	9.40%	9.74%	5.63%	6.21%	5.85%	2.77%	1.79%	4.70%	4.59%	3.59%	5.27%	4.60%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	30	31	22	30	24	29	12	14					
	No. referrals received	<100	100-200	>200	17	26	11	26	15	19	17	21					
	No. cases reviewed	<100	100-200	>200	86	90	68	82	68	87	61	69					
Adult Social Care	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				969	955	639	967	861	814	874	860	889				
	Care and Support Assessments and 3 Conversations Completed - Total				352	357	283	316	352	356	243	306	309				
	Monthly Adult contacts completed by Team				1,142	1,185	1,024	1,349	1,170	1,250	1,066	1,167	1,209	1,147	1,178	1,126	1,127

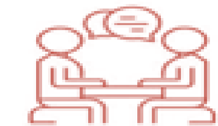
[Emergent] Score Card for WT Tiers – Tier 2 & 3

Tier	Activity in-month	Thresholds			Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Tier 2: Specialist Community Services																	
ASC Safeguarding Concerns	Concerns received				321	342	308	375	355	321	303	335	364	351	328	318	
	Concerns progressing to s42 eqnuiry				32	63	82	75	77	56	40	58	47	59	57	64	
	% of concerns progressing to s42 enquiry				10%	18%	27%	20%	22%	17%	13%	17%	13%	7%	17%	20%	
	Safeguarding cases in progress				97	99	36	44	70	52	58	55	93	76	57	59	

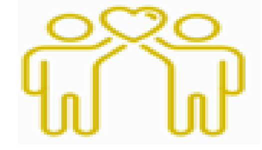
Tier	Activity in-month	Thresholds			Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Tier 3 : Interimediate Care, Unplnanned Care & Crisis Services																	
Care Navigation Centre	Calls received	<435	435-512	>512	1142	1310	1475	1463	1109	1232	1191	1272	1205	1153	1120	1120	1413
Rapid Response Team	Referrals received	<160	160-247	>247	285	307	339	313	245	325	269	292	251	280	281	319	345
	% admission avoidance	<73%	73%-87%	>87%	90.2%	93.8%	90.3%	89.8%	88.6%	80.2%	83.3%	93.5%	100.0%	90.0%	70.1%	83.1%	92.5%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50-57.5	<50	50.59	49.17	50.53	52.40	41.50	42.40	38.00	38.66	38.25	29.11	24.00	32.38	38.68
	Average number of days MSFD	>5.75	5.0-5.75	<5.0	4.0	3.4	3.5	2.7	2.8	2.6	2.5	2.7	2.95	2.92	2.50	2.43	3.27
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21-25	21<	25	34	27	31	32	30	31	32	34	30	22	22	23
	Domiciliary Pathways - Average service users				223.8	244.25	275.5	267.7	267.7	285	283.2	281.5	259	244.2	241	241	217
	Bed-based Pathways - Discharged ALOS	>36	24-36	24<	52	39	46	17	17	40	40	38	37	30	25	25	25
	Bed-based Pathways - Average beds in use				78	82	64	77.8	77.8	76.6	67.7	67.75	61.25	67.2	70.5	70.5	68.4
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	210	174	230	160	163	194	199	206	180	213	185	213	223
	Prevent Readmission	35<	35-50	>50	11	7	21	3	7	17	8	5	6	2	7	5	8
	Early Supported Discharge	40<	40-54	>54	61	40	55	54	57	28	43	37	68	52	44	35	40
	Assisted Discharge	35<	35-50	>50	82	109	99	63	59	64	34	52	105	54	45	20	23

Tier 0 Resilient whg The H Factor Social Prescribing Programme – August Stats

243 Clever Conversations



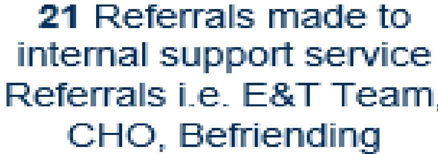
104 Home visits Completed



20 sign up to the Social Prescribing programme

43 completed/improved WEMWBS questionnaire

11 Referrals to Money Advice Team



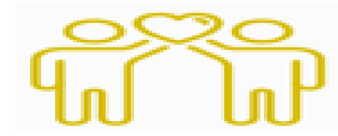
21 Referrals made to internal support service Referrals i.e. E&T Team, CHO, Befriending

18 Referrals made to external support service Referrals i.e. Rethink, Mind Kind, Bereavement, Adult Social Care etc

Diabetes Matters Champion Engagement Programme

30 new referrals received

155 Clever Conversations



117 New customers engaged

1 Community Events attended

1 Referral to Money Advice Team

5 Referrals made to external support service Referrals

11 Referrals made to internal support service Referrals

WHG - Diabetes Matters – Case Study

Background EC was referred to the Diabetes Health champions by a colleague in the Kindness Champion team as this customer had been identified as lonely and isolated. This customer is 77yrs old and was a single parent whose children had moved away from her. EC had multiple health conditions
EC has heart disease and had previously been fitted with a pacemaker, mobility issue due to pain, high blood pressure, high cholesterol, was anaemic and mental health issues linked to confidence and anxiety. EC had been borderline diabetic for 25 years. On 18th Nov 2021 EC was diagnosed with type 2 diabetes.

Support Offered
EC was signposted by the Kindness Champion as adopting healthy behaviours was central to improving confidence to leave the home. EC Says I think if you ask for advice you must take it. My health champion came to visit me at home where I was comfortable, A what matters to me assessment was completed and it showed that EC really did want to change her lifestyle. EC used to eat breakfast and one big meal in a day. The health champion helped EC with advice in my diet by advising to spread my meal over a day and to include lot of vegetables and fruits with less sugar. Before EC would drink 15 cups of coffee daily, the health champion advised EC to cut down on the coffee and advised to try things like herbal tea, no added sugar diluted squash instead of fruit juice. The health champion also advised me to increase my physical activity and to improve my mental health by listening to the music and reading books. The Perma Model of wellbeing was used to support EC to set their own goals and establish a timeframe to work towards to achieve them. Improving EC's knowledge of her diabetes and confidence to try new things have been central to her PERMA goals.
EC was previously using a wheelchair to go out and slowly with support EC began to feel she could walk outside herself. She can now go to the local shop without any support. EC has managed to get her sugar levels consistently down to being borderline again and she is motivated to continue this work further.

When EC was asked about her Health Champion, she said It's always good to see her, she makes me smile, she helped me to take the seriousness out of me which has worked as a medicine for me. She encouraged me in so many ways to get rid of worries, stress and brought lot of changes in my life which helped me controlling my sugar level. Now I am so positive and stronger. I did lots of efforts to bring my sugar down. My latest blood test show that my sugar level at the borderline. I am so thankful for whg for helping me to achieve this goal.
Before I was thinking why I am living but now I want to live more and have a new goal I want to fly to see other country.

EC is now ready to commence looking at her loneliness and will be supported by the Kindness Champions to commence this next part of her journey
EQ5D Final Score - 75

A.C.E - Reducing the impact of poverty on children and families

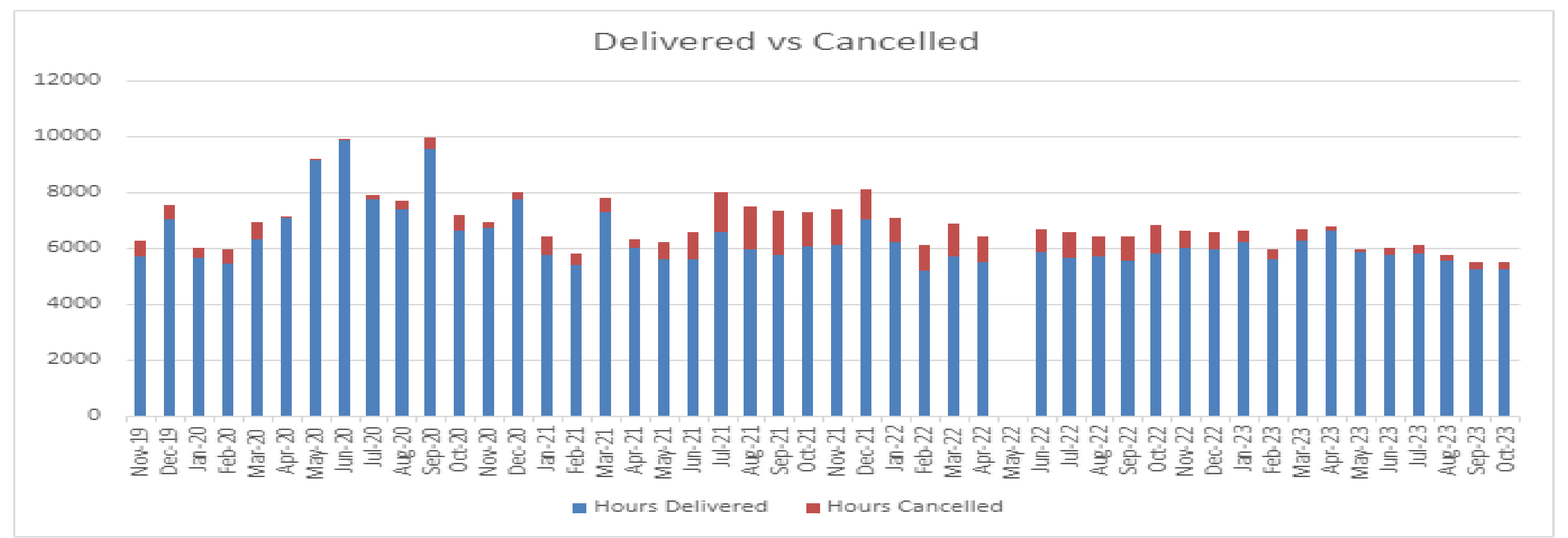
- A.C.E is a proof of concept and a partnership programme designed, delivered by whg and health
- Focus upon improving parents, children's self care of the child's asthma and reducing avoidable hospital admissions
- A referral pathway is established with Walsall Healthcare NHS Trust and whg
- **93** Children have been supported through A.C.E increasing parents skills, access to health services
- whg are presenting A.C.E at the National Ask About Asthma Campaign in September
- A co authored blog about the programme will be circulated at the national AAA Conference
- Learning from the proof of concept is being used to launch year 2
- https://www.insidehousing.co.uk/insight/insight/how-a-walsall-social-landlord-is-fast-tracking-damp-repairs-for-children-with-asthma-82319

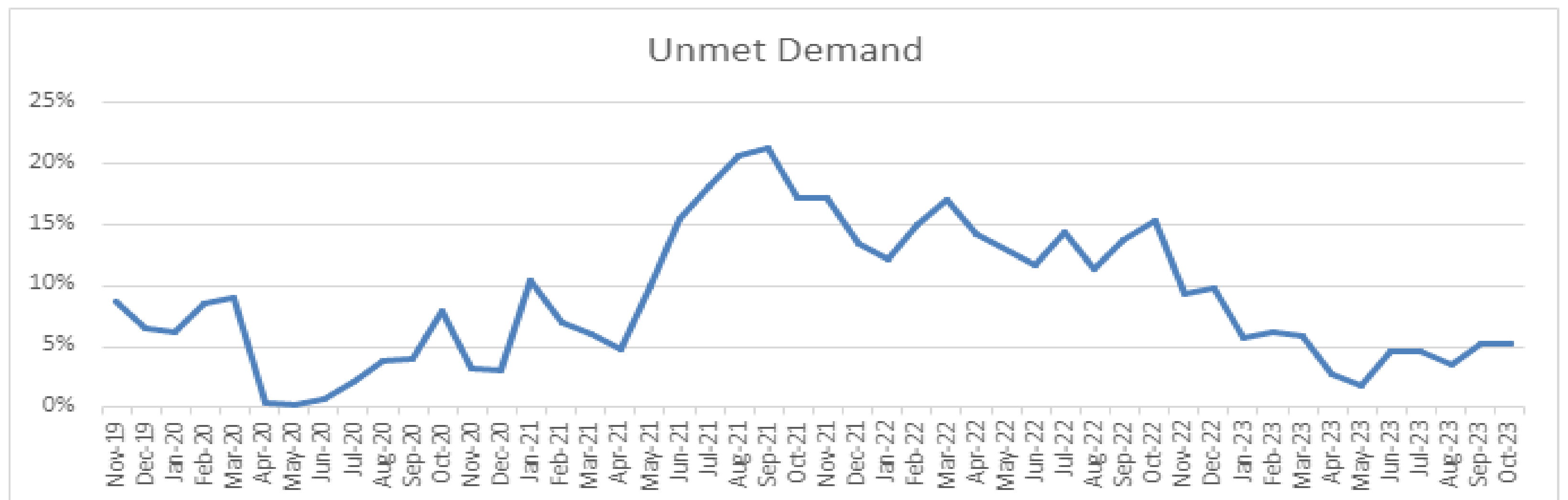
Left to right: Connie Jennings, social inclusion manager at WHG; Lisa Cummings, senior specialist paediatric asthma practitioner at Walsall Healthcare NHS Trust; Tracey Longon, mum of eight; and Ruth Jones, social prescriber at WHG, all work on the programme

Tier 1:

Community Nursing Capacity and Demand:

Walsall Together





The Locality Teams delivered 6,015 hours during October 2023. The number of cancelled hours decreased compared to the previous month.

The improvement in both hours delivered and cancelled is a result of further recruitment and mitigation measures to ensure that cancellations are kept to a minimum.

Last updated : October 2023

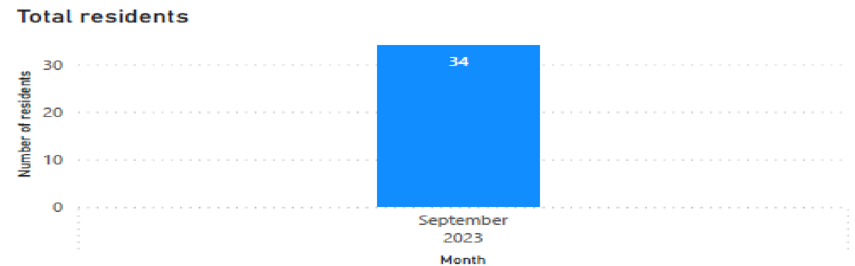
Tier 1: Making Connections Walsall

Making Connections Walsall - Client summary

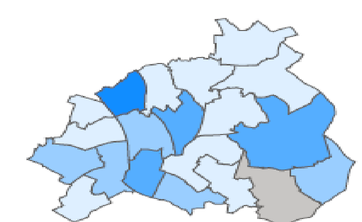
Source: DCRS (Data Collection & Reporting Service)

Referral date

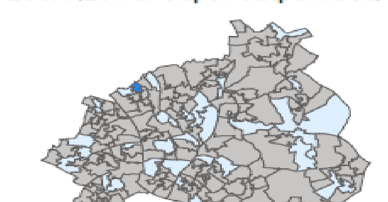
01/09/2023 30/09/2023



Electoral ward

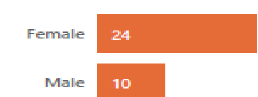


LSOA (Lower Super Output Area)



client_type	n	%
Making Connections	34	100.0%
Total	34	100.0%

Locality	n	%
North	10	29.4%
East	9	26.5%
West	8	23.5%
South	7	20.6%
Total	34	100.0%



Residents age

ethnicity	n	%
A: White _ British	22	64.7%
99: Not Known	9	26.5%
H: Asian or Asian British _ Indian	1	2.9%
J: Asian / Asian British _ Pakistani	1	2.9%
M: Black / Black British _ Caribbean	1	2.9%
Total	34	100.0%

consider_themselves_disabled	n	%
Disabled	18	52.9%
Not Known	9	26.5%
Not disabled	7	20.6%
Total	34	100.0%

long_term_physical_health_condition	n	%
Yes	27	79.4%
Not stated	7	20.6%
Total	34	100.0%

Total residents
34

Total contacts
65

PROUD OF OUR PAST, OUR PRESENT AND FOR OUR FUTURE

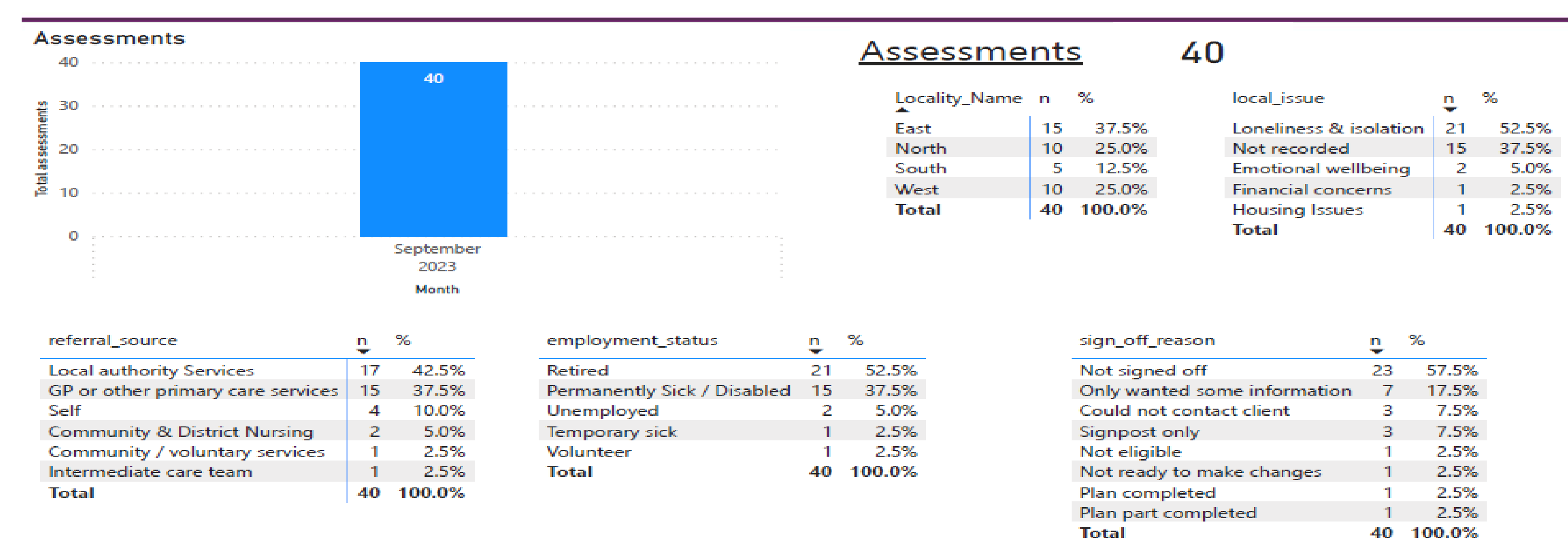
Last updated - September 2023

Tier 1: Making Connections Walsall

Making Connections Walsall - Assessment & Goals Summary

Source: DCRS (Data Collection & Reporting Service)

client_type
- COVID_19
- Making Connections



Assessments 40

Locality_Name	n	%
East	15	37.5%
North	10	25.0%
South	5	12.5%
West	10	25.0%
Total	**40**	**100.0%**

local_issue	n	%
Loneliness & isolation	21	52.5%
Not recorded	15	37.5%
Emotional wellbeing	2	5.0%
Financial concerns	1	2.5%
Housing Issues	1	2.5%
Total	**40**	**100.0%**

referral_source	n	%
Local authority Services	17	42.5%
GP or other primary care services	15	37.5%
Self	4	10.0%
Community & District Nursing	2	5.0%
Community / voluntary services	1	2.5%
Intermediate care team	1	2.5%
Total	**40**	**100.0%**

employment_status	n	%
Retired	21	52.5%
Permanently Sick / Disabled	15	37.5%
Unemployed	2	5.0%
Temporary sick	1	2.5%
Volunteer	1	2.5%
Total	**40**	**100.0%**

sign_off_reason	n	%
Not signed off	23	57.5%
Only wanted some information	7	17.5%
Could not contact client	3	7.5%
Signpost only	3	7.5%
Not eligible	1	2.5%
Not ready to make changes	1	2.5%
Plan completed	1	2.5%
Plan part completed	1	2.5%
Total	**40**	**100.0%**

Goals 57

goal	n	%
Reduce anxiety/low mood	21	36.7%
Actions to enable goal achievement	12	21.1%
Connect more: Join a group	10	17.6%
Information required	7	12.3%
Learn something new: Take a course/Start new hobby	5	8.8%
Build confidence/independence	1	1.8%
Give/volunteer more: Volunteer/Help somebody	1	1.8%
Total	**57**	**100.0%**

referral_to	n	%
Community / voluntary services	29	50.9%
Local authority services	15	26.3%
Other (put details in 'Referral_other')	3	5.3%
Emotional Wellbeing Services	2	3.5%
GP or other primary care services	2	3.5%
Advice and Guidance	1	1.8%
Bereavement Support	1	1.8%
Citizens advice	1	1.8%
Dementia cafe	1	1.8%
Disability services	1	1.8%
Lunch Club	1	1.8%
Total	**57**	**100.0%**

PROUD OF OUR PAST, OUR PRESENT AND FOR OUR FUTURE

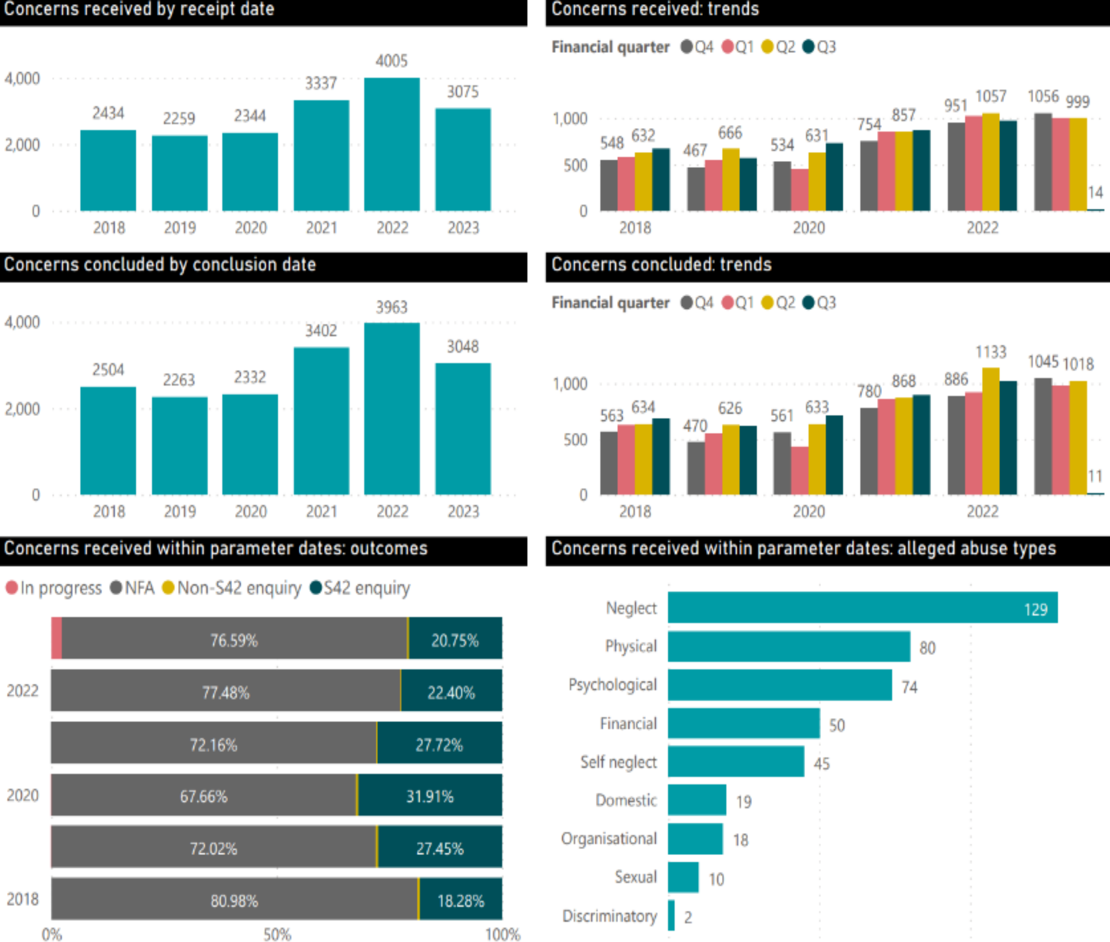
Tier 2:
Adult Social Care

ASC have received 318 concerns which a decrease in cases on the previous month.

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

There are currently 64 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.



Last updated : September 2023

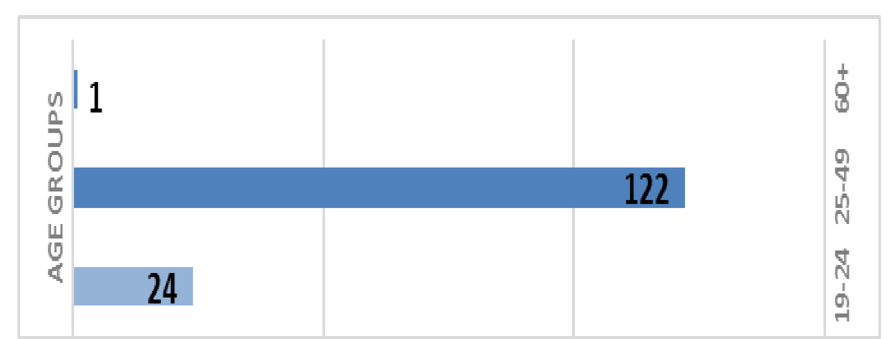
Last updated : October 2023

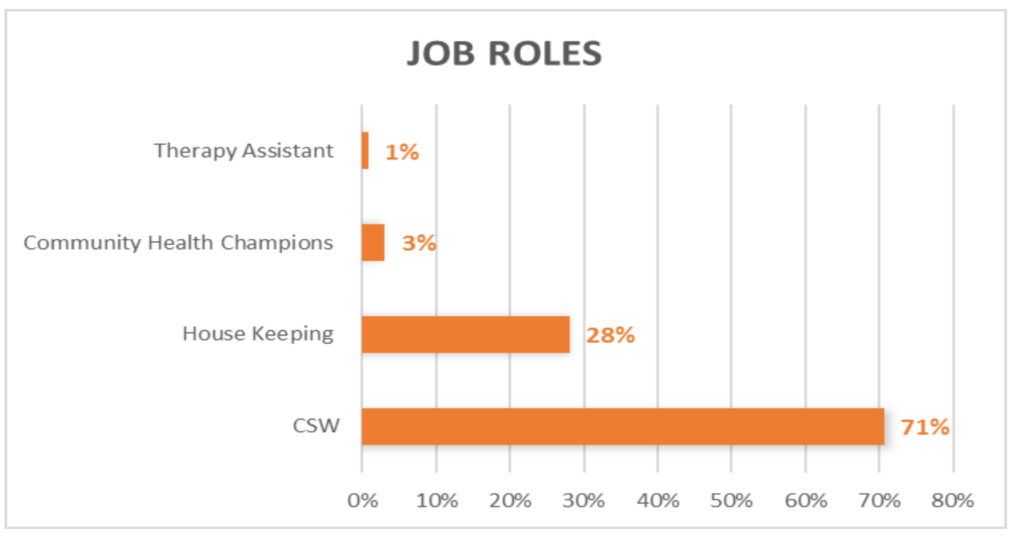
Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2022/23

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	22/23 Result	April 23/24 Data	May 23/24 Data	June Q1 Data	July 23/24 Data	Aug 23/24 Data	Sept Q2 Data	Oct 23/24 Data	Nov 23/24 Data	Dec Q3 Data	Jan 23/24 Data	Feb 23/24 Data	Mar 23/24 Data	23/24 Target	Comments
3D (formerly 1C): The proprtion of people who use services who receive direct payments	Mosaic		613	800	785	789	601	586	618	625	634	643	660	664	673	66							
	AACM		1951	1978	2069	2100	2206	2184	2275	2303	2314	2372	2404	2411	2431	2431							
	Tina James/ Paul Calder/Eve Morris		**31.4%**	**40.4%**	**37.9%**	**37.6%**	**27.2%**	**26.8%**	**27.2%**	**27.1%**	**27.4%**	**27.1%**	**27.5%**	**27.5%**	**27.7%**	**27.4%**							
2B (formerly 2A): Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & call off forms	7	11	22	10	24	18	20	27	1	6	9	11	15	19	20						15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	166,383	166,383	166,383	166,383	166,383	166,383							
	Tina James/ Paul Calder/Eve Morris	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**11.9**	**16.1**	**0.6**	**3.6**	**5.4**	**6.6**	**9.0**	**11.4**	**12.0**						**9.1**	
2B (formerly 2A): Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & call off forms	271	309	311	329	301	311	284	302	16	53	76	97	139	168	195						300	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	59,500	59,500	49,649	49,649	49,649	49,649	49,649	49,649							
	Tina James/ Paul Calder/Eve Morris	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**562.4**	**598.0**	**31.7**	**106.8**	**153.1**	**195.4**	**280.0**	**338.8**	**392.8**						**594.1**	
2D (formerly 2B): Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services.	Mosaic	254	113	220	55	76	94	79	106	139	106	114	128	101	119	123							
	ICS	317	130	266	73	91	125	103	123	162	123	134	147	119	144	138							
	Kerrie Thorne	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**78.1%**	**86.2%**	**85.8%**	**86.2%**	**85.1%**	**87.1%**	**84.9%**	**82.6%**	**89.1%**						**82.0%**	
2E (formerly 1G): Proportion of people who live in their own home or with their family.	Mosaic	473	497	505	502	494	489	490	483	2303	2384	2471	2535	2596	2633	2702							Metric widened to all long term service users under the revised ASCOF Framework implemented from April 2023. Metric previously concerned LD service users aged 18-64 only
	AACM	551	585	587	596	574	573	576	573	3217	3345	3474	3573	3668	3794	3891							
	Tina James/ Paul Calder/Eve Morris	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**85.1%**	**84.3%**	**71.6%**	**71.3%**	**71.1%**	**70.9%**	**70.8%**	**69.4%**	**69.4%**							
4B Proportion of S42 enquiries where a risk was identified and the reported outcome was that this risk was reduced or removed	Mosaic									47	67	58	31	46	33	58							New ASCOF metric introduced from April 2023
	AACM									52	75	65	35	49	38	63							
	Donna Gyde									**90.4%**	**89.3%**	**89.2%**	**88.6%**	**87.2%**	**87.2%**	**87.3%**							

TIER 2 Workforce Development Work 4 Health

147 secured employment





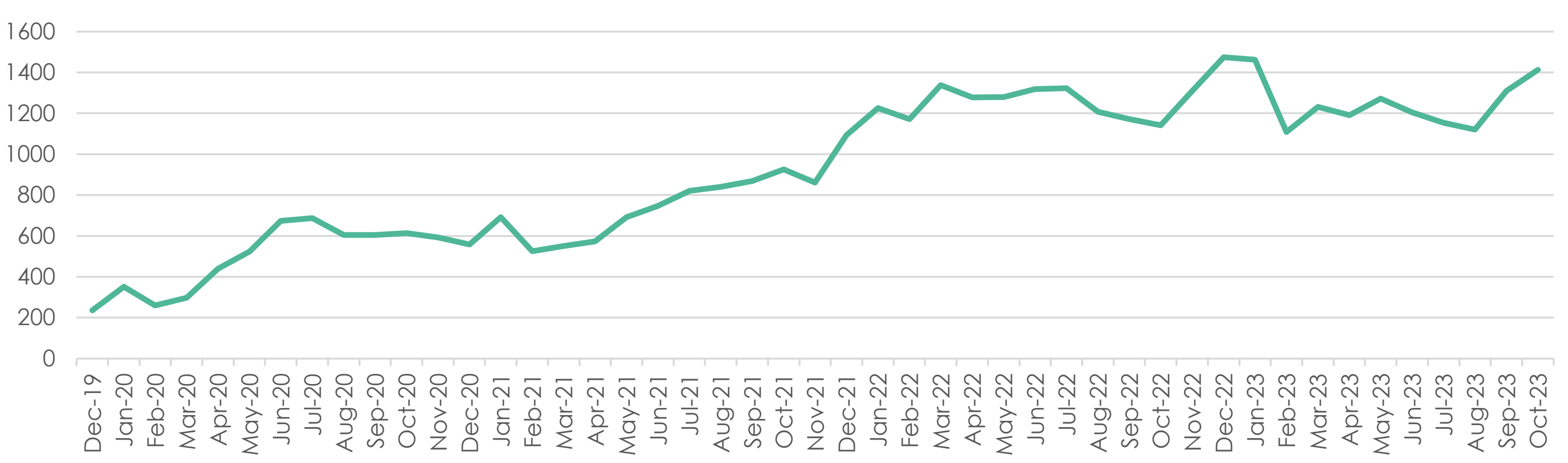
Social Value generated £2,121,530

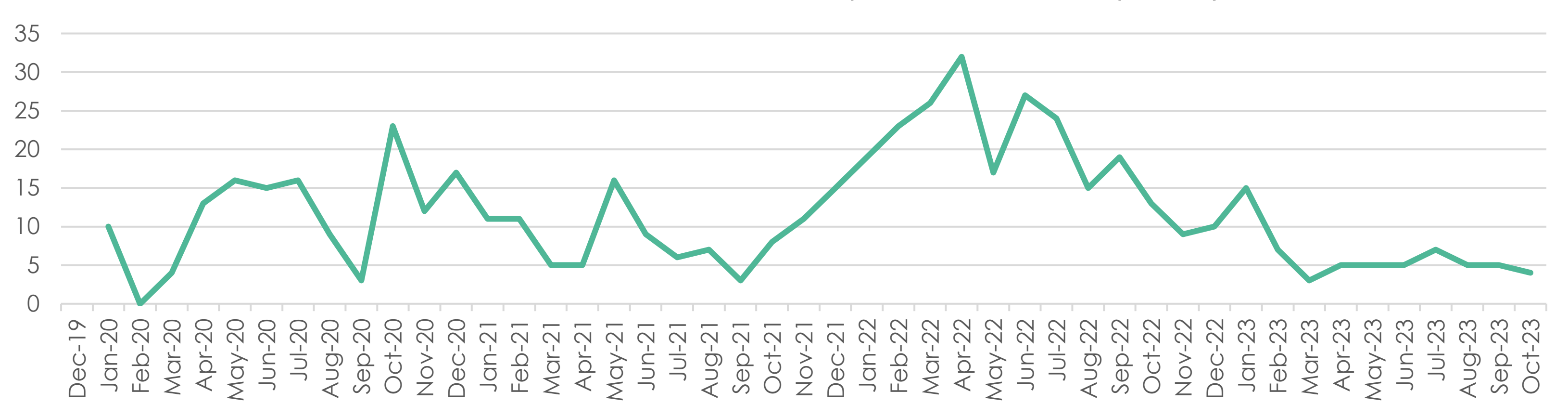
82% Unemployed prior to commencing NHS job role

56% BAME

Tier 3:
Care Navigation Centre (CNC):

Walsall Together





The CNC continued to receive a high level of referrals in October 2023

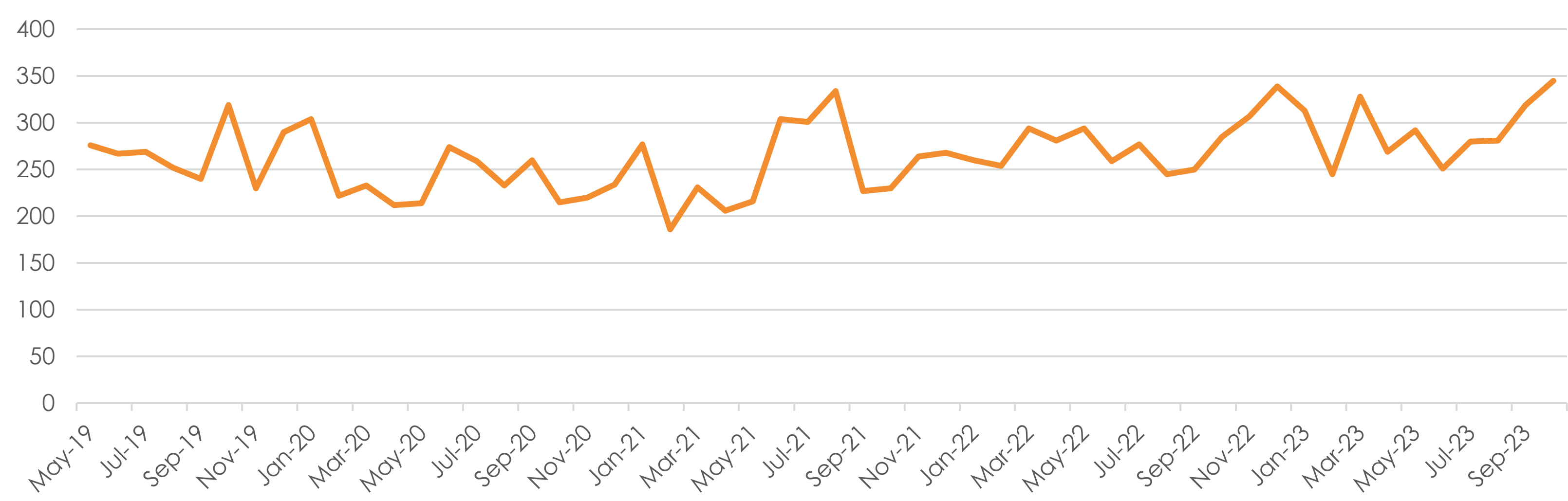
The expansion of capacity that has been embedded has enabled to CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

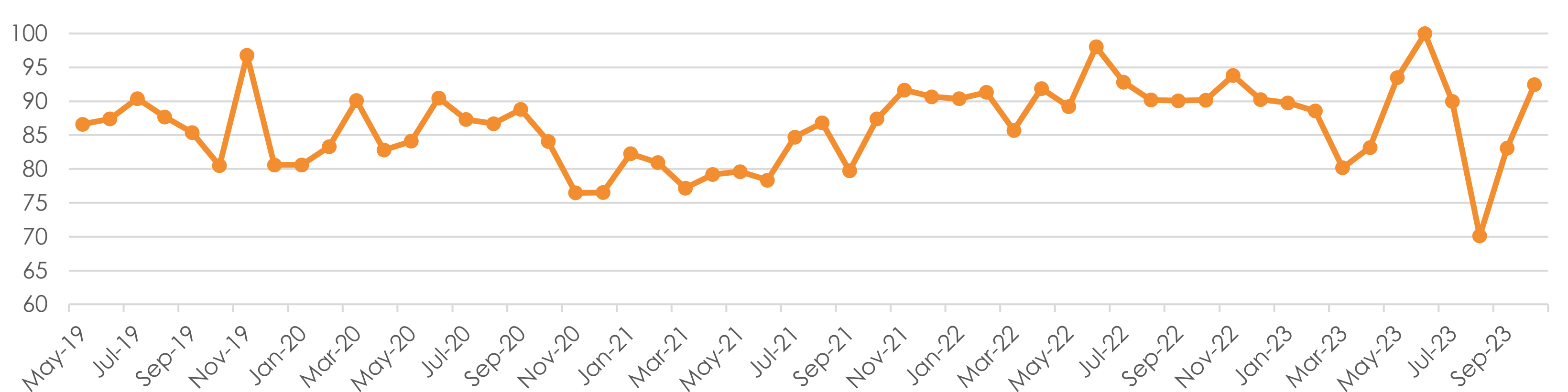
The high call volumes are a result of the enhanced service that has been implemented. This includes the further expansion of CNC capacity streaming patients directly from WMAS into Community pathways and services strengthening of disposition pathways into Rapid Response and Integrated Front Door teams.

Additionally, a 999/111 SPA has been implemented through CNC for ED divert into FES, AEC, SACU and Gynae Early pregnancy services.

Last updated : October 2023

Tier 3: Rapid Response



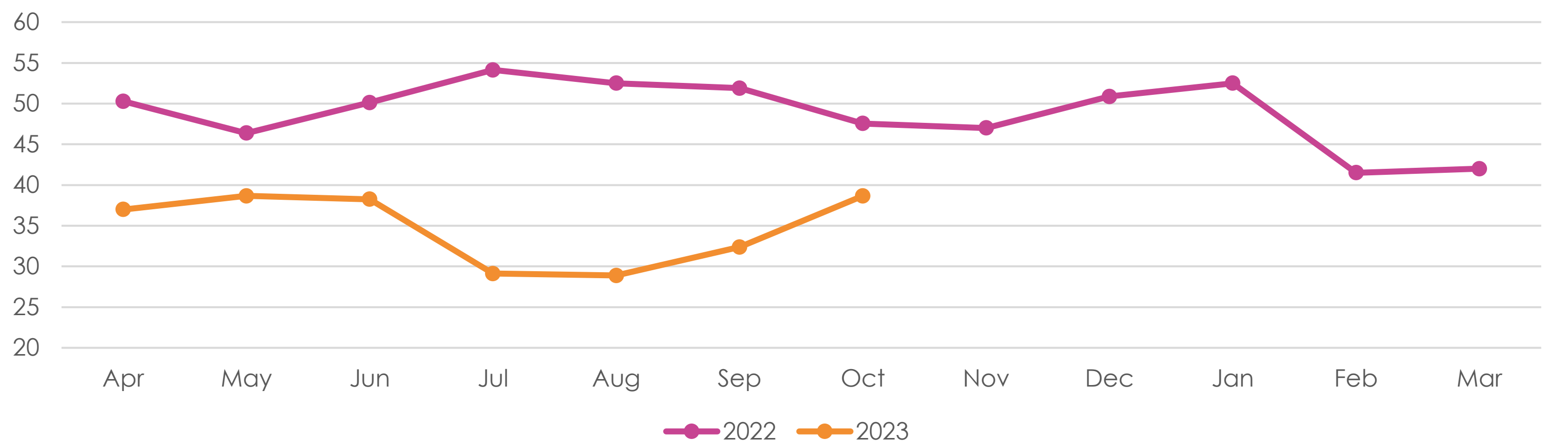


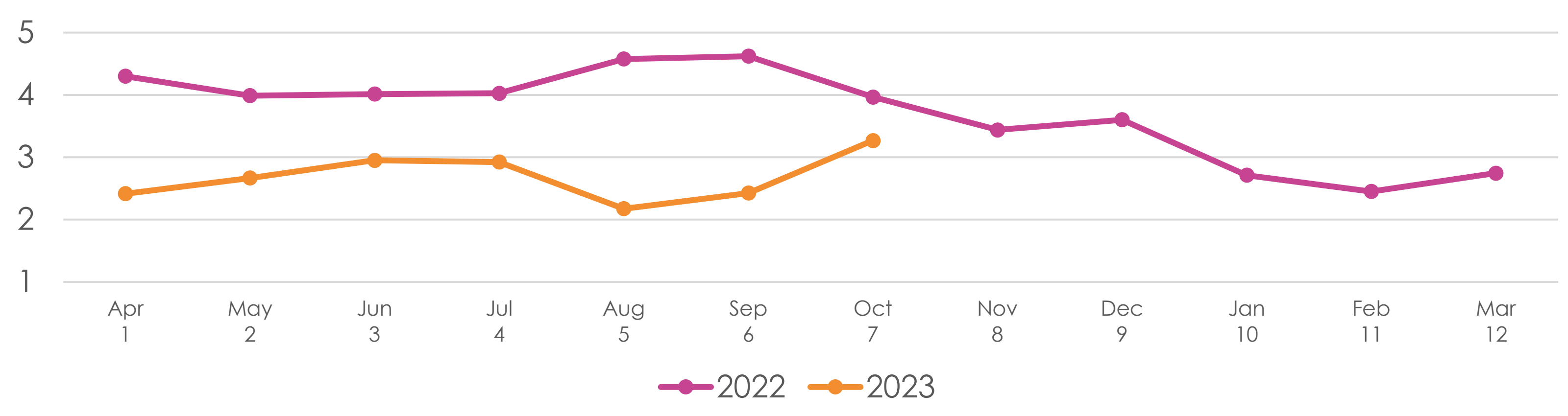
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non-clinical referrals. This was initially set up as a pilot however is now embedded within the service. This has not led to a significant level of referrals to date and is being managed within the present capacity of the service.

Additional capacity within Rapid Response have been implemented in order to manage the increase in dispositions from WMAS and NHS 111.

Last updated : October 2023

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 39 patients during October 2023





The number of patients on the MSFD list averaged 38 patients during October 2023 with the average length of stay maintained at an average of 3 days demonstrating good flow.

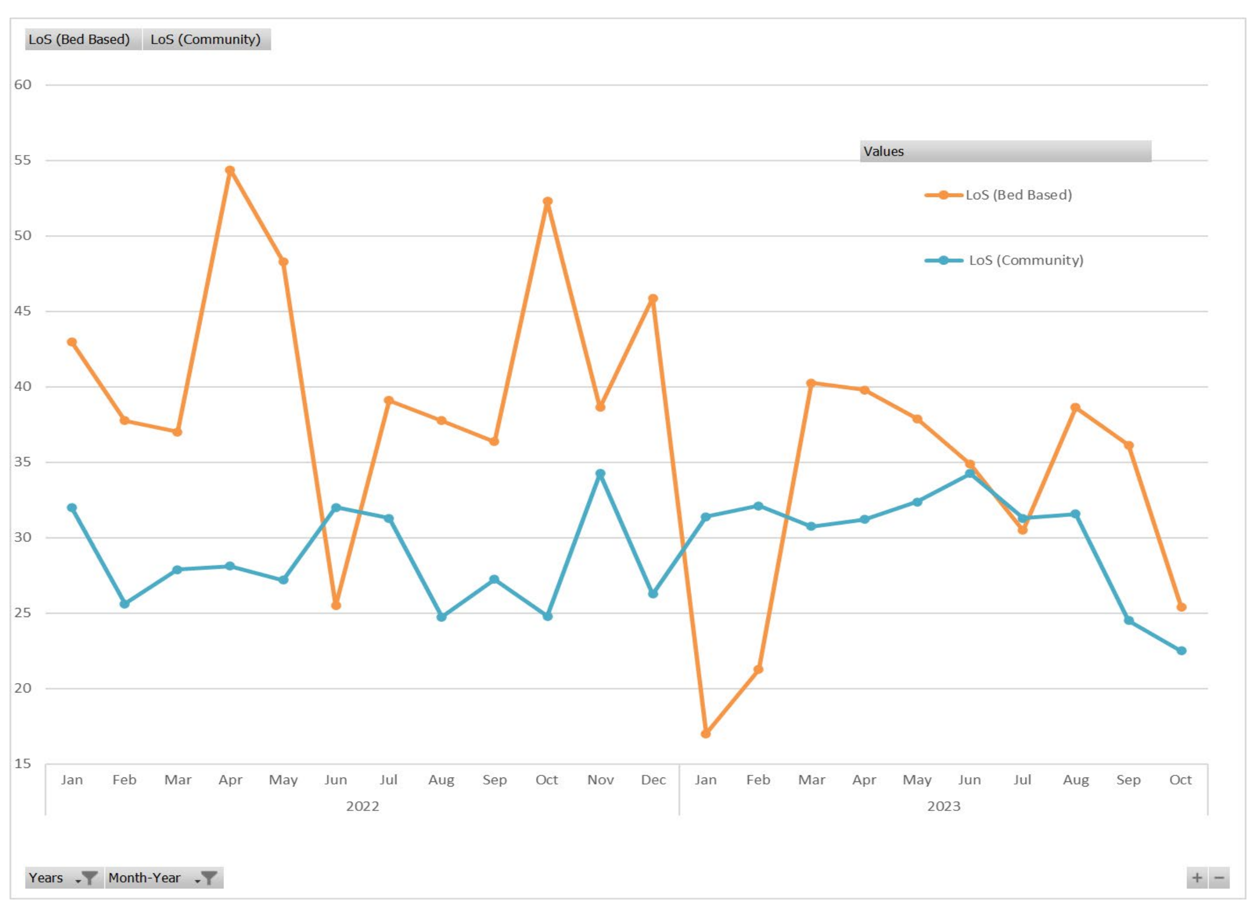
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients. This includes working collaboratively with partner organisations within the system to address the repatriation of patients.

The Intermediate Care Service has also started to pilot a light touch assessments of patients meeting specific criteria in pathway one to enable a full supported assessment in their own home. This enables a more accurate assessment of their needs.

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: October 2023

Tier 3: Domiciliary and Bed-Based Pathways

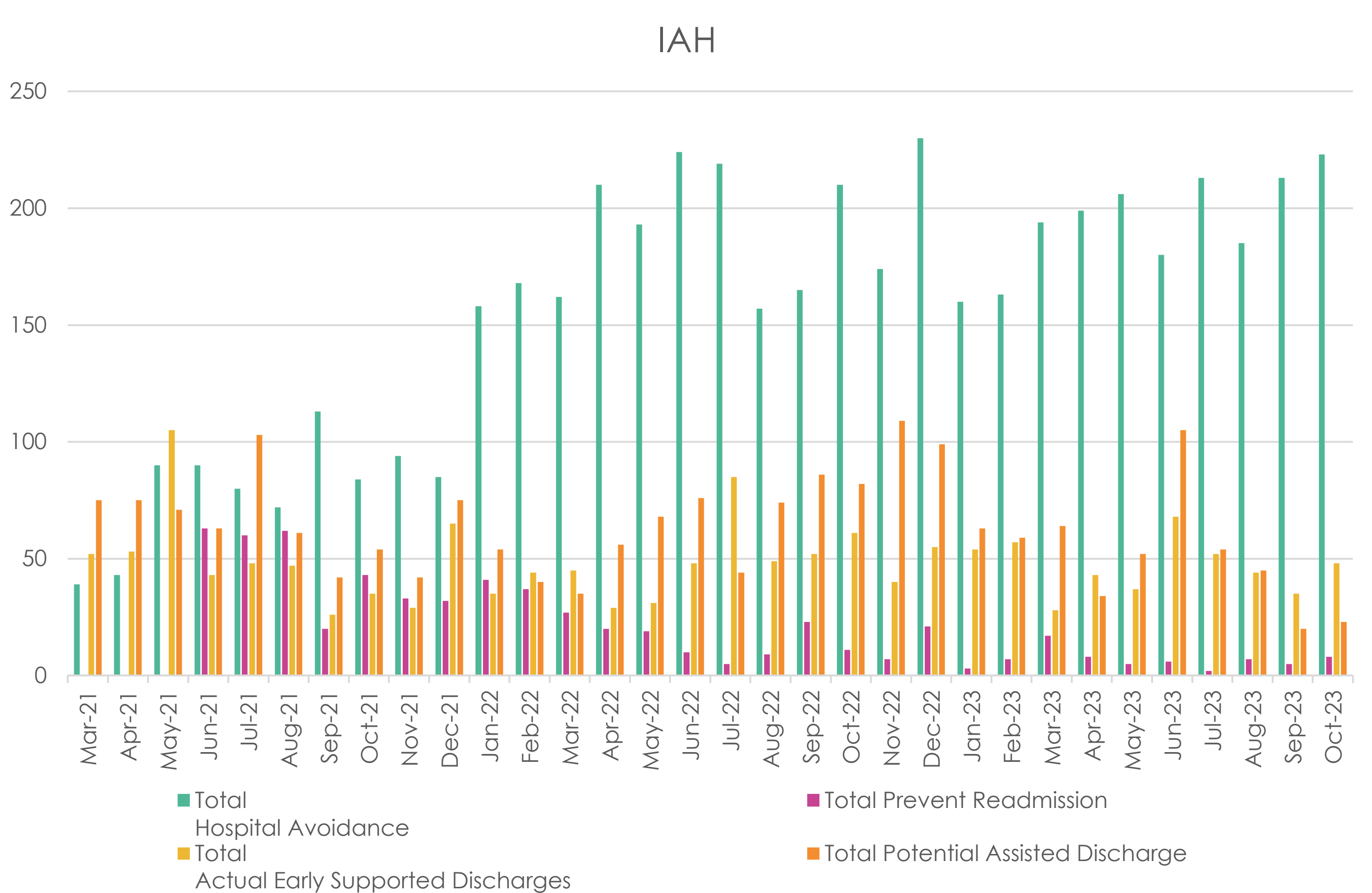


- Therapy demands and the change in national model is having a significant impact on community ICS therapists, unplanned crisis demands and hospital discharges remain key priorities in patient safety.
- Due to Covid, individuals have been more unwell and therefore have needed rehab/Reablement for a longer 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 : October 2023

Tier 3/4:
Integrated Assessment Hub:

Walsall Together



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 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 : October 2023

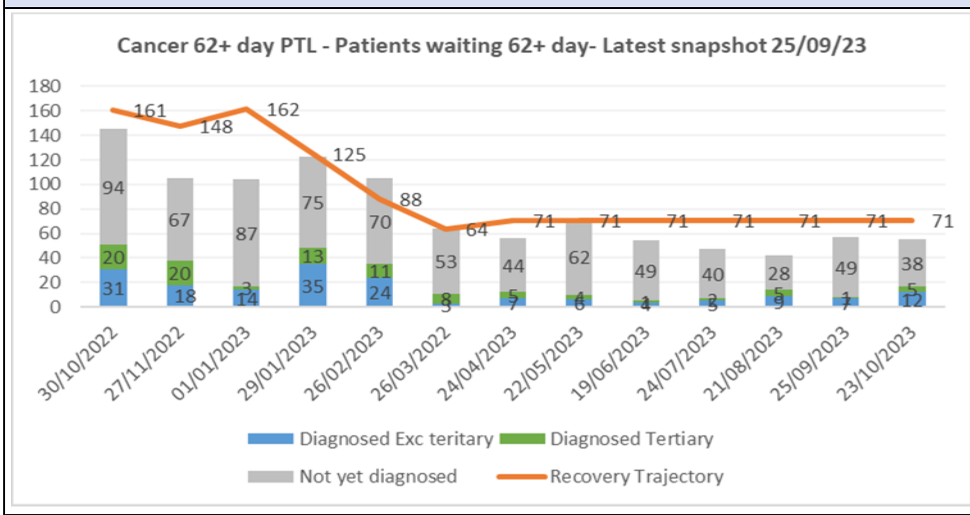
Tier 3/4:
Virtual Wards

Wards	Planned Go Live	Actual Go Live	Beds Plan	Actual Beds Open	Actual Admissions Sep 23	% Of Capacity Used	Step down vs Step up	Av. LOS (days)	% Face to Face contacts	No. of Readmissions
Acute Respiratory Infections	Jul 2022	Jul 2022	25	20	30	28%	30/0	5.4	90%	4
Palliative Care	Jul 2022	Nov 2022	15	15	31	50.6%	7/24	7	N/A	2
Hospital @ Home	Sep 2022	Dec 2022	20	20	57	68.3%	56/1	6.4	85%	2
Frailty	Jul 2022	Jan 2023	40	20	27	27%	24/3	6	92%	4

Strategic Aim: CARE

Strategic Objective: **We will prioritise the treatment of cancer patients, focused on improving the outcome of those diagnosed with the disease**

Board Level Metric(s): **Reduce the 62 day cancer backlog to 39 by the end of March 2024**



Analyst Narrative:

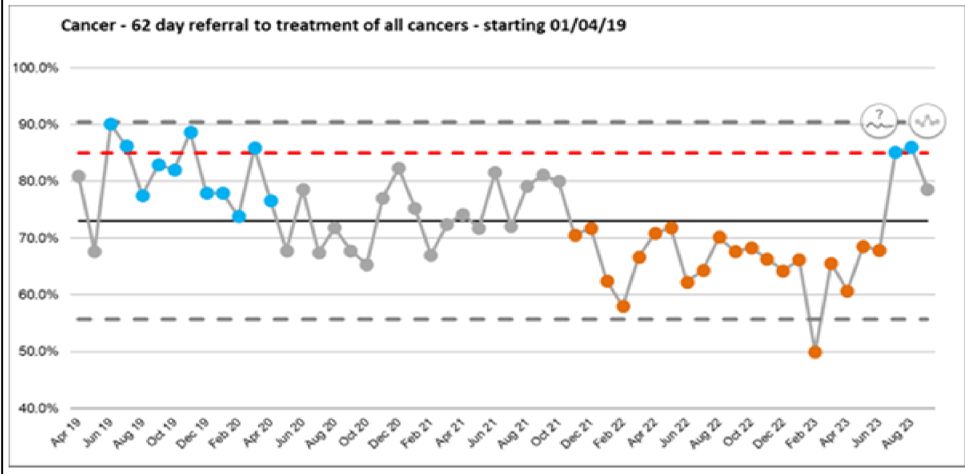
The Trust remains ahead of trajectory for the reduction in patients waiting over 62-days. Work continues to reduce colorectal waits, as a significant contributor to the 62-day+ cohort. The Trust did not achieve the national standard of 85% (for Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer) in September however this is not showing any statistical concern and remains above the average (second chart).

Submitted forecast for patients waiting 62 days +:

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
123	117	111	106	100	95	89	84	78	72	67	61

The trusts national ranking for 62 day referral to treatment of all cancers was 13th nationally and 6th out of 20 trust regionally. This places the Trust in the upper quartile of performance nationally out of 119 reporting Trusts.

SUPPORTING METRICS



Executive Narrative:

Issues:

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.

Actions:

Mitigation plans were put in place for patients that had appointments on industrial action days.

Cancer alliance funded posts have been accepted for operationalisation by the Investment Committee.

Request to SWBH to increase radiology capacity in breast 2ww clinics

Endoscopy expansion Business Case approved at P&F Committee in June, £780k/year investment 3,000+ additional endoscopies /year.

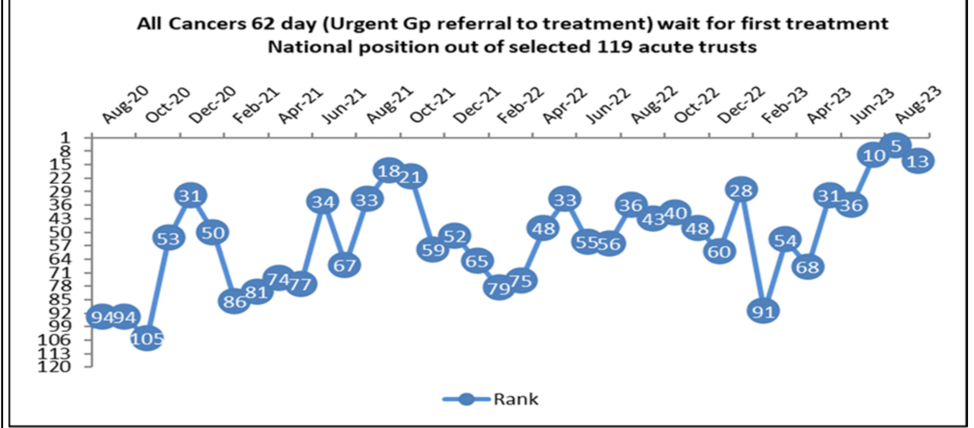
Black Country Pathology Services presented a recovery plan during April to the Cancer Board

Due to recent challenges with 2ww capacity, the cancer team have implemented a 6 week forward look of available capacity for 2ww appointments against predicted demand with an agreed escalation process to the care group and the Deputy Divisional Director of Operations

Strategic Aim: CARE

Strategic Objective: **We will prioritise the treatment of cancer patients, focused on improving the outcome of those diagnosed with the disease**

Board Level Metric(s): **Reduce the 62 day cancer backlog to 39 by the end of March 2024**

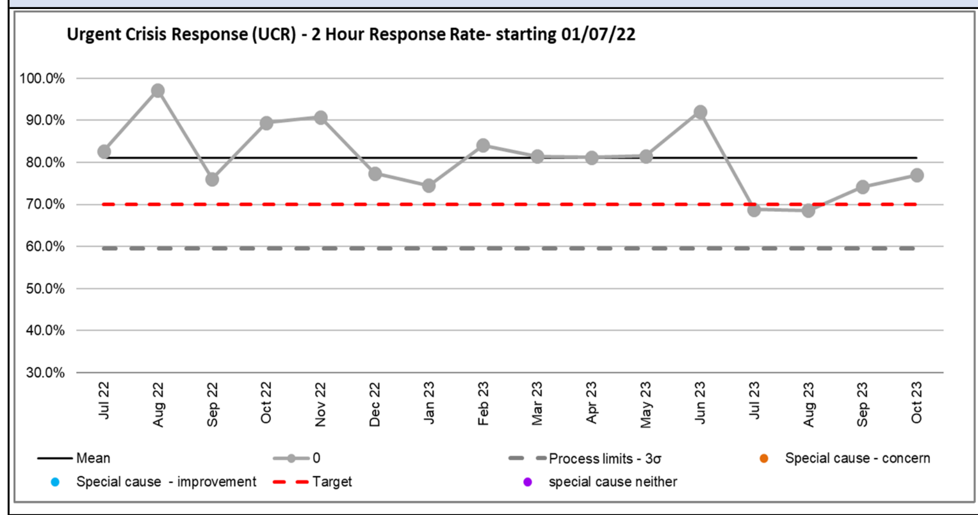


ACTION	BY WHO	BY WHEN
Endoscopy expansion business case	Director of Ops MLTC	From Oct 23 - into 24/25
BCPS recovery plan - At Walsall we have set up a working group to look at the various workstreams to support the improvement	Interim Director of WC&CSS (support services)	

Strategic Aim: CARE

Strategic Objective: **We will deliver safe and responsive urgent and emergency care in the community and in hospital**

Board Level Metric(s): **Delivery of the urgent 2 hour Urgent Community Response standard**

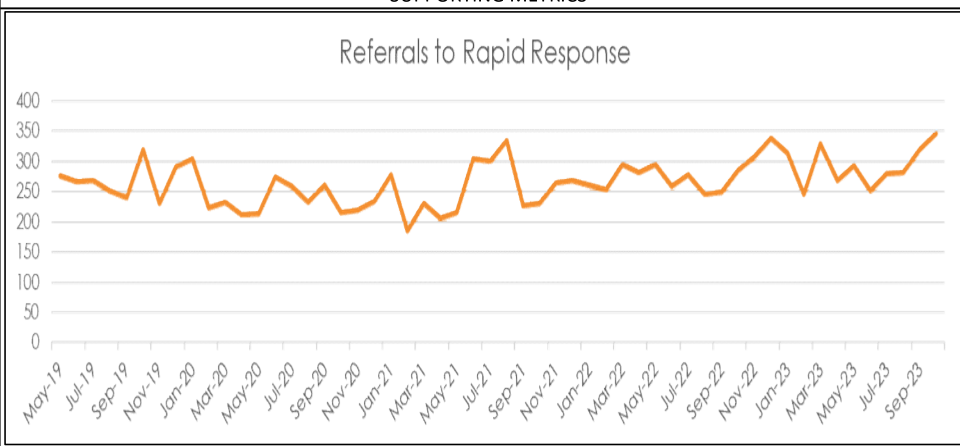


Analyst Narrative:

Performance against the national constitutional standards for response rates within 2 hours continues to be within normal statistical variation. October reported 77% above the target of 70%.

Rapid Response received 345 referrals in October. These are patients with acute exacerbation of symptoms. Rapid Response intervention led to 85% of patients avoiding an admission (293)

SUPPORTING METRICS



Executive Narrative:

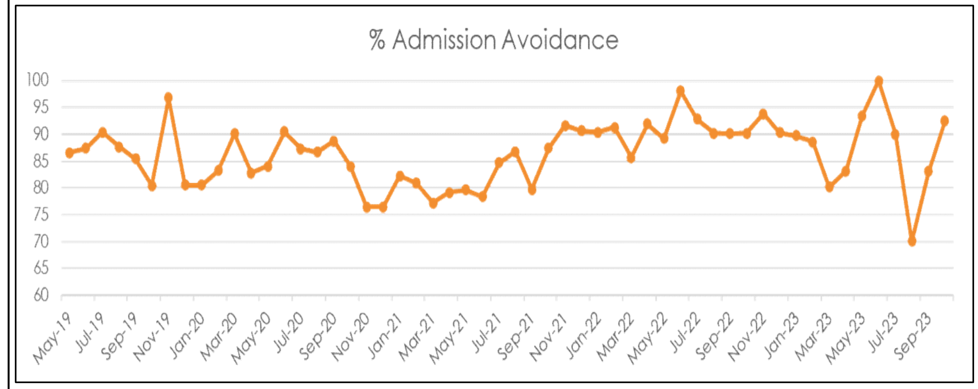
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for Avoidable Hospital admission referrals.

Additional capacity within Rapid Response has been implemented in order to manage the increase in dispositions from WMAS and NHS 111.

Strategic Aim: CARE

Strategic Objective: **We will deliver safe and responsive urgent and emergency care in the community and in hospital**

Board Level Metric(s): **Delivery of the urgent 2 hour Urgent Community Response standard**

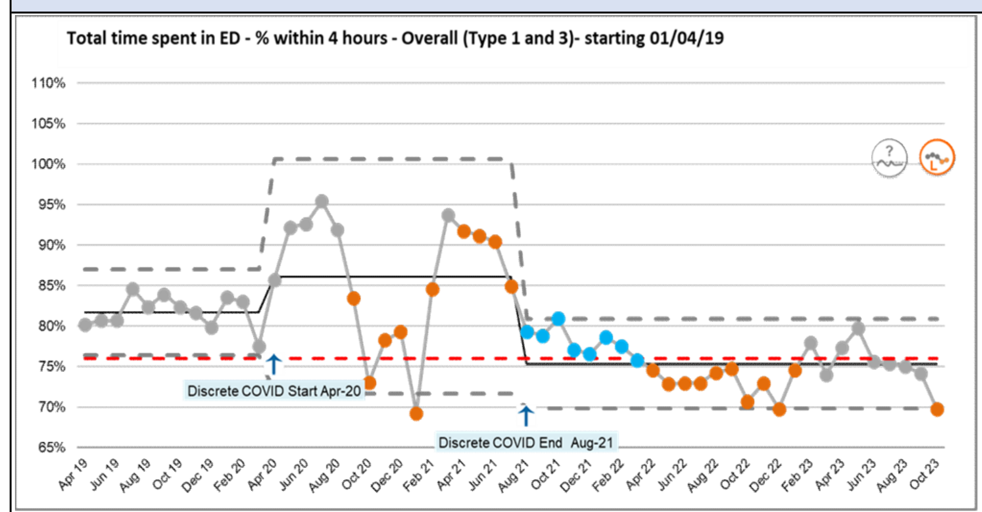


ACTION	BY WHO	BY WHEN
Ongoing work to improve data recording to ensure accurate reporting	Clinical lead UCR	

Strategic Aim: CARE

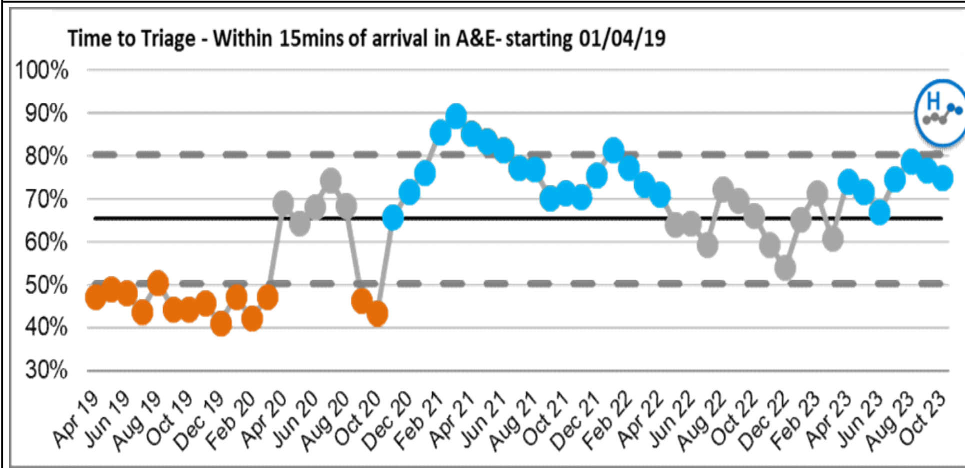
Strategic Objective: **We will deliver safe and responsive urgent and emergency care in the community and in hospital**

Board Level Metric(s): **Delivery of the 76% 4 hour A&E target**



Analyst Narrative:
From April 2023 the national constitutional target changed to 76% for Percentage of Accident & Emergency attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival.
In October the Trust fell short of this target with a performance of 69.8%, this is showing a statistical decline for the first time since February 2023 (noting the application of stepped change on the chart for the Covid period).
October was the highest month of Type 1 ED attendances received on record, and significant Exit Block for patients requiring admission from ED was experienced.
WHT's national ranking is 43rd best Trust out of 123 reporting Acute Trusts in September 2023. Regional ranking 6th out of 21 Trusts.
The Trust remains in the 2nd best quartile for the percentage of ED attendances spending 12 hours in ED from time of arrival compared to the national position.
Time to triage metric continues to show statistical improvement, this standard forms part of the Internal Professional Standards action plan and has yielded positive results.

SUPPORTING METRICS



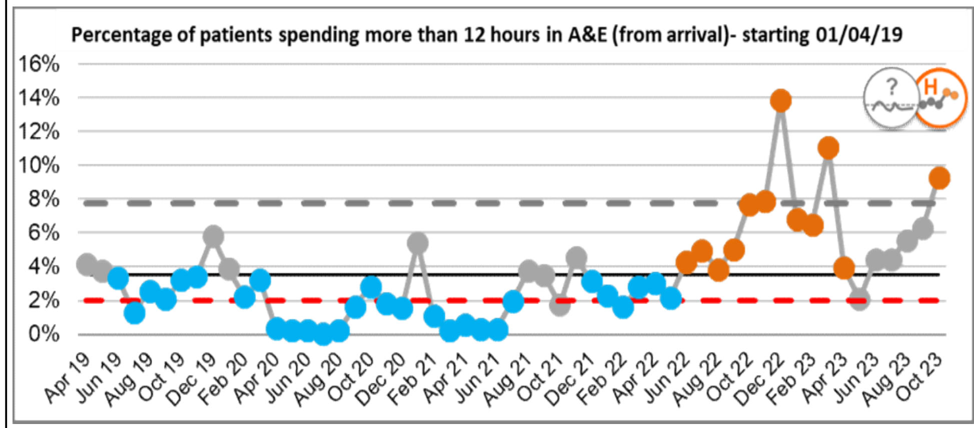
Executive narrative:
Issues: October 2023 was the highest month of type 1 attendances in ED on record. High cubicle occupancy caused by exit block for patients needing medical admission.
October had the second highest month of Intelligently Conveyed ambulances from other Trusts on record.
Ability to improve Non Admitted pathway.
Ability to effectively manage the increase in Mental Health presenting patients to ED.
Appropriate streaming of GP referrals.
Delays in accessing imaging (particularly CT)

Actions:
The COO, Divisional Team and ED Care Group have re-assessed a comprehensive plan to improve patient time in the ED, summarised below.
New Ambulatory Emergency Care Unit with expansion in Assessment rooms to take both returning AEC patients and GP referrals streamed from ED. The new Unit is scheduled to open in December 2023.
Introduction of a new Hot Imaging Suite, located adjacent to the new ED to open in Spring 2024.
21 Winter Plan general medical beds are open and have been throughout October.

Strategic Aim: CARE

Strategic Objective: **We will deliver safe and responsive urgent and emergency care in the community and in hospital**

Board Level Metric(s): **Delivery of the 76% 4 hour A&E target**

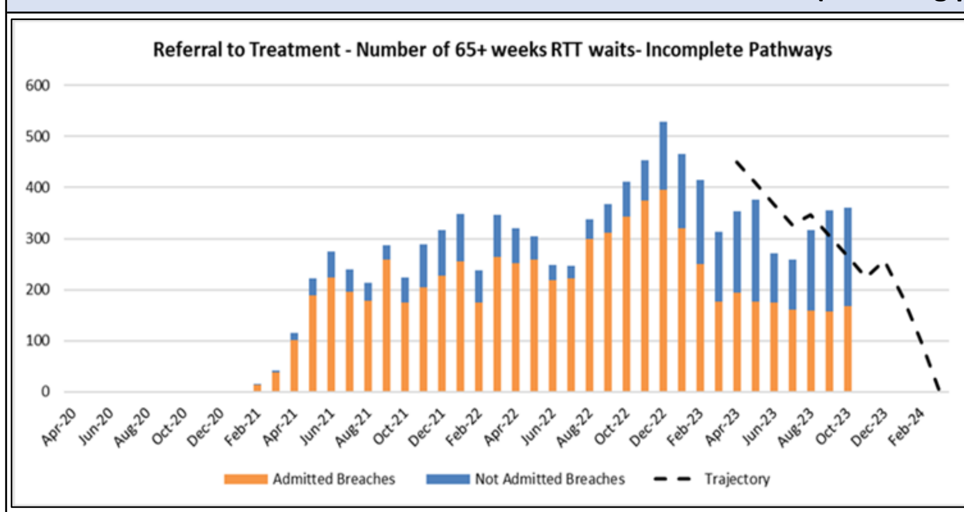


ACTION	BY WHO	BY WHEN
New Medical SDEC, expanding assessment spaces to 15 and streaming all GP referrals away from ED.	MLTC Divisional Team	Dec-23
Re-evaluate and test ED Escalation guidelines, including processes for ambulance handover	ED Clinical Lead / ED Matron / ED Care Group	Nov-23
Revise Discharge Lounge criteria and use of the D/L, with particular focus on pre 1100	MLTC Divisional Team	Nov-23
Complete PDSA cycles assessing the effectiveness of the CLASS and SMART Snr Decision Maker	ED Clinical Lead / ED Matron / ED Care Group	Nov-23
Adjust timetable to increase clinician staffing in ED and AEC on Monday and Tuesday	ED and Acute Care Clinical Director	Nov-23
Review SACU Criteria to support streaming of undifferentiated ambulatory patients with abdo pain	Medical and Surgery Divisional Teams	Nov-23

Strategic Aim: CARE

Strategic Objective: **We will deliver the priorities within the National Elective Care Strategy**

Board Level Metric(s): **Eliminate 78 weeks by the end of June 2023 (excluding patient choice) / Eliminate 65 weeks by the end of March 24 (excluding patient choice)**



Analyst Narrative:

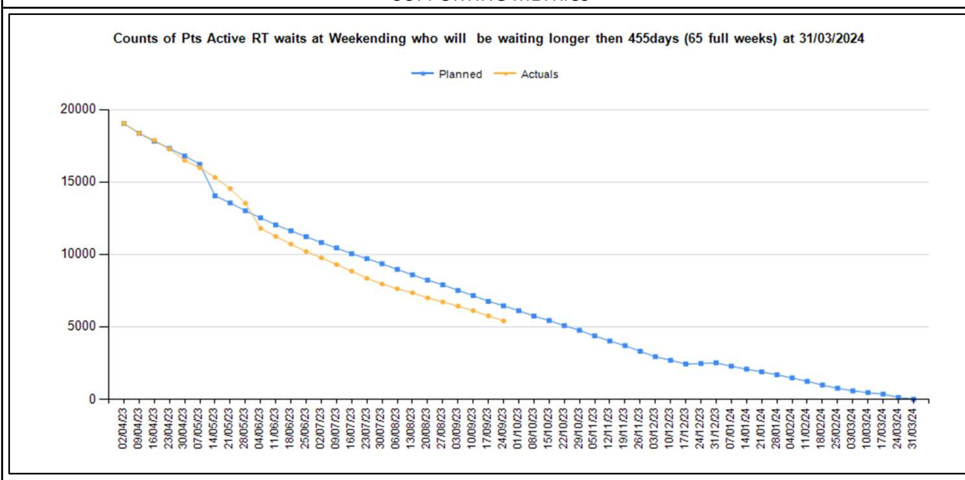
Although the number of 65 week breaches has not reduced in line with the submitted trajectory, the Trust is ahead of forecast against the 65 week cohort (patients who are at risk of still waiting 65 weeks at 31st March 2024) (second chart).

The Trust's 65-week waiting time (as a % of total PTL) is in the 2nd best quartile at 58th nationally (out of 120 trusts) and 8th regionally in the Midlands out of 21 Trusts. (third chart)

In October, the RTT performance was 57.21%, above forecast of 56%. Although below national median, the Trust's ranking position for RTT is demonstrating incremental improvement this financial year and critically the number of patients on the Trust's total elective waiting list is now falling from a peak of 35,882 in April 2023 to 32,456 in October 2023, against a backdrop of new record highs for the elective waiting list at national level each month.

The Trust continued to deliver no patients waiting over 78 weeks (excluding patient choice) for the 8th consecutive month.

SUPPORTING METRICS



Executive Narrative:

Issues: The Trust postponed 650 outpatient and 3 elective procedures due to industrial action in October 2023 (although lost elective surgical capacity was far greater than this as bookings into theatre lists on strike days were suspended once the strike dates were announced).

Actions: The Trust approved a business case to expand elective theatre sessions by 6.5 session per week. From 23rd October we have increased the number of elective sessions available, therefore whilst the session utilisation is consistent at 84%, the number of theatre sessions undertaken in month has increased to 643 in October compared with 612 in September. The increase in theatre sessions saw October achieve the highest number of sessions per month this financial year.

Increasing Patient Initiated Follow Ups (PIFU) to reduce DNA rates for follow up appointments.

Commencing the National Patient Mutual Aid Scheme (PIDMAS), which will allow patients to "opt-in" to move provider, 1st cohort is for patients waiting over 40 weeks.

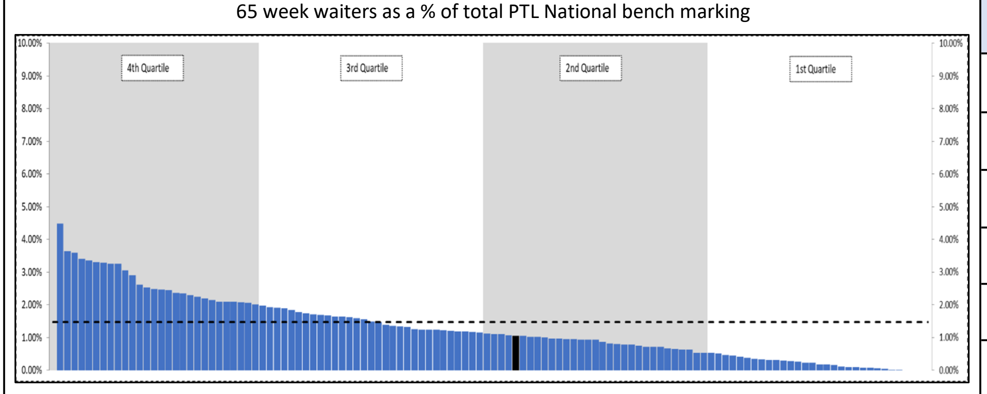
Plans have been put in place to support challenged specialties with achieving no patients wating at 31st March 2024 over 65 weeks, with additional clinics and theatre capacity.

Strategic Aim: CARE

Strategic Objective: **We will deliver the priorities within the National Elective Care Strategy**

Board Level Metric(s): **Eliminate 78 weeks by the end of June 2023 (excluding patient choice) / Eliminate 65 weeks by the end of March 24 (excluding patient choice)**

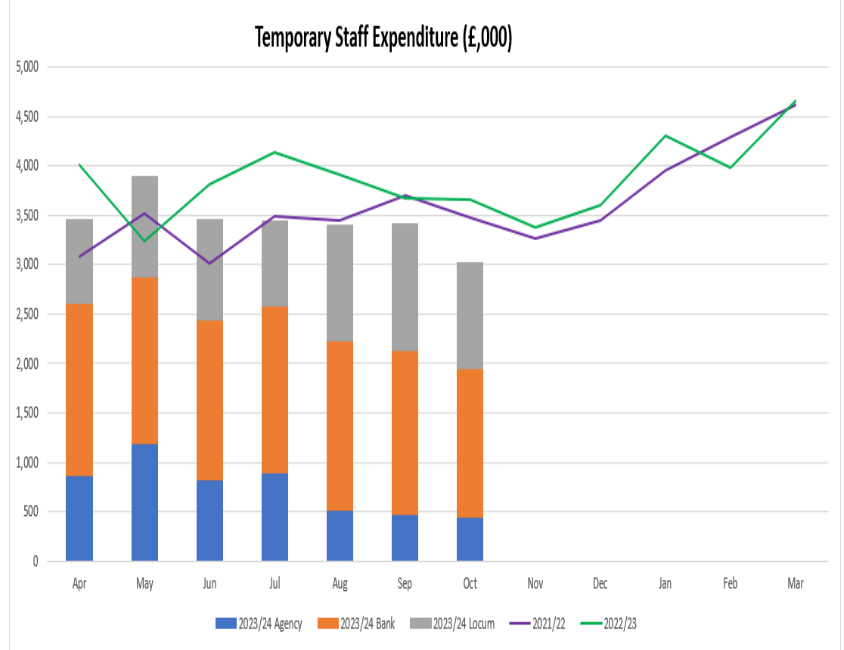
65 week waiters as a % of total PTL National bench marking



ACTION	BY WHO	BY WHEN
Participating in NHSE Further Faster Programme	Lead Div Director Ops DoS	Q4
Implementing PIDMAS Patient initiated digital mutual aid system)	Lead Div Director Ops DoS	Sep-24
Outpatients transformation Project (Internal)	Lead Div Director Ops DoS	Q3

Financial Performance to October 2023 (Month 7)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Subtotal Income	219,166	222,024	2,858
Subtotal Pay Expenditure	(153,276)	(158,705)	(5,429)
Subtotal Non Pay Expenditure	(72,437)	(79,271)	(6,835)
Subtotal Finance Costs	(7,485)	(7,971)	(486)
Total Surplus / (Deficit)	(14,031)	(23,923)	(9,892)
Plan Re-Profile	5,058	0	(5,058)
Adjusted Surplus / (Deficit)	(8,973)	(23,923)	(14,950)



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 has delivered a deficit of £23.923m at Month 7, this is £9.892m above the planned deficit of £14.031m.
- Income was £2.858m above plan (this includes £884k over performance against the ERF target) Staffing costs were £5.429m above plan and non-pay costs were £6.835m above plan. Pay overspends are caused by use of temporary staff above plan and profile differences between planned CIP and actual CIP. Non-Pay variance is caused by inflationary impact above the nationally allocated amount.

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.
- Year to Date Capital expenditure for Month 7 was £2.583m against a plan of £16.548m.

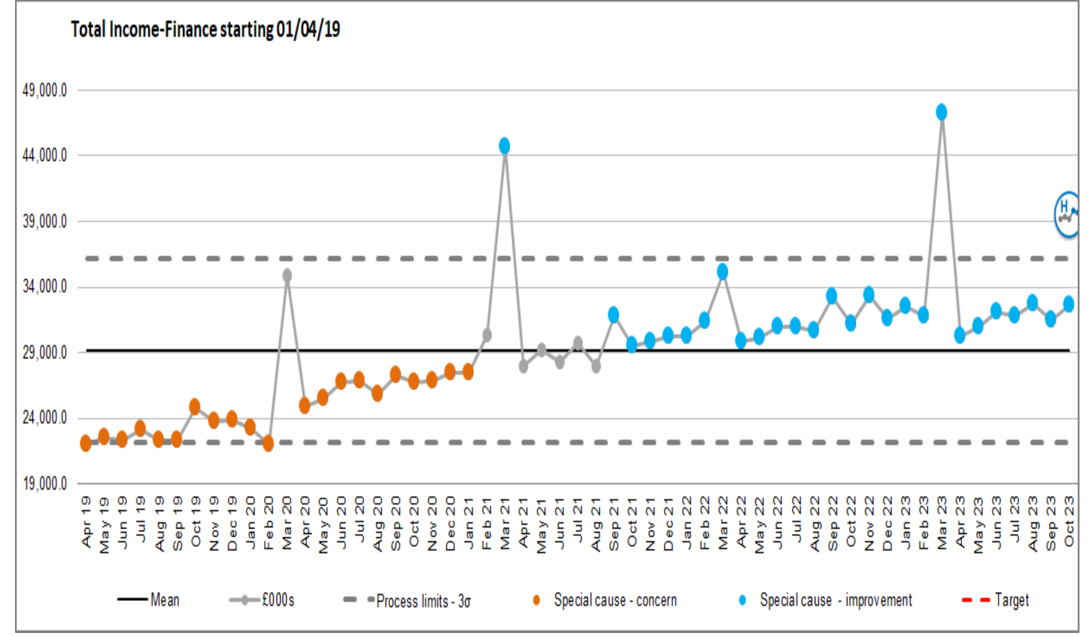
Cash

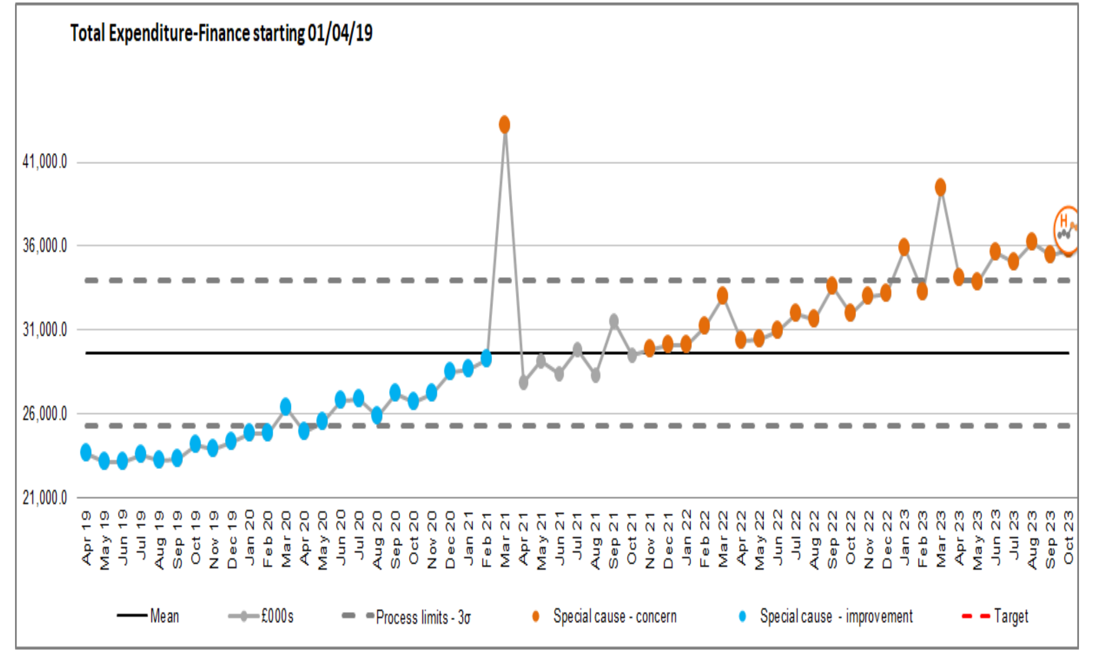
- The Trust currently holds a healthy cash position, however the forecast deficit results in the need for borrowing in future months. The trust is seeking cash support from the ICB during Q3.

Efficiency attainment

- Traditional CIP plans (£17.2m Divisional Target) are currently at 81% achievement (64% Recurrent & 36% Non- Recurrent)
- FOT delivers 65.5% of the £26.45m stretch original planned savings
- FOT savings of £17.3m of which £8.5m are high risk (£2.7m still to be identified) and £5.9m are medium risk schemes (including £3.3m of technical adjustments).

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).
- 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

- Expenditure spiked in March 2023 due to a provision for the 23/24 pay award non-consolidated retrospective, as the funding was received in that month
- 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

ENC 10.3.1

Report of the Group CFO

for the month of October (Month 7) 2023

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

Summary

Overview of Financial Performance

The Trust is reporting a YTD deficit of £23.923m at the end of Month 7. This is £9.892m adverse to the revised plan and £14.950m adverse to the original plan submitted to NHS England.

Income is positive to plan by £2.858m due largely to , £1.763m of Education & Training income (offset by costs) and additional income as the Trust is ahead of elective recovery targets.

Pay is overspent by £5.429m. The Trust has incurred extra costs providing cover for junior doctor and consultant strikes (£1.677m). While substantive pay is underspent due to vacancies, this underspend is more than offset by temporary staffing costs.

For non pay drugs are overspent by £1.038m. Clinical supplies and services overspend is being driven by increased usage of hearing aids in audiology, YMS Endoscopy outsourcing and wheelchairs. Non Clinical Supplies and other non pay overspend is driven by various inflationary pressures, adhoc / unfunded costs linked to security, small works etc in addition to cost pressures from insourcing and outsourcing to maintain diagnostic performance.

System Updates

The ICB has a YTD deficit of £88.7m, £31.8m adverse to plan (1.9%) with 5 out of 8 organisations off plan.

Capital

The 23/24 Trust capital programme is £24.403m. The constituent parts of the programme are £9.053m of Capital Resource Limit (CRL) from Black Country ICB, £12.6m of Public Sector Decarbonisation Scheme (PSDS) and £2.75m from NHSE for Front Line Digitisation. YTD expenditure on the programme is £2.580m. Programmes are suffering from differing delays. Discussions are continuing with PSDS and NHSE in regards to the Trusts theatres modernisation programme and for clinical purposes it has been proposed that works in the Old ED to develop hot imaging have a higher clinical priority than develop the ED Shell Space (beds for AMU). The Trust continues to forecast all funds being deployed in the financial year.

Risks

The Trust continues to have significant risk to its Revenue position. These risks are scrutinised through the Performance and Finance Committee but include achieving and developing CIP plans and pressures from increased use of bank staff.

Month 7 YTD I&E Performance – Walsall Healthcare Trust

	Plan £000s	Actual £000s	Variance £000s
Income			
Healthcare Income	208,210	208,703	493
Other Income (Education&Training)	4,553	6,315	1,763
Other Income (Other)	6,403	7,006	602
Subtotal Income	**219,166**	**222,024**	**2,858**
Pay Expenditure			
Substantive Salaries	(149,238)	(134,653)	14,586
Temporary Nursing	(3,040)	(10,791)	(7,751)
Temporary Medical	(676)	(8,736)	(8,060)
Temporary Other	(322)	(4,526)	(4,203)
Subtotal Pay Expenditure	**(153,276)**	**(158,705)**	**(5,429)**
Non Pay Expenditure			
Drugs	(13,516)	(14,554)	(1,038)
Clinical Supplies and Services	(10,823)	(12,846)	(2,023)
Non-Clinical Supplies and Services	(17,810)	(19,333)	(1,523)
Other Non Pay	(22,163)	(24,839)	(2,677)
Depreciation	(8,124)	(7,698)	426
Subtotal Non Pay Expenditure	**(72,437)**	**(79,271)**	**(6,835)**
Interest Payable	(7,485)	(7,971)	(486)
Subtotal Finance Costs	**(7,485)**	**(7,971)**	**(486)**
Total Surplus / (Deficit)	**(14,031)**	**(23,923)**	**(9,892)**
Plan Re-profile	5,058		(5,058)
Submitted Plan Profile	**(8,973)**	**(23,923)**	**(14,950)**

I&E Performance – Drivers of the Overspend YTD Month 7 – National Pressures

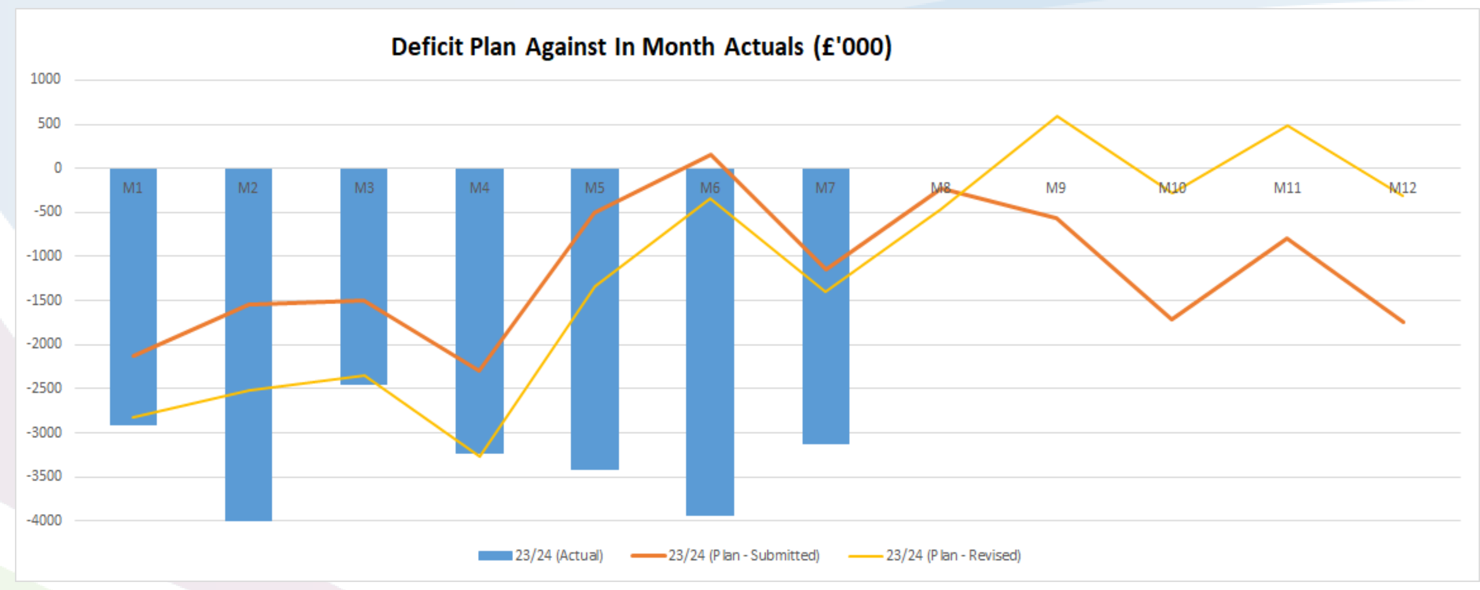
Drivers of the Deficit	YTD M7 £000's
Excess Inflationary Pressures	
Drugs (incl volume)	1,038
Energy (incl contracts and leases)	923
Business Rates	218
Provisions	345
RPI linked contracts (non PFI)	198
Excess Inflationary Pressures - sub total	**2,722**
Other Funding Pressures	
Pay award - 23/24	175
Other Funding Pressures - sub total	**175**
Drivers outside WHT Control	
Dr Strike - Acting Down	1,381
Dr Strike - Temp Costs	639
Dr Strike - Deductions	(343)
Drivers outside WHT Control - sub total	**1,677**
Subtotal National Pressures	**4,574**

The Trust is experiencing excess inflationary pressures (as Trusts are nationally), there is a slight pressure from the pay award and pressure from strikes.

I&E Performance – Drivers of the Overspend YTD Month 7 – Other Pressures

Drivers of the Deficit	YTD M7 £000's
Other Drivers	
CIP	2,219
ERF Over-performance (Included in CIP from Month 7)	0
Healthcare Income overperformance (Drugs and Devices)	(493)
Overperformance on Education and Training Income	(1,763)
Anaesthetics Consultant Locums	792
General Surgery Medical Staff	1,087
Paediatric Unfunded Rotas (Nursing and Medical)	1,536
Emergency Department Staffing	1,864
Gastroenterology Staffing	730
Elderly Care Staffing	929
Vacancy Underspends	(4,151)
Clinical Consumables	1,601
Patient Appliances	311
Imaging Outsourcing + Mobile MRI	615
Other	42
Other Drivers - sub total	**5,319**
Total variance to plan	**9,892**

I&E Performance – Walsall Healthcare Trust



- Revised Plan is for a deficit of £14.030m at Month 7. YTD actual shows an adverse variance to plan of £9.892m
- Important to note that NHSE did not allow WHT to update the financial plan profile and therefore are seeing a variance of £14.950m YTD in external reporting

Statement of Financial Position

STATEMENT OF FINANCIAL POSITION			
Statement of Financial Position for the month ending October 2023	Balance as at 31/03/23	Balance as at 31/10/2023	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Property, plant & Equipment	242,431	237,605	(4,826)
Intangible Fixed Assets	6,012	5,560	(452)
Receivables greater than one year	693	249	(444)
Total Non-Current Assets	**249,136**	**243,414**	**(5,722)**
Current Assets			
Receivables & pre-payments less than one Year	27,929	28,721	792
Cash (Citi and Other)	38,358	10,910	(27,448)
Inventories	3,629	3,763	134
Total Current Assets	69,916	43,394	(26,522)
Current Liabilities			
NHS & Trade Payables less than one year	(62,290)	(52,225)	10,065
Other Liabilities	(711)	(6,073)	(5,362)
Borrowings less than one year	(6,527)	(5,398)	1,129
Provisions less than one year	(183)	(183)	-
Total Current Liabilities	(69,711)	(63,879)	5,832
Net Current Assets less Liabilities	**205**	**(20,485)**	**(20,690)**
Non-current liabilities			
Borrowings greater than one year	(120,584)	(118,269)	2,315
Total Assets less Total Liabilities	128,757	104,660	(24,097)
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	252,913	252,912	(1)
Revaluation	65,284	65,284	-
Income and Expenditure	(162,566)	(189,441)	(26,875)
In Year Income & Expenditure	(26,874)	(24,095)	2,779
Total TAXPAYERS' EQUITY	128,757	104,660	(24,097)

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)

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).

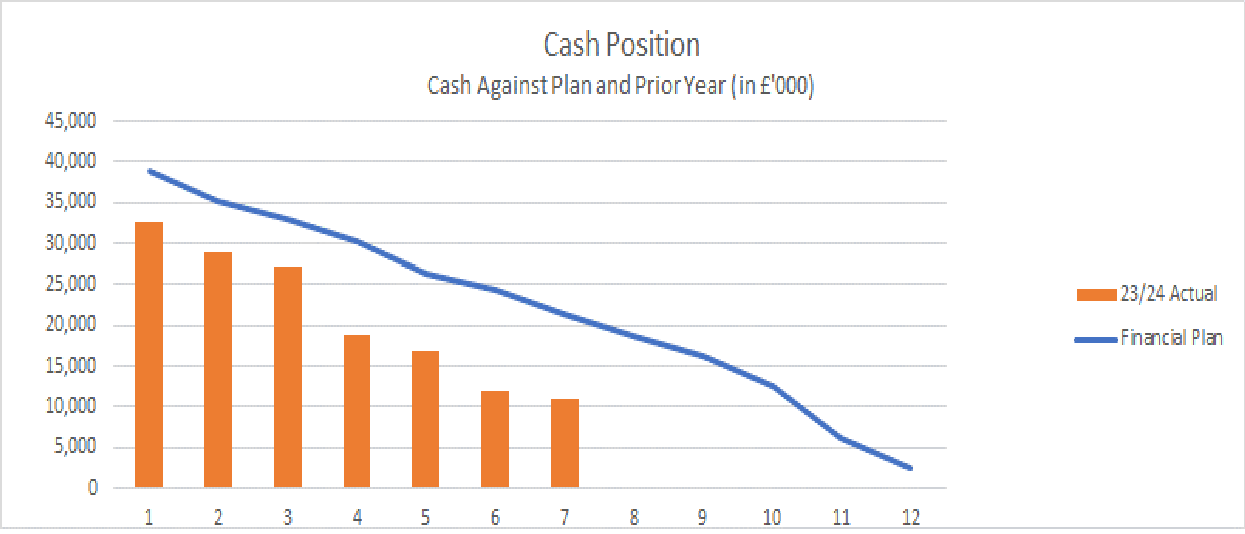
There will be a need to accurately forecast cashflows at Trust and system level as there is a possibility that cash will need to move around the system if providers have insufficient working capital to operate.

Trade payables/accruals have reduced from March 23 by £11m due to the payment of invoices and release of balance sheet provisions within the plan. This is also reflective of the current cash balance movements

Cashflow

CASHFLOW STATEMENT Statement of Cash Flows for the month ending October'23	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(16,978)
Depreciation and Amortisation	7,870
Donated Assets Received credited to revenue but non-cash	0
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(353)
Increase/(Decrease) in Trade and Other Payables	1,243
Increase/(Decrease) in Other Liabilities	0
Increase/(Decrease) in Stock	(130)
Increase/(Decrease) in Provisions	0
Other movements in operating cash flows	0
Interest Paid	(6,327)
Dividend Paid	(1,418)
Net Cash Inflow/(Outflow) from Operating Activities	**(16,093)**
Cash Flows from Investing Activities	
Interest received	**854**
(Payments) for Property, Plant and Equipment	**(9,836)**
Initial Indirect costs in respect of new right of use assets	**0**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(8,982)**
Net Cash Inflow/(Outflow) before Financing	**(25,075)**
Cash Flows from Financing Activities	(2,373)
Net Increase/(Decrease) in Cash	**(27,448)**
Cash at the Beginning of the Year 2023/24	38,358
Cash at the End of the May	**10,910**

- The cash balance as at 31 October 2023 is £10.9m, a £1.1m decrease on the previous month and a decrease of £10.4m on financial plan.
- The cash balance has moved by £27.4m (decrease) on the closing balance at March 2023 of £38.4m.



Income	£m	
	30.7	Block Payments
	4.4	Health Education England (Oct 23 to Jan 24 funding)
	0.8	Non-NHS
	0.7	VAT Income
	0.1	Interest
	36.7	

Expenditure	£m	
	(23.0)	Pay related costs including Tax, NI and Pension costs
	(10.1)	Non Pay
	(2.7)	Unitary
	(1.2)	NHS LA
	(0.8)	Other Expenditure
	(37.8)	
	(1.1)	

Capital

The trust has spent £2.58m of Capital YTD to 31st October 2023, which is an underspend of £13.97m against planned YTD Capital of £16.5m. Of the £2.58m YTD Spend:

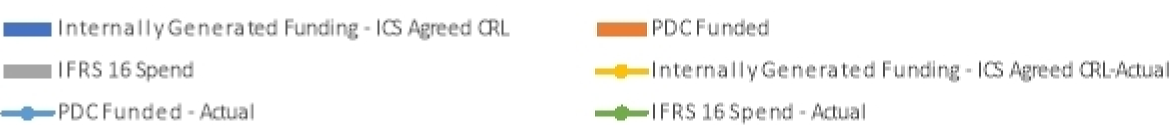
•£1.7m relates to capital spend which the ICS is measured against, which is an underspend of £8.98m vs plan due to timing of orders. No PDC Funding YTD spend leading to a variance of £1.5m vs plan YTD due to business cases undergoing approval. The trust expects to meet the CRL plan of £11.8 at the end of the year.

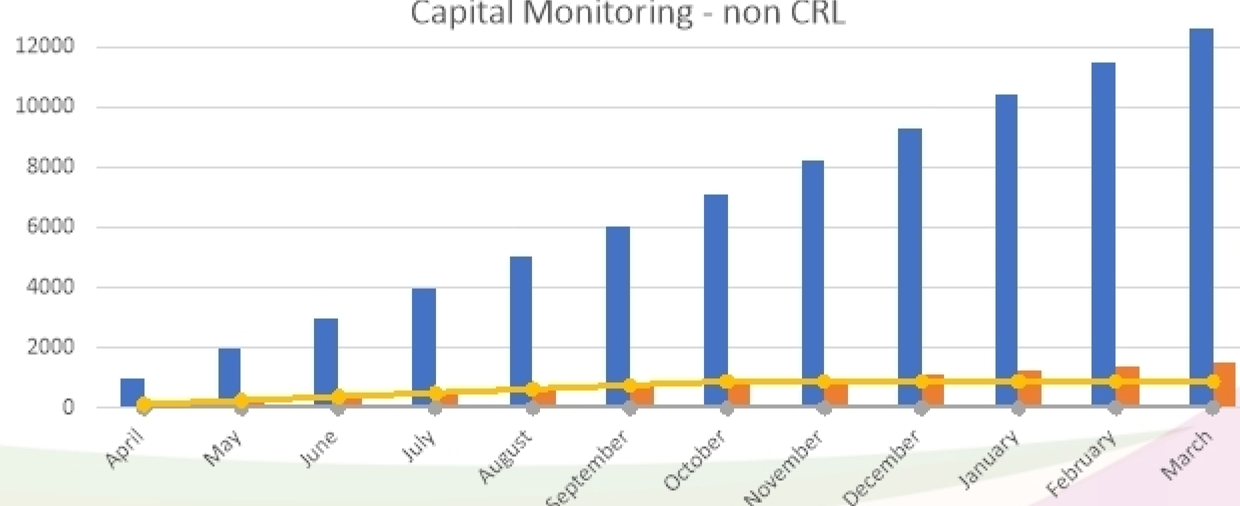
•The balance of the YTD Capital spend of £0.88m relates to PFI/IFRIC 12 capital while the variance of £4.99m vs plan is as a result of no actual cost yet against the PSDS grant funds.

•BCPS request to transfer CRL allocation of £53k to support high priority replacement schemes.

Scheme	M7 YTD Budget £'000s	M7 YTD Spend £'000s
Estates:		
PFI Lifecycle:	868	883
Old ED works+A&E Other	3,000	585
Lead Lined Room	620	-
Estates Lifecycle	560	645
New Build-Non Clinical (PSDS Match Funding)	5,000	-
Theatre Refurb	3,000	58
Health Records	1,000	
Estates Total	**14,048**	**2170**
Medical Equipment:		
Medical Equipment	500	258
Medical Equipment Total	**500**	**258**
Information Management & Technology:		
IT Equipment	500	154
Information Management & Technology Total	**500**	**154**
PDC Funding		
IM&T PDC Funding	1,500	
PDC Funding Total	**1,500**	**-**
Grand Total	**16,548**	**2,583**

Capital CRL Monitoring





PSDS Grant Fund
PFI/IFRIC 12/Donated Spend
PSDS Grant Fund - Actual
PFI/IFRIC 12/Donated Spend - Actual

Care Colleagues
Collaboration Communities

Efficiencies Plan Overview

	CIP Plan Submitted to NHSE £'m	Plans at Month 7 £'m	% Achievement	Recurrent	Non Recurrent
Traditional' CIP (including ERF)	17.2	14.0	81%	64%	36%
Technical Adjustment requested	7.2	3.28	43%	0%	100%
Stretch Requested	2.05	0	0%		
Total	26.45	17.28	65.3%	51%	49%

Percentage CIP per NHSE	**6.80%**	**4.40%**			

The Trust was given 2 additional financial challenges later in the planning round which it classed as CIP while plans developed. The above table breaks down the elements of the plan between the headings and the achievement against each.

At the time of writing the final PWC report is awaited and may support a change in technical adjustment.

Efficiencies FOT by Division

Division	Target	Green	Amber	Red	Total
MLTC	3,908	156	538	1,994	**2,688**
DoS	3,474	1,169	760	60	**1,989**
WCCSS	3,882	627	495	564	**1,686**
Community	2,621	21	644		**665**
Estates	1,250	147	38	99	**283**
Corp (IMT)	444	380			**380**
Corp (HR)	242	129	82		**211**
Corp (Fin)	360	2,845			**2,845**
Corp (Nurs)	314	203			**203**
Corp (Comms)	21	21			**21**
Corp (COO)	188	103			**103**
Corp (Med)	253	78			**78**
Corp (Govern)	173	51			**51**
Corp (Improv)	70	223			**223**
Procurement (Divisional)				209	**209**
Unidentified/ Stretch	7,200			2,415	**2,415**
Balance Sheet	2,050	3,276			**3,276**
Total	**26,450**	**9,429**	**2,556**	**5,341**	**17,326**

FOT divisional savings of £17.3m of which £8.5m are high risk (including £2.7m still to be identified) and £5.9m are medium risk schemes (£3.3m of technical adjustments).

FOT delivers 65.5% of original planned savings

Enc 10.4.1

Black Country Integrated Care Board
Civic Centre
St Peters Square
Wolverhampton
West Midlands
WV1 1SH
Telephone Number: 0300 0120 281
Email: Sally.Roberts11@nhs.net

Our Ref: SR/NH

31st October 2023

FAO Chief Executives, Chief Nursing Officers and Chief Medical Officers

Dear All

As the chair of the Local Maternity and Neonatal System for the Black Country, I am seeking your support for a peer review of still births across the Black Country System.

As you are all aware, the Black Country have high rates of neonatal mortality compared to the England average. Despite some decreases in stillbirth and neonatal death rates in the years to 2020 there has been a steady increase since. The Local Maternity and Neonatal System (LMNS) monitors both stillbirths and early neonatal deaths monthly via the Quality and Safety Group and the increase in stillbirths and neonatal deaths continues in 2023, but we have identified that this is at a more significant rate for still births.

The members of the LMNS Quality and Safety Group, who are made up of senior representatives from across the Black Country providers maternity and neonatal services, as well as external partners have discussed this issue at length. They have determined that it would be informative to undertake a systematic review of still births across our system with the aim to reduce mortality and sustain improvement. This approach has also been supported by the LMNS board. I have attached the Terms of Reference for your perusal.

A local independent multidisciplinary panel will be established to undertake the review and will consider the still birth deaths from April 2023 to September 2023. The review group will bring together a breadth of experience, expertise, and perspective from across the system and will be led by the LMNS.

The anticipated completion of this will be January 2024, once LMNS have approved the final recommendations and report, we will ensure the report is also shared through relevant trust committees. Following completion of the review, we expect there to be a short life task and finish group established to progress with the Quality Improvements identified from the findings of the review, utilising the QI approach and support from a well-established team in our system.

Please do not hesitate to contact myself, Dawn Lewis (LMNS Risk and Quality Assurance Midwifery Lead/Chair of Q&S LMNS sub-group) or Helen Hurst (LMNS Director of Midwifery) if you wish to discuss further detail.

Many thanks for your support.

Kind regards

S Roberts

Sally Roberts
Chief Nursing Officer/Deputy Chief Executive Officer/Chair of Black Country Local Maternity and Neonatal System

Enc: Terms of Reference
CC: Helen Hurst and Dawn Lewis

Terms of Reference

Thematic review of stillbirths occurring across the Black Country from April 2023 to September 2023

Black Country LMNS

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Terms of Reference

1. Introduction and background

The Black Country have high rates of neonatal mortality compared to the England average. Despite some decreases in stillbirth and neonatal death rates in the years to 2020 there has been a steady increase since. The LMNS monitors both stillbirths and early neonatal deaths monthly via the Quality and Safety group and the increase in stillbirths and neonatal deaths continues in 2023.

An independent multidisciplinary panel will be established to provide a systematic review of stillbirths occurring in the Black Country from April 2023 to September 2023.

2. Role of the Group

The review group will bring together a breadth of experience, expertise, and perspective from across the system to:

- Provide an independent muti disciplinary panel to conduct a systematic review of stillbirths occurring in the Black Country in the first 6 months of the financial year 2023.
- Review the perinatal mortality review tool report (PMRT report) for each of the stillbirths in the Black Country from 1st April 2023 to 30th September 2023.
- Several of the stillbirths, those that occurred intrapartum, will have been referred to HSIB for investigation and this report together with the PMRT report may be awaited. These will be treated as exceptions.
- If an HSIB report is available for any of the stillbirths this will be included in the thematic review.
- Note the contributory factors identified in each report and note the incidental factors identified in each report.
- Identify any modifiable factor and grade the significance according to the chart at *Appendix 1.*
- Identify any factors that relate to any elements in the saving babies lives care bundle.
- Aggregate findings to identify interlinked contributory factors to inform and direct improvement.
- Advise the ICB, LMNS and four maternity providers of any identified themes via a written report. The findings will inform quality improvement to support sustainable change.

3. Responsibilities of members

Members of the panel will be provided with all available perinatal mortality review reports related to stillbirths in the identified period. This will aid individual review prior to the panel meetings.

Members of the panel will attend each of the Microsoft Teams meetings and using an agreed set of review tools will review each report identifying both contributory factors and incidental factors.

A summary of the discussion of each case will be completed in an agreed database that will assist with subsequent analysis of themes. This will be shared following the meeting.

4. Confidentiality and information sharing

All materials and information shared with the group are assumed to be confidential unless otherwise stated.

Members will not disclose information or written materials to other parties unless directed by the chair.

5. Declaration and Conflicts of Interest

5.1 A conflict of interest occurs when an individual's ability to exercise judgement or act in a role is, could be or is seen to be impaired or otherwise influence by their involvement in another role or relationship. It is where there is or could be a clash between the personal or private interests of an individual and the panel where this would affect the individual's performance of their panel duties.

5.2 This definition covers both actual conflicts of interest (where there is a material conflict between one or more interest) and perceived conflicts of interest (where an impartial observer could reasonably suspect there to be a conflict of interest regardless of whether there is one or not). It also applies to circumstances where a potential conflict (either actual or perceived) could arise in the future.

5.3 A record of any interests will be an agenda item for each panel meeting.

6. Membership

ICB Mortality Review Group Chair
Consultant Neonatologist CDOP
Consultant Public Health
ICB Head of Quality and Safety, Sandwell Place
ICB Lead Nurses for Child Mortality x2
LMNS Lead Midwife Risk and Quality Assurance

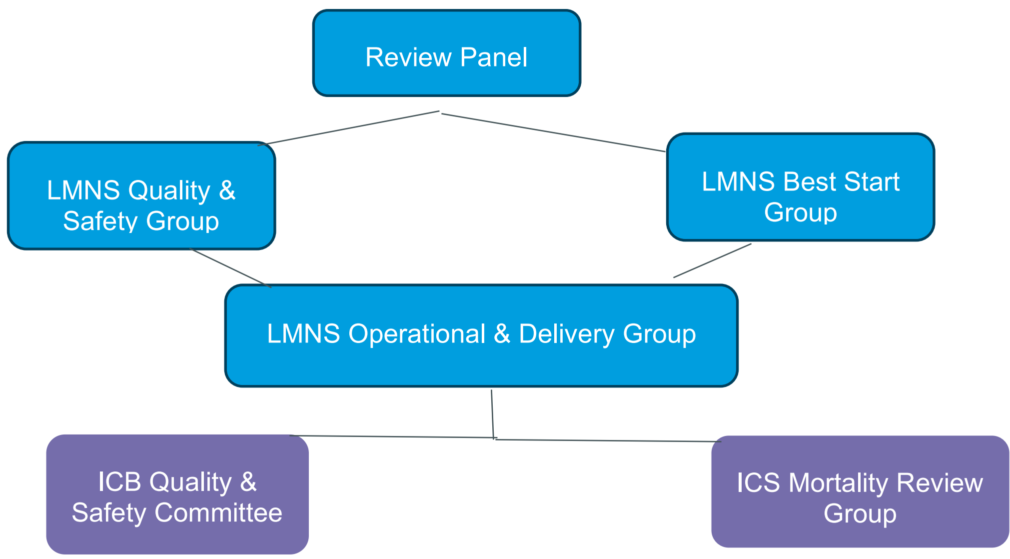
7. Frequency of meetings

7.1 The group will meet fortnightly in order to complete the review in a timely manner.

8. Quoracy

8.1 The group will be considered quorate if 50% of the members are present.

9. Governance and accountability



10. Reporting and communications

The panel will provide a thematic report following completion of the review of all available PMRT reports. The report will summarise identified themes and learning. There will be reference to any progress already achieved in respect of the themes.

Appendix 1

If care or treatment was identified to have fallen below standards expected the review team will consider this as a 'modifiable factor'. Each factor will then be assessed to determine the extent to which it may have adversely impacted on the outcome. The factor will then be classified using the four classifications as below.

Definitions of modifiable factors.

Definitions of Modifiable Factors		
If the care provided to mothers and their babies did not meet the standards expected, the clinical review teams referred to this as a "*modifiable factor*". Four categories were used to grade the significance of each modifiable factor:		
0	**No Modifiable Factor**	No lessons to be learned.
1	**Wider Learning Factor**	Although lessons can be learned, the issue did not affect the overall outcome.
2	**Minor Modifiable Factor**	The issue was a contributory factor, but different management is unlikely to have changed the overall outcome.
3	**Major Modifiable Factor**	The issue contributed significantly to the poor outcome. Different management may have altered the outcome.

Paper to the Trust Board December 2023		
Title of Report:	Infection Prevention Update: October 2023	Enc No: 10.4.2
Author:	Stefano Oggiano, Lead IPCN, Amy Boden, Associate Director for Nursing Operations and Deputy Director Infection Prevention, Bal Boparai, Business Manager Infection Prevention,	
Presenter/Exec Lead:	Lisa Carroll, Chief Nursing Officer and DIPC	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☐No☒	Yes☒No☒
Recommendations: The committee is asked to note the contents of the report.			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Risk ID 351: Managing Clostridioides difficile in accordance with national recommendations to prevent a breach in National target of 26 cases. Score 12. Risk ID 354: Colleagues not meeting hand hygiene standards leading to increased risk of infection. Score 9. Risk ID 361: Failure to isolate patients due to high demand of isolation capacity. Score 20. Risk ID 3297: Limited surgical site infection surveillance in the absence of an SSI team. Score 16. On Risk Register: Yes☒No☐		
Changes to BAF Risk(s) & TRR Risk(s) agreed	Summary of IPC BAF demonstrated in this report.		
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.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe domain.
	NHSE	Yes☒No☐	Details: HCAI contract
	Health & Safety	Yes☒No☐	Details:
	Legal	Yes☒No☐	Details: Health and Social Care Act (2022)
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: IPCC 21.9.23
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- Multi-modal actions are taking place to prevent the incidence of *C.difficile.* A fishbone analysis has been undertaken to demonstrate actions undertaken and interventions to focus on.
- The fishbone analysis has identified significant improvements in sampling practice and reduced severity in *C.difficile* infection.
- The Infection Prevention annual audit programme is being completed as planned.
- Enteric audit cycles have identified improvements since educational interventions and DIPC briefing sessions.
- On-going education proving successful in response to incidents or as part of annual planned education such as “focus of the month”.
- IPS National conference, award winning poster and IPC team innovative project with Little Voices, multiple posters presented and oral papers.
- The IPCT have launched the delivery plan in collaboration with RWT IPCT.

Advise

- The IPC Team have been supporting a variety of Quality Improvement Projects and educational campaigns in response to Infection Prevention/ Antimicrobial Stewardship incidents, demonstrating local improvements.
- Antibiotic “time out” sessions are taking place with the combined infection service for targeted interventions to improve antibiotic prescribing.
- Focus in October 2023 focused on winter preparedness.
- Multiple IPC policies are currently outstanding and pending review and approval.
- The deep clean programme is now on hold as Ward 5/6 is open to additional winter capacity

Alert

- The Trust are over trajectory for the financial year for *C. difficile* cases, with 59**/26** cases by end of **September** 2023.
- Themes *for C. difficile* cases this financial year: deemed avoidable due to inappropriate antibiotics.
- The trust is in line to be over trajectory for the financial year for Pseudomonas aeruginosa BSI, with 5/6 by the end of November 2023.
- Surgical site infection (SSI) surveillance is limited due to no dedicated SSI surveillance team.
- Cluster of SSIs identified within T&O and maternity services.
- 10-20 patients a day with high priority isolation requirements is in open bays due to limited isolation rooms and increasing isolation demand.
- Blood culture contaminates remains at 5%

- The organisation has experienced first full ward closure due to Norovirus this financial year.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Safe and responsive urgent and emergency 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 in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement
Improve the Healthcare of our Communities	• Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Infection Prevention & Control Monthly Report
October 2023

Audits Annual Plan 2023/2024

Audit	Location	Plan	Related strategic theme	Related Compliance Criterion	Progress
Full Ward Audit	All Inpatient Wards	To be completed by August 2023	IPC in the environment and fundamentals	1,2,6,9,10	Completed
Community Audits	Community clinics and units	To be completed by October 2023	IPC in the environment and fundamentals	1,2,6,9,10	In progress
Departmental Audits	Acute site departments	To be completed by January 2024	IPC in the environment and fundamentals	1,2,6,9,10	In progress
Hand Hygiene and PPE	Acute services and community bed bases, community	*Quarterly:* June 23, September 23, December 23, March 24.	IPC fundamentals	1,6,9,10	On-going Q1 completed. Q2 completed.
Hand Hygiene and PPE	Community nursing team	To be completed by October 2023	IPC fundamentals	1,6,9,10	On-going
Indwelling device care	All Inpatient Wards	*Bi-annually:* August 23 and February 2024	MSSA/MRSA interventions, IPC fundamentals, Preventing Syndromic Infections	1,6,9	Completed August 23 – Commenced new cycle
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	1,2,4,5,6,7,8,9	On-going
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	1,2,6,7,8,9,10	On-going

Education and Focus of the Month.

The IPC team continued to deliver and respond to face-to-face training invites in MLCC and for specific areas including, IPC updates for Midwifes, Paediatrics update, IV therapies, ANTT, Fundamentals of Care (ward specific), CSW induction, New Medical Students, Teaching Tuesdays etc.

October 2023 ad-hoc education session included:

- 51 staff were capture for:
  - CPE screening criteria
  - Generic IPC refresher
  - Enteric risk
  - Urine sampling & UTI
  - AMS IV to PO
  - Fusion IPC Tag
  - Microguide
  - CURB scoring
- 136 staff attended the IP Delivery Plan stand – Back to Basic in collaboration with IPCT at RWT.

Focus of the month: Winter Preparedness.

As part of our IPC annual programme of work, October's focus was around winter preparedness.

Resources:

Winter training.pptx

A total of 135 staff were captured across the organisation.

Weekly IPC update.

A weekly IPC update to each division. This includes five key messages to share across your clinical areas. Topical items based on recent incidents, identified learning, local surveillance, or in accordance with National guidance and campaigns will be included. Topics included:

- Surgical Site Infections
- Respiratory etiquette
- Bed cleaning poster
- Joint IPC delivery
- Norovirus and management

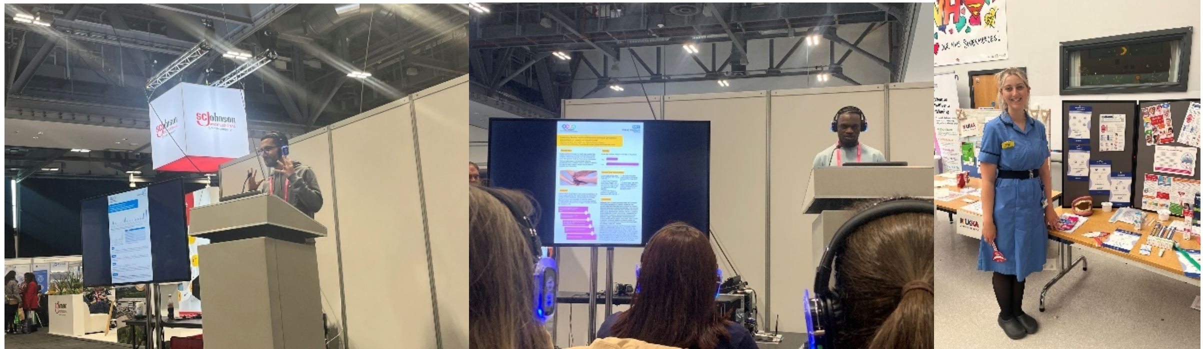
Infection Prevention Society – Annual Conference 2023

The IPS conference this year was a fantastic opportunity for the IPC Team to showcase their work, with a total of 9 abstracts approved for posters and presentations.

One presentation was from Amy Boden on the Little Voices campaign, incorporating patient voice into improving standards of IPC and implementing a novel way of monitoring hand hygiene compliance. Little Voices won the Gold Award for Patient Experience at the IPS awards ceremony.

Lead IPCN Stefano Oggiano presented on QI project “Decolonisation confusion?”, highlighting improvements in decolonisation prescribing through the implementation of a sticker from the IPCT Team onto the prescription chart. This has led to being approached by the research team at GAMA healthcare on a wider piece around skin decolonisation.

The team also delivered 3 poster presentations on topics including CPE screening, mouth care education and supporting newly recruited nurses in IPC practices:



The team produced a variety of posters for display in the main exhibition hall, and also won Best Poster Award at the IPS conference for the introduction of a Nursing Associate role as part of a *C.difficile* intervention.

Policies

Policy	Draft	Agreed at ICC	Sent to Policy Management	Intranet status
MRAB	Sent for comments	On-hold issue with ICE	On-hold issue with ICE	December 2022
Administration and responsibilities for IPC within Walsall Healthcare NHS Trust	Completed	Ongoing	Ongoing	July 2023
Infection Control Procedures for the deceased patients.	Completed	Ongoing	Ongoing	September 2023
Blood Borne Virus	Completed	Ongoing	Ongoing	September 2023
RSV	Awaiting	NA	NA	September 2023

Outbreaks:

Bay closures October 2023:

- **17 bay** closures for COVID contacts across all divisions during the month due to unexpected COVID-19 cases.
- **6 bay** closures for norovirus

Ward closures:

Ward	Closed	Opened
Ward 10 - Norovirus	19/10/23	27/10/23

COVID19 outbreak declared to NHS England.

There have been 2 COVID19 outbreaks declared to NHS England via the National Outbreak reporting system.

Due to increasing pressure on the organisation and high increase of prevalence, these outbreaks are managed as bays restriction with appropriate control measures in place.These areas will require monitoring for up to 14 days.

Outbreaks actions outstanding:

The following action Is outstanding from VRE outbreak reported in September.

- Dr Abras was asked to feedback to doctors regarding documentation of cannulation to be completed by doctors when they are involved in the insertion of an indwelling device

Review of Healthcare acquired COVID-19 cases.

As of November 2022 IPCC, any HCAI COVID19 will be reviewed in line with the NHS E Midland guidance, therefore routine data collection will not be completed by the IPCT.

A review of possible harm will be undertaken at day 28; if any harm a data collection will be completed, and incident managed in line with trust incident management policy.
HCAI cases will still be monitored to identify any possible outbreak definition (two or more cases within two incubation period).

National definitions of cases confirmed over 7 days from admission are considered healthcare acquired: 8-14 days probable HCAI and over 15 days definite HCAI.

The results of the reviews can be found below:

	Total number HCAI
August	5
September	45
October	82
November	35
December	60

January 2023	18
February	53
March	78
April	20
May	6
June	3
July	9
August	9
September	22
October	23

Dates admission to confirmation of positive result:

	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23
8-14 days	4	14	39	19	34	1	34	39	7	3	0	7	5	20	9
> 15 days	1	31	43	16	26	17	19	39	13	3	3	2	4	2	14

Healthcare-acquired Infections.

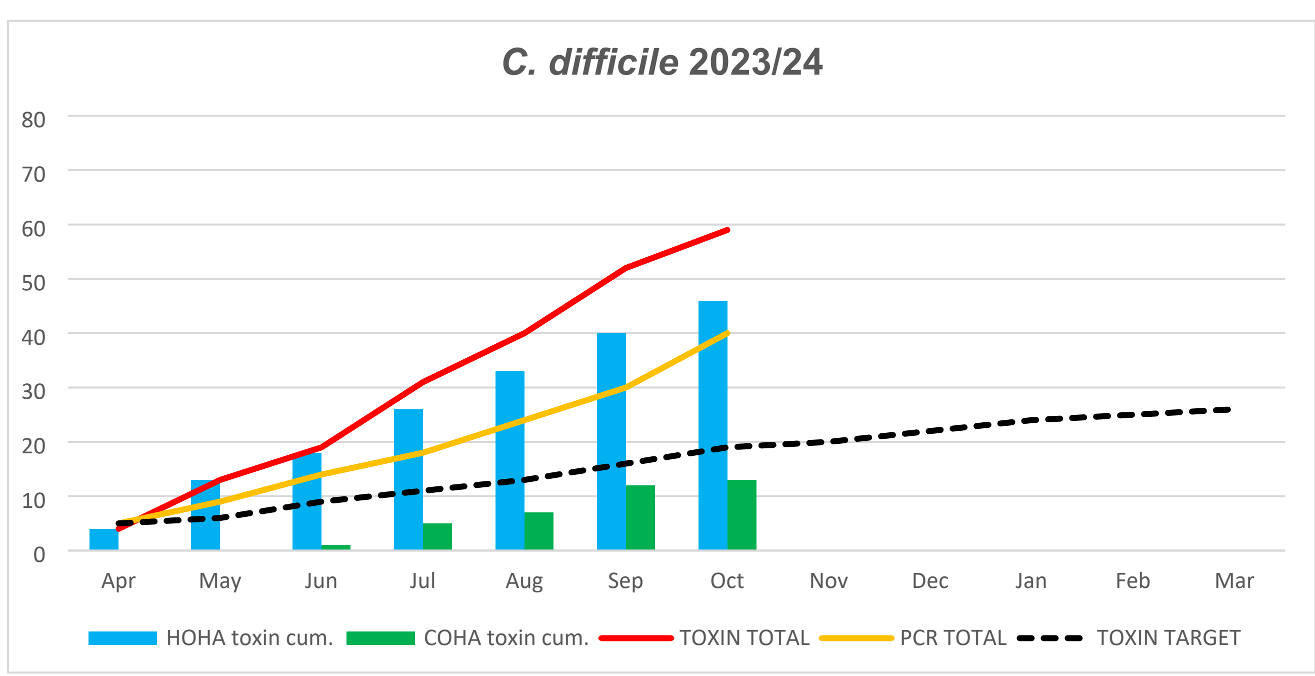
Important to note that figures will be reported as *Hospital-onset healthcare-associated (HOHA), Community-onset healthcare-associated (COHA)* and *Community-onset community-associated (COCA).* HOHA and COHA are counted toward the trust trajectory.

Clostridioides difficile Toxin.

The National Trust target for 2023/24 is 26 – a total of **6** HOHA and **1** COHA CDIs have been reported.

The cumulative trajectory for the year:

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	2
Actual cases per month	4	9	6	12	9	12	7					
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	26
Acute Cumulative actual	4	13	19	31	40	52	59					



Surgery

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	1	2	2	3	3	4	4	5	6	6	7
Actual	1	4	6	6	7	8	8					

MLTC

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	2	3	5	7	9	11	13	14	15	16	17	17
Actual	3	9	13	25	33	44	51					

Women and children's

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	1	1	1	1	1	1	1	1	1	1	1
Actual	0	0	0	0	0	0	0					

Community (Hollybank/palliative care centre)

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	1	1	1	1	1	1	1	1	1	1	1
Actual	0	0	0	0	0	0	0					

CDI – RCA/Findings and actions

A total of 7 C. difficile cases were reported during October 2023, following review of the cases 2 cases were deemed avoidable, and 5 cases were unavoidable.

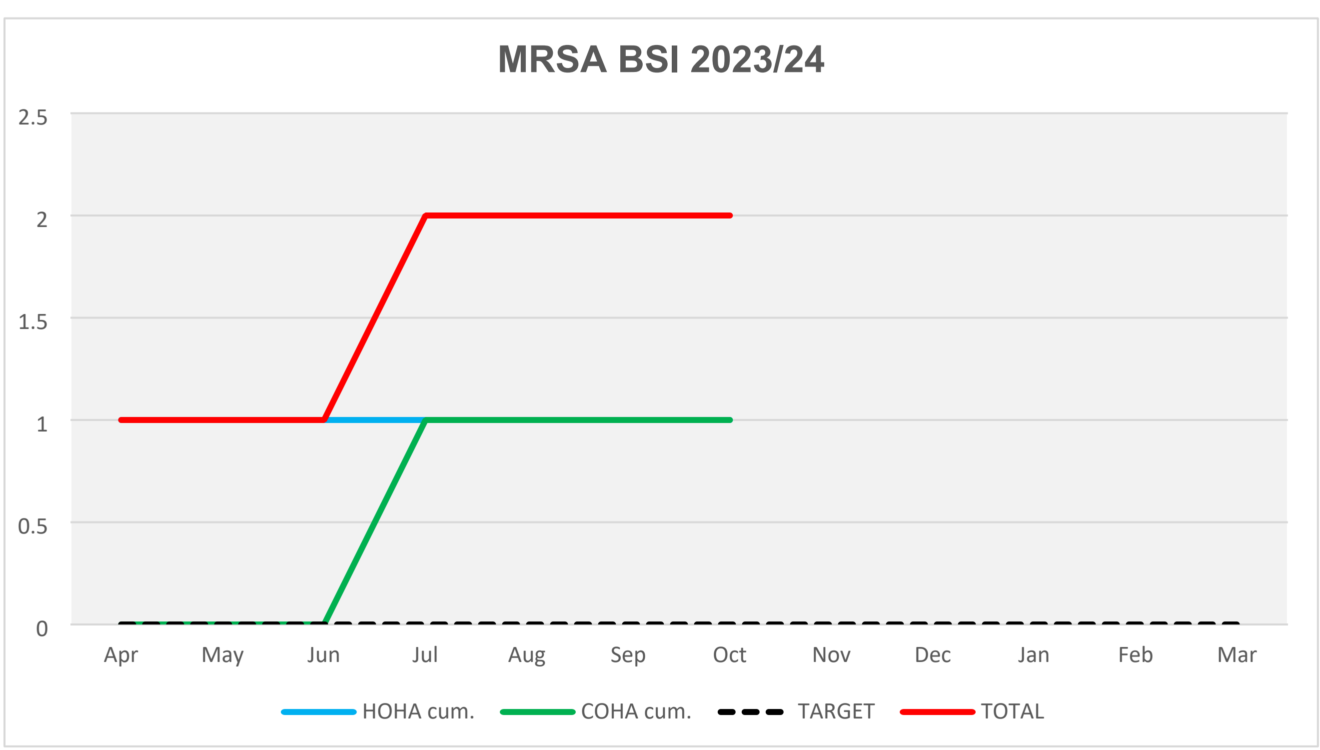
There have been 4 wards with a period of increased incidents, ribotyping has been requested and some results are pending.

A visit from the ICB has been reported to take place on the 14th November to examine our C. difficile cases.

Ward case attributed to	Root Cause	Avoidability	Ribotyping Result
W29	Likely due to current medical condition, however poor antimicrobial prescribing could have contributed to the CDI	Avoidable	741
W15	Attributed due to delayed specimen. Patient presented with loose stool high risk due to ongoing chemotherapy treatment, with multiple risk factors identified. Patient monitored using BSC sample taken on day three of admission.	Unavoidable	220
W1	Cdiff relapse	Unavoidable	Result pending
W1	Likely relapse, patient continued to have diarrhoea in the community despite completing course of Vancomycin. Re-presented with loose stool, initial stool sample negative. Patient continued to deteriorate haemodynamically with ongoing loose stool. Repeat samples not tested, fourth sample C.difficile positive	Unavoidable	Result pending
W2	Patient has high risk factors for CDI, however high-risk antimicrobial use maybe a contributing factor for new C difficile infection.	Avoidable	Result pending
W29	Patient C.diff positive during previous admission, likely colonised. High risk due to contributing risk factors. Patient identified with loose stool on admission however stool specimen was delayed.	Unavoidable	Result pending
AMU	Although delayed sample and inaccurate BSC, patient presented with a 1-month history of diarrhoea accompanied with abdominal pain. Patient has several; predisposing factors.	Unavoidable	NA

MRSA Bacteraemia

The National Trust target for 2023/24 is 0 cases. No MRSA bacteraemia's identified.



Surgery

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	0	0	0	0	0	0					

MLTC

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Actual	1	1	1	2	2	2	2					

Women and children's

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	0	0	0	0	0	0					

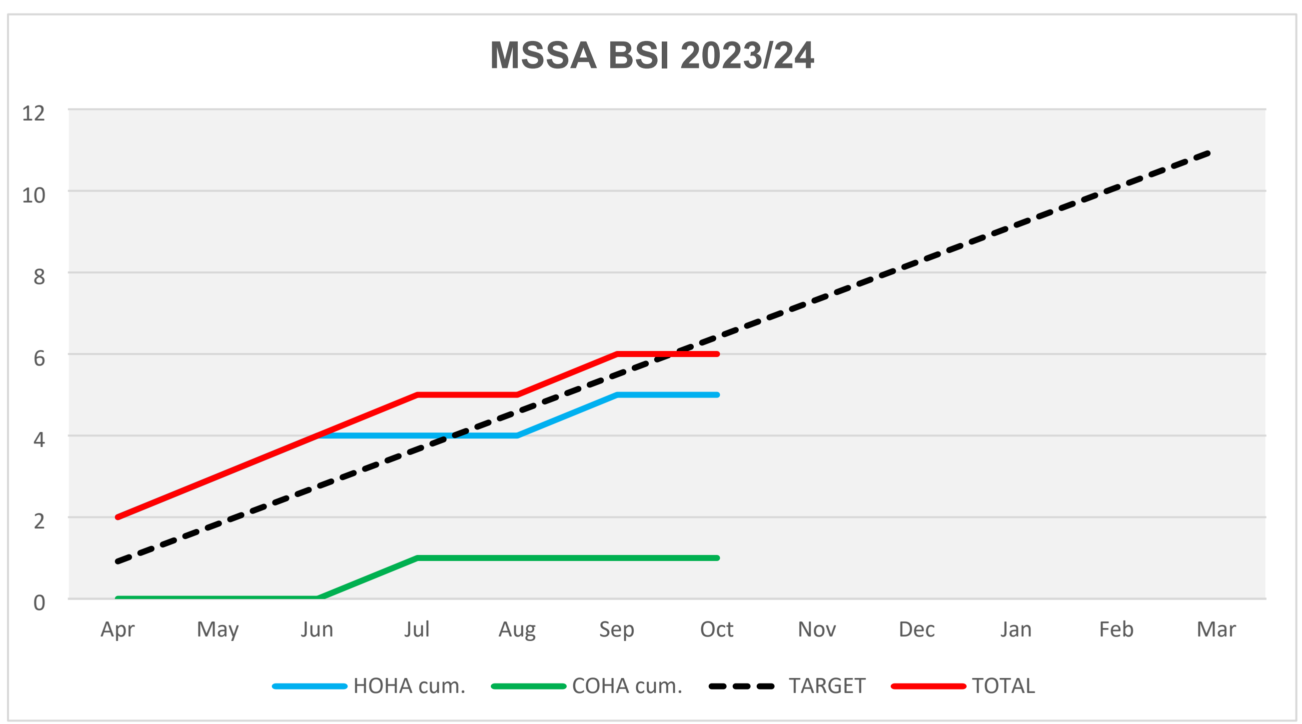
Community (Hollybank/palliative care centre)

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	0	0	0	0	0	0					

MRSA screening: This data is currently being discontinued and will not be reported while the issue continues. Please ensure monitoring of MRSA screening (as per policy) continues at local level.

MSSA Bacteraemia.

In the abcence of national target the internal target is 11. No MSSA bacteraemia reported.



Surgery

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	1	1	2	2	2	3	3	3	4	4	4
Actual	0	0	0	0	0	0	0					

MLTC

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	1	1	2	2	3	4	4	5	5	6	6
Actual	2	3	4	5	5	6	6					

Women and children's

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	1	1	1	1	1	1	1	1	1	1	1
Actual	0	0	0	0	0	0	0					

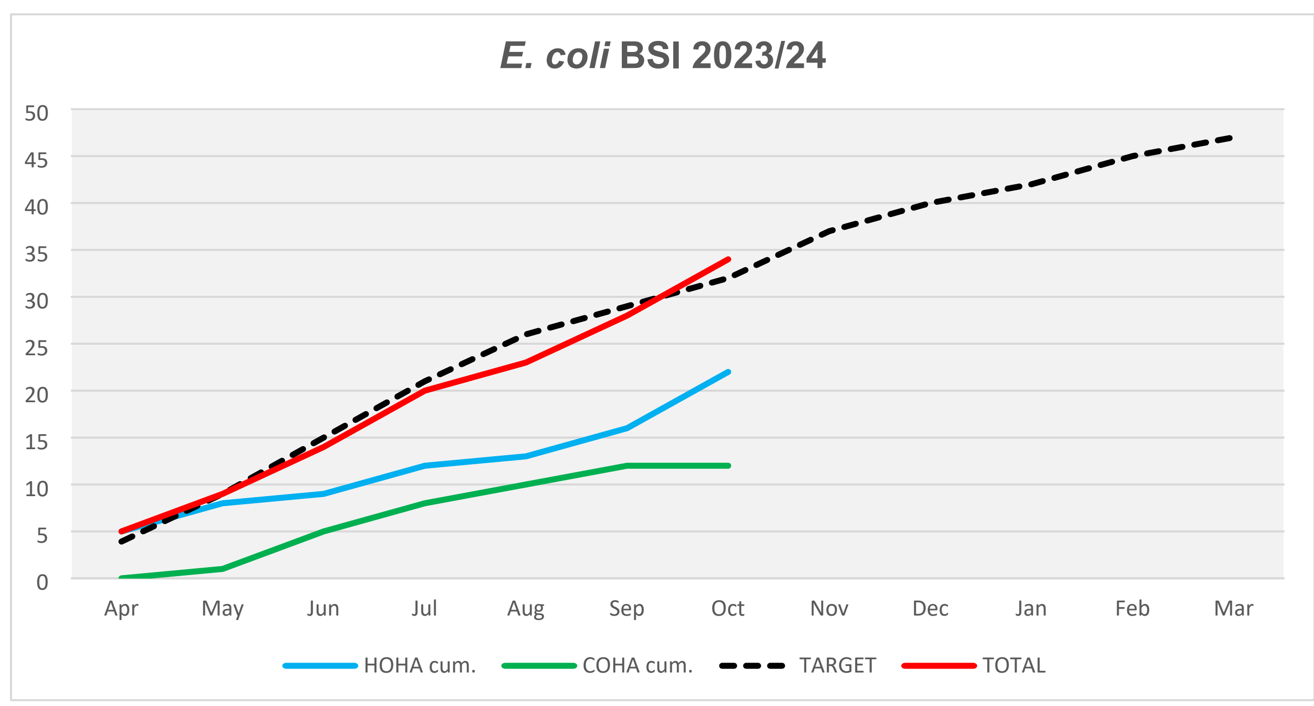
Community (Hollybank/palliative care centre)

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	0	0	0	0	0	0					

Gram-negative bacteraemia.

E. coli Bacteraemia.

The National Trust target for 2023/24 is 47 – a total of 6 HOHA and 1 COHA E. coli bacteraemias have been reported.



Surgery

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	1	3	5	8	10	10	11	12	13	13	14	14
Actual	3	3	3	4	5	8	10					

MLTC

20203/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	3	6	9	11	14	16	18	20	22	24	26	27
Actual	2	6	10	15	17	20	25					

Women and children's

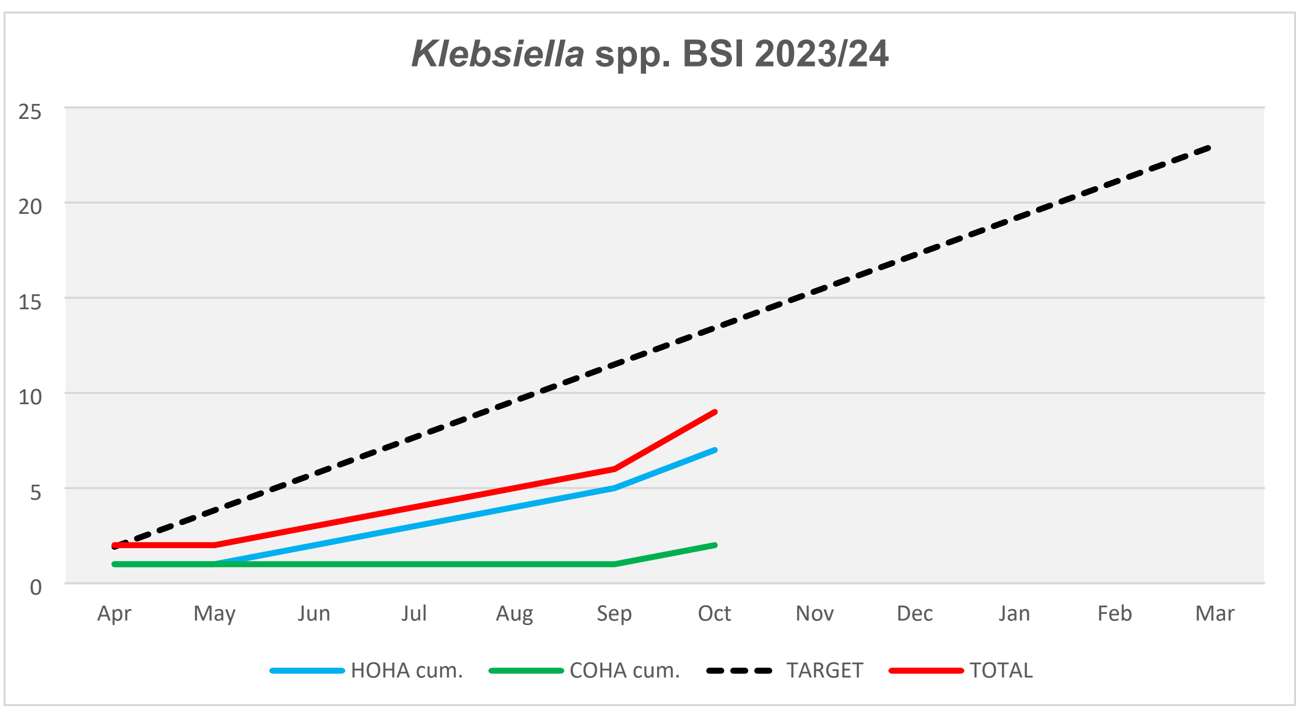
2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	1	1	1	2	2	3	3	3	3	3
Actual	0	0	1	1	1	1	1					

Community (Hollybank/palliative care centre)

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Trajectory	0	0	0	1	1	1	1	2	2	2	2	3
Actual	0	0	0	0	0	0	0					

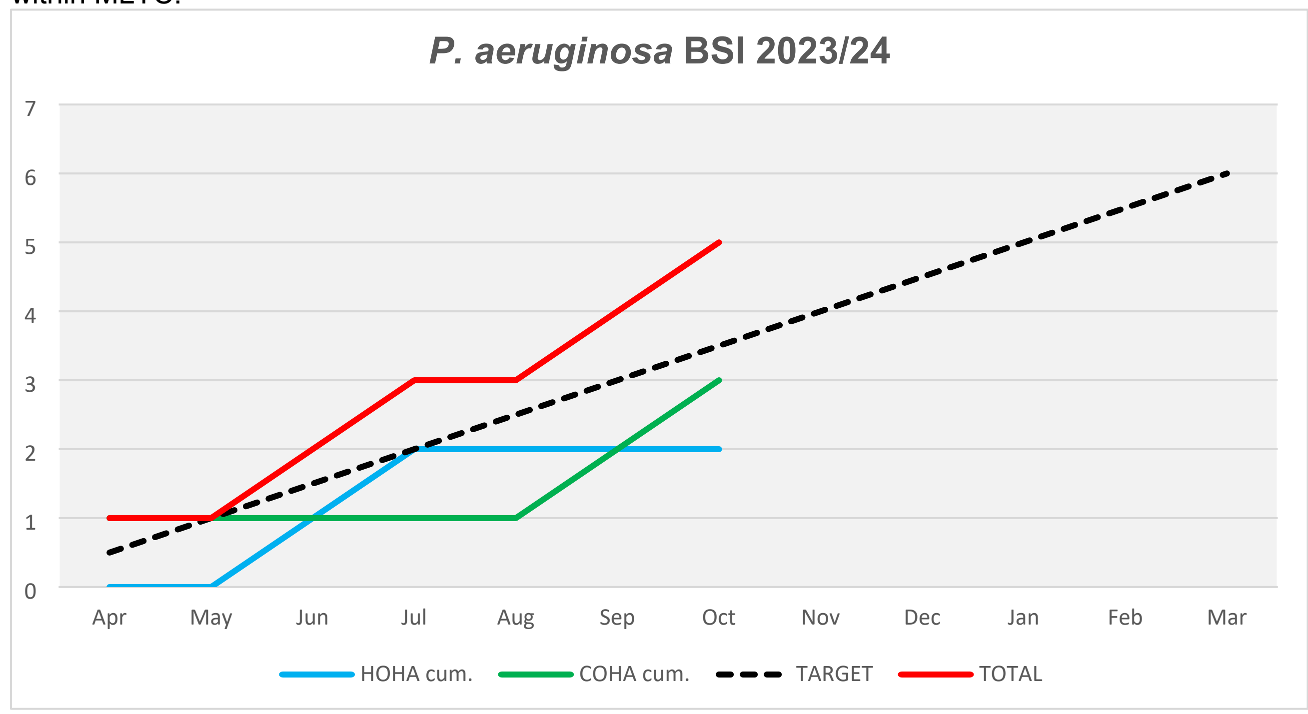
Klebsiella species Blood cultures.

The National Trust target for 2023/24 is 23 – 2 HOHA and 1 COHA Klebsiella spp. have been reported, 2 within MLTC and 1 within Surgical division.



Pseudomonas aeruginosa blood culture.

The National Trust target for 2023/24 is 6 – 1 COHA Pseudomonas aeruginosa bacteraemia reported within MLTC.



Surgical Site Infections

During October 14 cases were investigated for surgical site infections.

Operation	Total cases investigated	Superficial infection	Joint space Infection	Deep Infection	Not classed as an SSI	Case review outstanding
T&O	9	3	0	1	2	3
Maternity	5	1	0	0	2	2
Total	14	4	0	1	4	5

1 maternity case from September that is classed as a deep infection is awaiting a full RCA.

Cluster of T&O cases

A cluster of T&O cases potential infections were identified which led to elective surgery been postponed from 12 – 18th October 2023 resulting in cancellation 40 patients.
Issues identified during the review of these cases included:

- Brand of sutures and that we had not had the NICE guidelines recommendation of antimicrobial sutures for all orthopaedic surgery.
- Preoperatively and intraoperative methods
- Wound closures
- Dedicated ring fenced clean orthopaedic ward.
- HSDU staffing and concerns of sub-standard sterilisation with holes in trays.
- Theatre etiquette
- District nursing supplies when seeing patients in the community.
- Patient education- more robust information required for patients on discharge regarding their surgical wound.

One together framework.
Following a cluster of T&O Cases there have been several meetings to update One Together Framework, including:

- Cacoons to be implemented end of October 2023.
- Surgical site dressing trial discussed, plan to commence trial for emergency T&O cases.
- Interoperative temperature recordings - update required
- Antimicrobial sutures to be used for all joints, arthroplasty cases.
- Elective cases admitted directly to ward 20a. However pre-operatively warming not implemented at time of report.
- Surgical site dressings – following surgical site dressing meeting the division have agreed to trial Mepilex border for emergency T & O cases.

Monthly meeting to take place to update one together frame, date for November 2023 to be confirmed, report to be presented to Infection Control Committee.

Cluster Maternity Cases

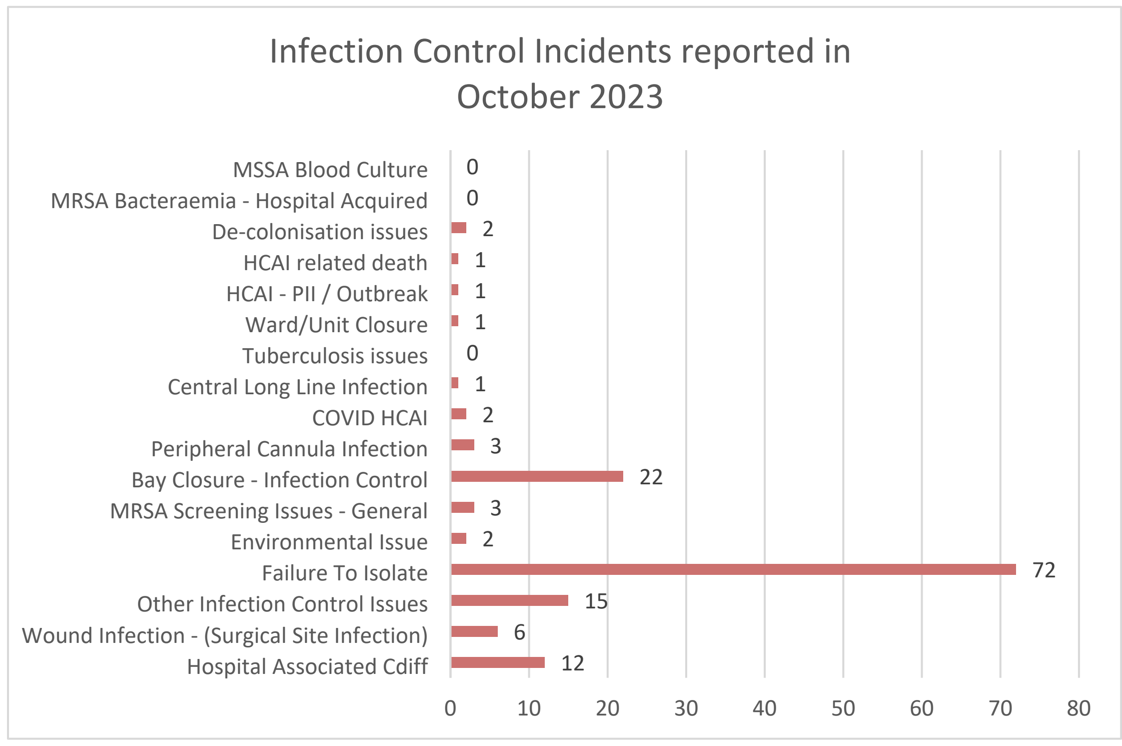
A cluster of maternity cases has been reported to the IPC team, a meeting has been arranged for Tuesday 7th November 2023 to review the cases.

COVID HCAI Incidents led by division - on-going Incidents for review:

During October 6 new cases have been identified where COVID HCAI and have died within 28 days and have COVID on of the death certificate, they cases are awaiting review by the division.

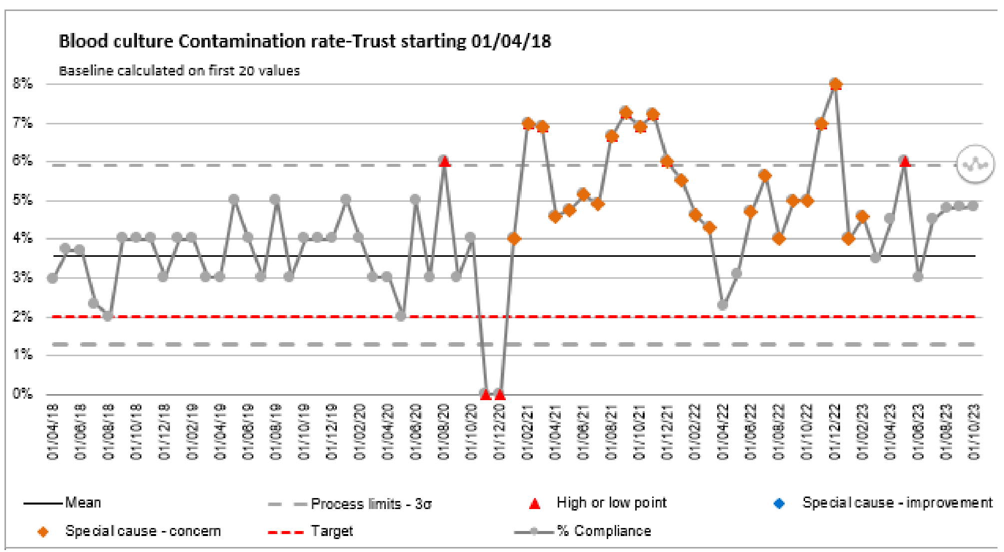
Infection Control Incidents

A total of 143 incidents have been reported during October compared to 138 recorded in September 2023.

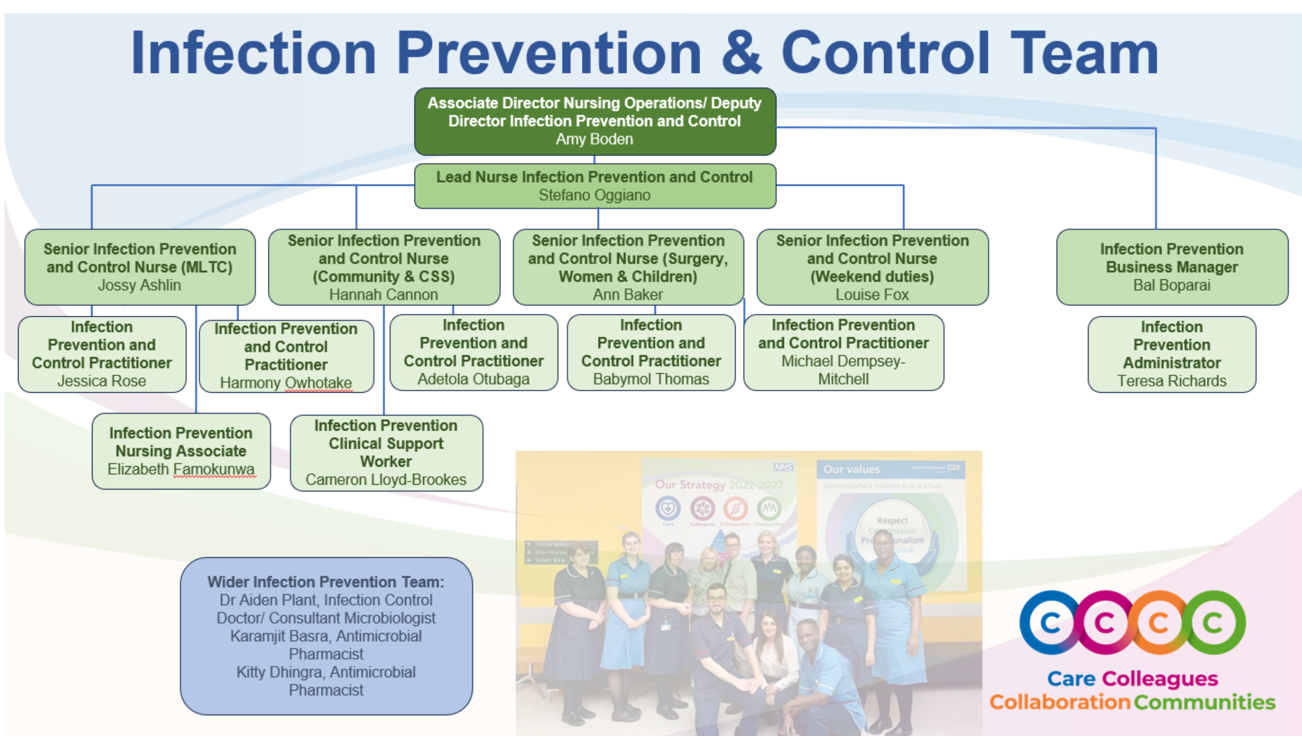


Blood Cultures – update graph

Blood cultures contamination rates for the month of October is 5%, same value as previous months.



IPC Team Structure.



As of November 2023, Babymol Thomas commenced with the IPC team.

Enc 10.4.2

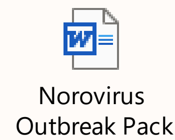
Winter is coming!

Winter brings additional pressures on healthcare services and is a period of increased demand. It's time to start preparing for presenting infections which are associated with winter.

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

Norovirus

- Outbreaks of Norovirus have a big impact on a patient’s journey in a healthcare setting, particularly for discharge plans. Early identification and IPC management will prevent further transmission. The outbreak pack attached gives further information on effectively monitoring patients, IPC precautions and patient/visitor information.
- Norovirus is a group of viruses which are the most common cause of gastroenteritis known as ‘winter vomiting viruses.
- Norovirus is highly infectious and can be transmitted very easily, as when patients have active symptoms, Norovirus can transmit through the air and then settle onto surrounding surfaces, such as bed side tables, bed rails etc. Then people touch surfaces and eat with contaminated hands, leading to ingestion of the virus to cause infection. Our vulnerable patients can develop further complications due to Norovirus, such as deterioration in condition and dehydration. We are all susceptible to developing this illness, and therefore our IPC precautions are essential to minimise transmission.
- Symptoms include sudden onset of diarrhoea and/or vomiting symptoms. Patients may also have pyrexia, a headache and aching arms and legs.



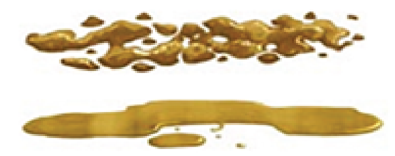
Norovirus Outbreak Pack

Does your patient have a NEW onset of diarrhoea symptoms? (Type 5-7)

Type 5
Soft blobs with clear-cut edges (passed easily)

Type 6
Fluffy pieces with ragged edges, a mushy stool

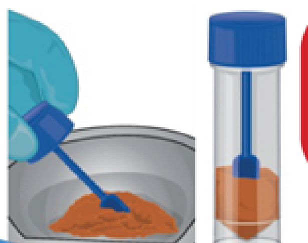
Type 7
Watery, no solid pieces, entirely liquid



Suspect infectious cause if:

- ☑ The patient has not had an enema or laxatives in the last 24 hours
- ☑ Symptoms are not clearly attributable to an underlying condition (e.g. inflammatory bowel disease/overflow) and infectious cause has not recently been ruled out from previous sampling

- ☑ Isolate the patient from 1st episode of diarrhoea
  POT IT. SEND IT. REPORT IT.



Waiting for multiple episodes of diarrhoea before isolating a patient can increase risk of transmission of infectious diarrhoea to other patients. Not sending a sample from the first episode of diarrhoea can lead to delayed diagnosis and poor patient outcomes.

DON’T DELAY! SEND THE SAMPLE TODAY

COVID19 and Respiratory Illnesses

Our Respiratory Tract Infection Management manual, supports decision making on assessing patients with possible respiratory tract infections (RTIs); including testing requirement, correct placement and streaming of patients and personal protective equipment; this applies to both emergency and elective pathways.

You can find multiple appendices, including list of RTI symptoms, inpatient screening guide for COVID19, Step-down criteria assessment for COVID19 inpatients, support to RediAir machines, CO2 monitor action card, WHT cleaning matrix, AGP list, a respiratory guidance table including a variety of organisms that are known to cause RTIs and their management, including IPC actions and ultimately a guide on where the use of a face mask is required.

Staff guidance respiratory pathway

[COVID Staff Risk Assessment - important update - Trust (xwalsall.nhs.uk)]

Respiratory pathway

https://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/1603/ipc/00347-ipc-guidance-april-2023-v2.pdf

When you need to wear a mask

(this applies to all areas including **inpatients, outpatients and community settings**)

When caring for a patient who is suspected of having or confirmed to have an active respiratory tract infection or droplet transmissable pathogen*.

When caring for a Clinically Extremely Vulnerable (CEV) patient.

On personal risk assessment.

If a patient or a colleague requests you to wear a mask.

When caring for contacts of a confirmed droplet infection or in an outbreak involving an infection spread via droplet route.

Emergency Portal (when assessing patients for symptoms of respiratory tract infections or contact status): ED, AMU, SACU, Maternity, Paediatric, FES.

When you don't need to wear a mask

Office areas.

Hospital corridors.

Inpatient areas
(Unless specified above, masks are not required in other inpatient areas).

Training environments and meetings.

*Examples of infections transmitted via droplets

SARS-CoV-2 (COVID-19)
Influenza A/B
Respiratory Synctial Virus (RSV)
Bacterial meningitis

Seasonal respiratory viruses
Bordetella pertussis "whooping cough"
Chlamydophila pneumoniae

Diptheria
Mumps
Pneumocystis jirovecii pneumonia (PCP)

Pneumonia without a known microbiological cause, or caused by MRSA, PVL, Group A streptococcus or Pneumocystis jirovecii (PCP)

Care Colleagues
Collaboration Communities

COVID19 and other circulating respiratory infections

Symptoms of respiratory tract infections (RTIs, including COVID19) CAN include:

- a high temperature or shivering (chills) – a high temperature means you feel hot to touch.
- on your chest or back (you do not need to measure your temperature)
- a new, continuous cough – this means coughing a lot for more than an hour, or 3 or
- more coughing episodes in 24 hours
- a loss or change to your sense of smell or taste.
- shortness of breath
- feeling tired or exhausted
- an aching body, or any muscle aches or pains that are not due to exercise.
- a headache
- a sore throat
- a blocked or runny nose
- loss of appetite
- diarrhoea
- feeling sick or being sick

CATCH IT

Germs spread easily. Always carry tissues and use them to catch your cough or sneeze.

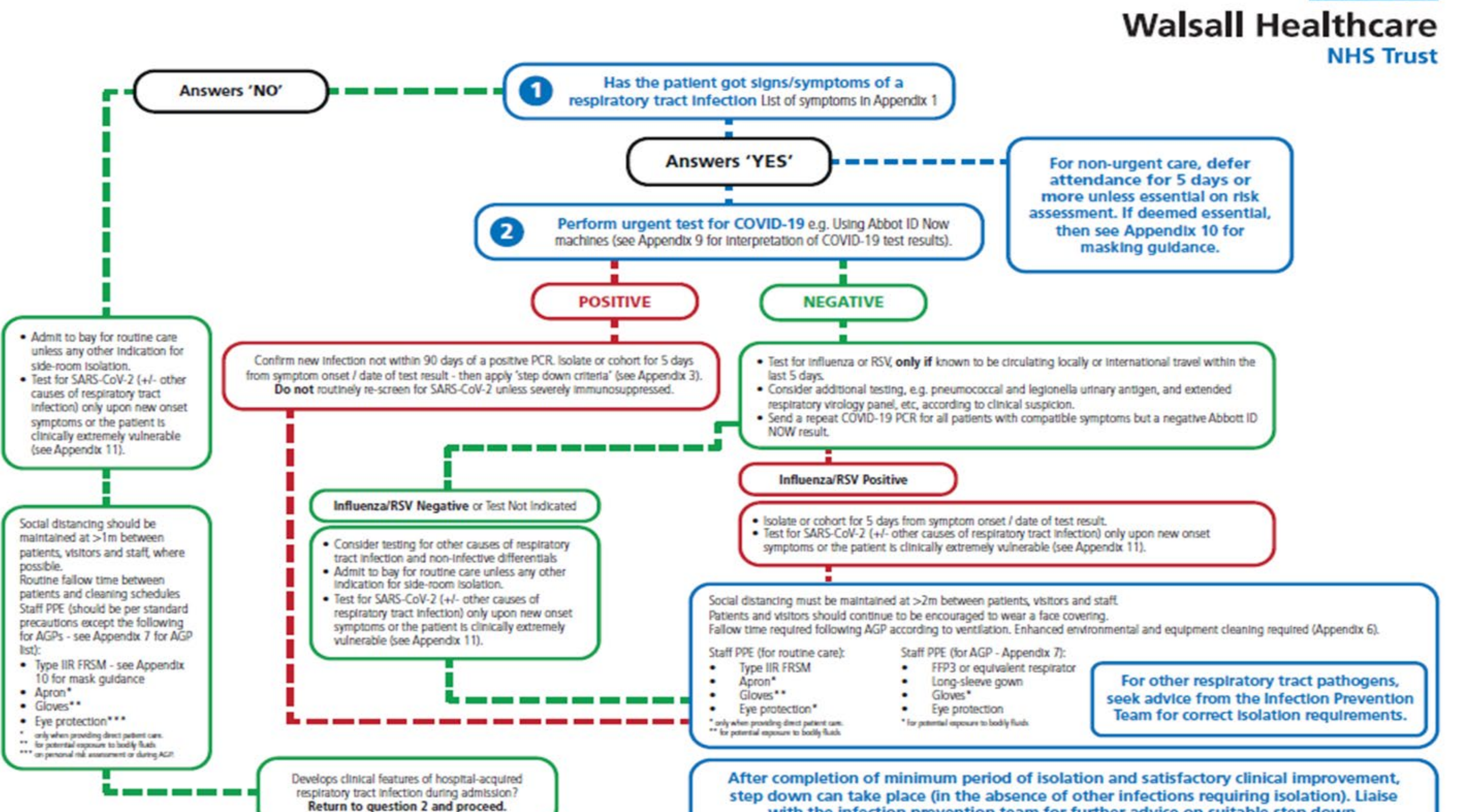
BIN IT

Germs can live for several hours on tissues. Dispose of your tissue as soon as possible.

KILL IT

Hands can transfer germs to every surface you touch. Clean your hands as soon as you can.

Respiratory Pathway



Care Colleagues
Collaboration Communities

ISOLATION

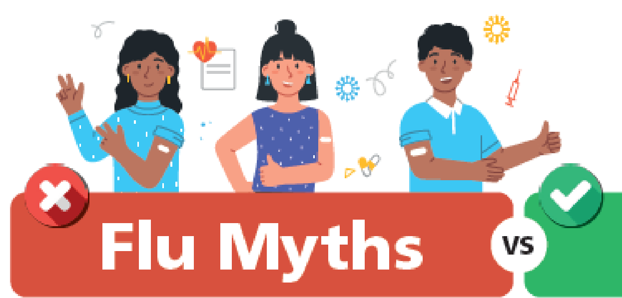
- Suspect infectious cause
- Isolate the patient in a single room
- Wear a fluid resistant surgical face mask when caring for patients with suspected Norovirus, confirmed Norovirus or attending a restricted bay due to Norovirus. Confirmed or suspected respiratory pathogen
- Apply gloves when there is any potential exposure to body fluids. Wear aprons for direct contact with the patient/patient's environment.
- Wash hands with soap and water following any contact with the patient/patient surroundings. Ensure patients are supported to wash their hands after using the toilet and before eating meals.
- Clean equipment/patient surroundings with a "green to chlorine" approach
- Segregate linen with a red alginate bag followed by a white linen bag
- Dispose of waste into infectious waste stream (orange bag)
- Escalate to the IPC team!

Importance of effective communication of IPC risks

- Keep an eye on fusion, if patients have a past medical history of an infection such as C.difficile or MRSA this has an alert on fusion in RED
- Ensure handovers are correctly giving to the receiving ward, including any IPC risks to prevent outbreaks through incorrect placement of patient.

Protect yourself and others from Influenza and COVID-19 this winter

- It's that time of year again, where we are asking all staff to get vaccinated – it's the most effective way to boost your natural immunity and protect yourselves and those around you against flu and COVID-19.
- Flu vaccinations are now available to all Trust staff. You are strongly encouraged to get vaccinated to protect yourselves, those most vulnerable in our communities, patients in our care and colleagues who you work alongside.
- Most clinical areas have a designated peer vaccinator to administer the flu vaccine so staff can get vaccinated without leaving their department. Find out who the peer vaccinators are for your area or division.
- For staff working in non-clinical areas, or if a nearby peer vaccinator is not on duty, you can get your flu vaccination at the mobile vaccination hub in front of Costa Coffee, Walsall Manor Hospital



Flu Myths	vs	Flu Facts
The flu vaccine gives you the flu		**The injected flu vaccine cannot cause flu because there are no active viruses in the vaccine.** Your arm may feel sore where you were injected, and some people get a slight temperature and aching muscles for a day or two, but other reactions are very rare.
Having the flu is just like having a heavy cold		**A bad bout of flu is much worse than a heavy cold.** Flu symptoms come on suddenly and sometimes severely. At best it may cause a sore throat, runny nose and other cold-like symptoms. At worst it can result in sepsis, chronic heart disease, pneumonia and multi-organ failure. For those with existing health conditions, it can be fatal.
Once you have a flu jab you are protected for life		**The viruses that cause flu can change every year, so you need a vaccination each year that matches the new viruses.** The vaccine usually provides protection for the duration of the flu season that year.
I'm healthy so don't need to be vaccinated		**Healthy people can still carry the virus.** Even if catching flu yourself might do nothing worse than leave you housebound for a week, if you pass it on to a vulnerable patient, colleague or family member, the consequences for them could be much worse.
Pregnant women cannot have the vaccine		**Pregnant women should especially get the flu vaccine since their immune systems are weaker than usual.** Flu during pregnancy can be extremely dangerous for women and their babies – increasing the risk of miscarriage or premature labour.
Vitamin C and a healthy diet can prevent the flu		**No, it can't.** Many people think that taking daily vitamin C supplements will stop them getting flu, but there's no evidence to prove this.
The flu jab has pork in it		**This is not true.** The adult flu jab does not contain any pork or gelatine. (The children's nasal spray however does).
Antibiotics can treat the virus		**Antibiotics are used to treat infections caused by bacteria, not for viruses such as the flu.** So don't think that flu treatment is readily available.

To all NHS staff this winter,
thank you

YOU CAN
BE A WINTER
HERO

C C C C
Care Colleagues
Collaboration Communities

Quarter 2 Safeguarding Report to Trust Board to be held in Public 13 December 2023		
Title of Report:	Black Country and West Birmingham STP Safeguarding Assurance Framework – Q2 report 2023 – 2024.	Enc No: 10.4.3
Author:	Mak Inayat – Deputy Head of Safeguarding	
Presenter/Exec Lead:	Lisa Carroll - Chief Nursing Officer and DIPC	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☒	Yes☐No☐	Yes☒No☐
Recommendations:			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ On Risk Register: Yes☐No☐		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats			
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: eg. Well-led
	NHSE	Yes☒No☐	Details: Safeguarding
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details: Safeguarding
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	None		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☒No☐	Date: 13.11.23

Summary of Key Issues using Assure, Advise and Alert
Assure • Safeguarding Children Level 3 and Safeguarding Adults Level 3 training overall compliance has improved in Q2. • Midwifery safeguarding supervision improved in Q2. There is on-going work to improve and support recording of supervision compliance for midwives.
Advise • Band 8a Lead Nurse for Safeguarding Children will be leaving the Trust and recruitment process has commenced, interviews will take place on 30.11.23. • Business Support Manager Band 5 substantive post is now progressing through recruitment. • The safeguarding team are currently working with learning and development team to map and align staff groups to the new agreed Safeguarding adults and children training packages.
• 1.0 WTE and 0.8 WTE Named Nurse for children Band 7 vacancies are out for advert. • Safeguarding Adults and children compliance will reduce significantly when mapping of staff form training needs analysis is completed and implemented. • Staff working with children will require to undertake and additional package Level 3 Childrens Specialist training involving two hours face-to-face session annually.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

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Safeguarding Quarter 2 Report to

Trust Board

EXECUTIVE SUMMARY

1.1 The safeguarding policies are continually reviewed and progressing to completion. WHT and RWT are working collaboratively to complete outstanding policy work which is progressing and has resulted in completion of a number of policies (Appendix 1).

1.2 Safeguarding Staff from Domestic Abuse Policy is in the final stages of completion and is requiring amendments requested by the Policy Group. The policy is requiring support from HR and Medical directorate implementing routine enquiry questions during IPDR's and Health and Well-Being checks.

1.3 A joint RWT/WHT 'Managing Allegations of Behaviour Indicating Unsuitability to Work with Children and Adults with Care and Support Needs' policy is in the final stages requiring support from the Local Authority adult and children managing allegation leads and WHT HR.

1.4 The safeguarding team has the following vacancies which are progressing through the recruitment process. 1.0 WTE and 0.8 WTE Named Nurse for children Band 7. Band 8a Lead Nurse for Safeguarding Children and Business Support Manager Band 5 substantive post is progressing through recruitment.

1.5 There is ongoing work for WHT to provide assurance against the DBS recording process. The reporting of the DBS for new starters has improved in Q2 to 93.90%.

1.6 WHT are continually working with ICB and WSP to complete an action plan following the Walsall Local Authority Joint Targeted Area Inspection (JTAI) in November 2022 Q3. The were two pertinent actions for WHT – safeguarding supervision and health records.

2.0 The safeguarding team are currently working with learning and development team to map and align staff groups to the agreed training packages as per training needs analysis.

2.1The work to review adults and children's packages is on-going. The WHT/RWT adult safeguarding team are reviewing and developing an eLearning adult Level 3 package.

2.2 WHT/RWT safeguarding team are developing a variety of face-to-face training packages required for the Level 3 Children's Specialist training these sessions will include themes identified in case reviews for local learning such as professional curiosity.

2.3 During Q2 Safeguarding Children Training Level 1 compliance has reduced month on month to 90.40% at the end of Q2 (Data end of Q1 92.41%). Safeguarding Children Training Level 2 compliance has increased in Q2 to 92.06% (Data at the end of Q1 91.13%).

2.4 Safeguarding Level 3 Children Training overall compliance has improved in Q2 to 76.97% from 72.87% in Q1. WHT have access to various packages for safeguarding training to increase access including the national e-learning package to the current programme.

2.5 There is a risk the compliance will reduce once the training needs analysis is implemented due to the increase in staff requiring completing Safeguarding Children's Core Level 3

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training. In addition, those staff working with children will also be required to complete Level 3 Childrens Specialist training which will involve a two-hour face-to-face session annually.

2.6 During Q1 the compliance for Safeguarding Adult Level 1 and 2 training remained constant with over 94.13% for Level 1 and 90.94% for Level 2. Level 3 training compliance has improved slightly in Q2 to 80.50% however reduced overall compared to 81.59% in August 2023.

2.7 The Safeguarding Team Adult and Children Level 4 training is 100%. All staff are encouraged to attend regular L4 training updates. The joint work with WHT/RWT training task and finish group are working with L&D to develop a process to capture Level 4 compliance on My Academy.

2.8 The Oliver McGowan LD e-learning Level 1 training is improving month on month to 52.37% at the end of Q2 compared to 50.00% in August. The trajectory to achieve 95% is to be agreed.

2.9 The Prevent Level 3 Training compliance has improved slightly in Q2 to 92.63% compared to 91.29% in August 2023. All staff are now required to complete Prevent level 3 in line with Home Office recommendations.

3.0 Health Visitor and School Nurse supervision compliance has reduced in Q2 due to a multitude of factors such as increase in staff requiring safeguarding supervision and staff absence impacting on capacity. All practitioners that are outstanding have been prioritised and scheduled to be seen.

3.1 Maternity services are offered a range of one to one, group supervision however recording and monitoring compliance has been challenging. Regular meetings with the four midwives delivering safeguarding supervision have been initiated to support and monitor compliance. Safeguarding supervision has improved slightly in Q2. The Named Midwife and the Deputy Head of Safeguarding will monitor and support recording of supervision compliance and this will be reported to the TSG.

3.2 Safeguarding Champions programme (children and adults) involving bi-monthly meetings offering alternative group supervision and themed sessions of learning involving internal/external speakers. Domestic abuse was covered at the time of drafting this report incorporating the ‘Think Family’ approach to safeguarding.

4.0 There have been no published reviews in Q2 however to prevent identification WSP have published the recommendations of one completed review. Therefore, there have been minor changes in the reviews open to WHT which is a total of 14 reviews in the WSP system.

- 4 Child reviews (SCR/LCSPR)
- 1 Child Rapid Review
- 4 Adult reviews (SAR)
- 2 DHR’s
- 1 Child CSA tabletop review
- 1 Child Neglect Thematic Review (4 family groups)
- 1 WHT Single-agency review

4.1 WHT have contributed to the chronologies, reports and participated in the multi-agencies’ discussion following the death of 5 children, none of these children were scoped for consideration of Child Safeguarding Practice review (CSPR).

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5.0 During Q2 the Safeguarding Children Team received 127 contacts (in Q1 89 contacts received) from practitioners requiring advice, support, and guidance these requests are increasing month on month. Themes included children with mental health concerns; pregnant young person; children living in home's where domestic abuse is featured, female genital mutilation concerns; poor home conditions and the recurring theme of children not being brought to their appointments. Parental concerns included mental health and substance misuse.

5.1 There has been a slight decrease (13%) in the number of high domestic abuse cases heard at MARAC. 145 MARAC cases were discussed in Q2 involving 187 children (126 cases were discussed in Q1 which involved 229 children). The MARAC process is under review by Walsall Community Safety Partnership and West Midlands Police there is a plan to introduce a weekly MARAC triage process.

5.2 Daily Domestic Abuse Triage in MASH remains a key part of the safeguarding children team's work. During Q2 1194 cases were discussed where children were either present in the property or known to reside in the property. This compares to 1175 cases during Q1.

5.3 There were 15 pregnant females discussed in daily Domestic Abuse triage, this is a 50% increase when compared to Q1 which was reported as 7.

5.4 During 2022/23 Q4 the new Black Country ICB KPI for MASH was introduced. In Q2 the number of RED health checks completed in timescales was 73 (93%). Compared to 77 (100%) in Q1.

5.5 During Q2 648 out of 763 (85%) amber and information checks were completed within timescales in MASH. This compares to 685 out of 835 (82%) completed in Q1. The completion of checks is internally monitored and when required escalation process is evoked, in Q2 this was done on 1 occasion.

5.6 124 DoLS applications were submitted during Q2. The Safeguarding Adults Team have continued to provide regular ward support through daily floor walks which includes supporting staff to complete DoLS applications, ad hoc training regarding mental capacity assessment processes throughout Q2. MCA and DoLS is also covered in Level 3 Mandatory Safeguarding Adults Training for all registered professionals.

5.7 An MCA/DoLS plan (post CQC visit October 2022) has concluded the final MCA survey conducted Q2 will be presented to TSG in Q3. The results of the Q2 survey will support work and the progress will be reported to the Trust Safeguarding Group on a monthly basis.

5.8 Since Q2 the RESPECT audit has been completed by ward managers who will continue to lead on this audit.

5.9 Learning Disability and Autism team Business case was clinically approved in Q4 funding sources from partner agencies to support the proposal is to be established as next phase prior to implementation.

5.10 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. ICB, WHT and GPs are working together to finalise a sharing of information agreement for the GPs to share their learning disability registers to enable the flagging on the electronic patient records.

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

5.12 The development of a Trust wide All Age Learning Disability Policy has commenced in Q2 to present to the Trust's Policy group in Q4.

6.0 Following ICON week in maternity services during Q2 the ICB have requested the completion of an ICON audit. This requires clinicians to complete a survey and all antenatal and postnatal women are asked to complete a survey on discharge. The Named Midwife for Safeguarding will monitor the results which runs until Q4 feedback will be provided to the TSG.

6.1 During Q2, WHT responded to the Walsall Safeguarding Partnership request to undertake a peer review of their services for both children and adult areas. This was aligned to the Children Act (1989) and Care Act (2014). The review focused on leadership, training, supervision, audit and client feedback. This resulted in the Trust rating themselves as ‘good’ overall and was endorsed by the partnership stakeholder event in June.

6.2 The LD business case provides an opportunity assure that the Trust is working with RWT to address gaps in provision (as part of the collaboration across both organisations).

6.3 There is a forthcoming CQC inspection of adult social care planned in Walsall. WHT have been requested to lead on MCA/DoLs to support preparation of this programme. The date for this is unclear, but likely to be Q3 onwards.

6.4 There was 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.

6.5 In Q2 WHT are working with the ICB, WSP and Community Safety Partnership to review the meeting structure and WHT contributions to maximise meaningful intervention to the priorities of WSP and Community safety Partnership.

BACKGROUND INFORMATION

RECOMMENDATIONS – To approve the report.

APPENDICES Q2 report with Policy tracker and Safeguarding Dashboard.

Any Cross-References to Reading Room Information/Enclosures:

Comprehensive Q2 report.

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

This Q2 2023/2024 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

Q2 Update:

Annual report was completed and presented to Trust in July 2023. Data provided accordingly. Annual report for 2023/2024 will be presented in Q4.

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

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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

Q2 Update

The safeguarding policies are continually reviewed and progressing to completion. WHT and RWT are working collaboratively to complete outstanding policy work which is progressing and has resulted in completion of a number of policies (Appendix 1). The policy tracker is discussed at the Trust Safeguarding Group (TSG).

- Safeguarding Staff from Domestic Abuse Policy is in the final stages of completion and is requiring amendments requested by the Policy Group. The policy is requiring support from HR and Medical directorate to support with implementing routine enquiry questions during IPDR's and Health and Well-Being checks. HR are setting up a group to promote completing the final stages of the policy. The draft policy was promoted at the All-age Safeguarding Champions event on 01.12.23.
- A joint RWT/WHT 'Managing Allegations of Behaviour Indicating Unsuitability to Work with Children and Adults with Care and Support Needs' policy is in the final stages requiring support from the Local Authority adult and children managing allegation leads and WHT HR. The policy will be presented to HR in Q3 for oversight and support prior to submission to the policy group.
- During Q2 the safeguarding team has had challenges recruiting to the 1.0 WTE Named Nurse for children Band 7. At the end of Q3 there will be another 0.8 WTE Named Nurse for children Band 7 vacancy. Both vacancies are on TRAC waiting for finance to authorise.

  At the end of Q3 there will be a vacancy for the Band 8a Lead Nurse for Safeguarding Children the post has been approved and recruitment processes commenced.

  The seconded Business Support Manager Band 5 post is now progressing through recruitment for the substantive position. Once this post has been recruited the Band 4 Safeguarding administrator team leader post will be reviewed in Q3.

- There is ongoing work for WHT to provide assurance against the DBS recording process. The reporting of the DBS for new starters has improved in Q2 to 93.90%. The reporting of DBS for existing staff has remained consistent in Q2 and is currently at 91.50% although reduced overall. (Data 92.02% in June 2023).

- WHT have worked with ICB and Walsall Safeguarding Partnership (WSP) colleagues during Q2 in attending key meetings (to ensure full commitment, attendance, and participation). Feedback and key actions are presented on a feedback form along with the progress on the implementation plan to the TSG. WHT, ICB, WSP and Community safety. Walsall Safeguarding Partnership meetings have commenced to review and streamline health's contribution to meetings.

- WHT are continually working with ICB and WSP to complete an action plan following the Walsall Local Authority Joint Targeted Area Inspection (JTAI) in November 2022 Q3. The were two pertinent actions for WHT. Firstly, for staff to have consistent access to formalised safeguarding supervision the safeguarding team are working with the services to support delivery, and this will be referenced in the safeguarding supervision policy which is under review. Secondly to update IT systems within WHT with the introduction of one health records system accessed via the electronic patient records. The implementation of this in MASH to support the Named Nurses in collating information is proving to be a success.

Actions:

- To complete the recruitment of the two Named Nurse vacancies, the Lead Nurse for Safeguarding Children Post, Band 5 Business Support manager post and the Band 4 Safeguarding Administrator Team Leader post.
- To work collaboratively with RWT to ensure all policies are updated by Q4.

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.

Q2 Update

- WHT/RWT continue to review the training needs analysis to ensure competencies for healthcare staff remain in line with the Intercollegiate Document for Children (2019) and Adults (2018). WHT training needs analysis exceptions paper presented to WHT TSG in Q1 was approved. The safeguarding team are currently working with learning and development team to map and align staff groups to the agreed training packages.

  The work to review adults and children's packages is on-going. The WHT/RWT adult safeguarding team are reviewing and developing an eLearning adult Level 3 package. WHT have an interim adult Level 3 package which has received positive feedback.

  The national training package for children level 3 core has been rolled out in WHT in Q4. WHT/RWT safeguarding team are working jointly to consider a variety of face-to-face training packages required for the Level 3 Children's Specialist training these sessions will include themes identified in case reviews for local learning such as professional curiosity.

- The safeguarding training compliance is reported monthly at the TSG (for each Division) and via the Safeguarding Dashboard presented to CQRM quarterly which provides overall training compliance across the Trust (Appendix 2). The safeguarding team continual monitor training dates and provide additional dates to support improving compliance.

  There is an eLearning Level 3 children and an interim eLearning Level 3 packages are also available as an alternative to increase compliance. There is a strong focus on managers to release staff for training and this is monitored through monthly TSG. In Q1 a request to escalate and write to non-compliant staff was approved this process will be delayed until training needs analysis of mapping staff groups have been implemented and finalised.

- During Q2 Safeguarding Children Training Level 1 compliance has reduced month on month to 90.40% at the end of Q2 (Data end of Q1 92.41%). Safeguarding Children Training Level 2 compliance has increased in Q2 to 92.06% (Data at the end of Q1 91.13%).

- Safeguarding Level 3 Children Training overall compliance has improved in Q2 to 76.97% from 72.87% in Q1. WHT have access to various packages for safeguarding training to increase access including the national e-learning package to the current programme.

- There is a risk the compliance will reduce once the training needs analysis is implemented due to the increase in staff requiring completing Safeguarding Children's Core Level 3 training. In addition, those staff working with children will also be required to complete Level 3 Childrens Specialist training which will involve a two-hour face-to-face session annually.

- During Q1 the compliance for Safeguarding Adult Level 1 and 2 training remained constant with over 94.13% for Level 1 and 90.94% for Level 2. Level 3 training compliance

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has improved slightly in Q2 to 80.50% however reduced overall compared to 81.59% in August 2023.

- Attendance at the Mental Capacity Act training has improved to 80.51% compared to 78.74% in August 2023. Additional ward training continues to be provided by the safeguarding team to raise awareness of the subject area as part of the continued work.

- The Safeguarding Team Adult and Children Level 4 training is 100%. All staff are encouraged to attend regular L4 training updates. The joint work with WHT/RWT training task and finish group are working with L&D to develop a process to capture Level 4 compliance on My Academy.

- The Oliver McGowan LD e-learning Level 1 training is improving month on month to 52.37% at the end of Q2 compared to 50.00% in August. The trajectory to achieve 95% is to be agreed. The Trust is awaiting further guidance from the ICB on the plan to roll out the Oliver McGowan LD Level 2 training programme. ICB have advised recording e-learning compliance until face-to-face element available for staff to be fully compliment.

- Domestic Violence Training is included in both Adult and Children Safeguarding Level 3. The Independent Domestic Violence Advocate (IDVA) based in ED has been embedded and has been invited to the TSG to provide updates on data. The IDVA provides bespoke training and advice to staff in ED.

- The Prevent Level 3 Training compliance has improved slightly in Q2 to 92.63% compared to 91.29% in August 2023. All staff are now required to complete Prevent level 3 in line with Home Office recommendations.

- WHT Board children and adult training is 92% compliance. Board training was delivered on 1st November 2023.

Actions:

- Monitor all levels of Safeguarding Training compliance during Q3 and Q4 following implementation of training needs analysis.
- Complete mapping of staff to the WHT/RWT training needs analysis as per intercollegiate documents.
- The Oliver McGowan LD Level 1 training compliance will be monitored and reported at the TSG. The Trust will await further 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.

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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.

Q2 Update:

- During Q2, the Safeguarding Team specialists, including Named Doctors have been offered or have had access to safeguarding supervision including the new Named Safeguarding Midwife. It is noted that for most safeguarding professionals this supervision is provided externally by the ICB or other professional experts.
- At the time of writing this report the ICB adult designated Nurse has agreed to provide Safeguarding Supervision to the Band 6 Adult safeguarding nurses.

- The ICB lead on providing group safeguarding supervision and restorative supervision across the ICB footprint for the named nurses working in MASH this commenced in Q1. This provides a great opportunity for collaborative working across the networks.

Total number of Community Staff/midwives identified to receive safeguarding supervision within Q2	Q2 Compliance
Health Visitors: 31	17 = **55%**↓ Staff absence and capacity in both the safeguarding children team and 0-19 Service. 1 of the practitioners was off sick. 1 on maternity leave. 12 outstanding practitioners will be prioritised in Q3.
School Nurses: 34	24 = **71%**↓ Staff absence and capacity in both the safeguarding children team and 0-19 Service. 10 outstanding practitioners will be prioritised in Q3.
Community Midwives (Group): 43	16 = **37%**↑ 27 outstanding MW's practitioners will be prioritised in Q3.

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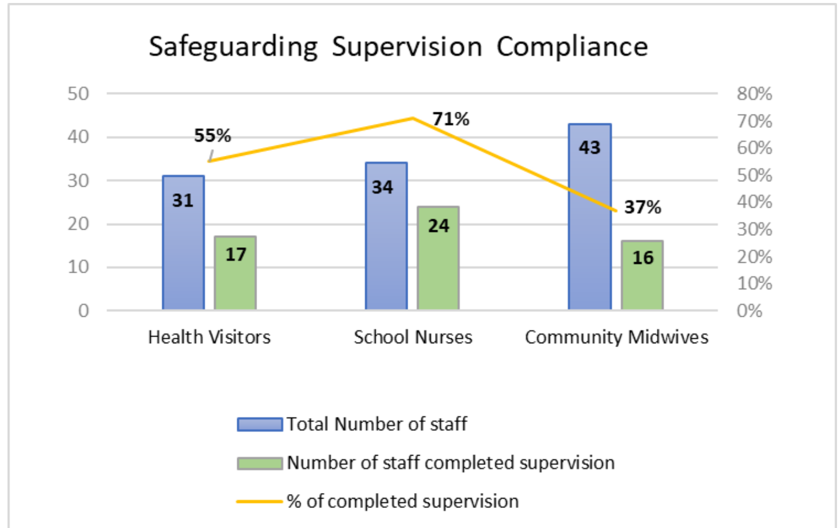

- In Q2 the safeguarding children team have continued to provide group safeguarding children supervision to support staff working in the 0-19 Service.

- Health Visitor and School Nurse supervision compliance has reduced in Q2 due to a multitude of factors such as increase in staff requiring safeguarding supervision and staff absence impacting on capacity. All practitioners that are outstanding have been prioritised and scheduled to be seen.

- During Q1 practitioners in Paediatric Emergency Department, Community Children's Team and Acute Paediatrics have had access to the 6 weekly safeguarding supervision sessions. The attendance to these sessions is improving and will be monitored and reported to TSG.

- In Q2 The Named Midwife for Safeguarding has completed her Safeguarding Supervision training and will support with delivering safeguarding supervision from Q3.

  Two more midwives have expressed interest to undertake safeguarding supervision training to support with delivering supervision to the maternity workforce. This will support in improving compliance within the hospital setting.

- Maternity services are offered a range of one to one, group supervision however recording and monitoring compliance has been challenging. Regular meetings with the four midwives delivering safeguarding supervision have been initiated to support and monitor compliance. Safeguarding supervision has improved slightly in Q2. The Named Midwife and the Deputy Head of Safeguarding will monitor and support recording of supervision compliance and this will be reported to the TSG.

- 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.

- Safeguarding Champions programme (children and adults) involving bi-monthly meetings offering alternative group supervision and themed sessions of learning involving internal/external speakers. Domestic abuse was covered at the time of drafting this report incorporating the 'Think Family' approach to safeguarding.

  The safeguarding team introduced the Trust's commitment to staff by introducing the Draft DA (Domestic Abuse) policy. These sessions are evaluated by those in attendance and the feedback has been incredibly positive an update will be provided at the next TSG.

- The WHT safeguarding supervision policy is under review to incorporate supervision offer for adult and children services.

Actions:

- To monitor supervision compliance (including maternity) 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 Q3.

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.

Q2 Update:

- During Q2, the safeguarding case review group has changed its name form Practice Review Group (PRG) to Joint Case Review Group (JCRG) and update was provided at the TSG. This group covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR).

- There have been no published reviews in Q2 however to prevent identification WSP have published the recommendations of one completed review. Therefore, there have been minor changes in the reviews open to WHT which is a total of 14 reviews in the WSP system.
    - 4 Child reviews (SCR/LCSPR)
    - 1 Child Rapid Review
    - 4 Adult reviews (SAR)
    - 2 DHR's
    - 1 Child CSA tabletop review
    - 1 Child Neglect Thematic Review (4 family groups)
    - 1 WHT Single-agency review

- WHT have contributed to the chronologies, reports and participated in the multi-agencies' discussion following the death of 5 children, none of these children were scoped for consideration of Child Safeguarding Practice review (CSPR). WHT are completing a single agency review for one child from Q1. No other agencies were involved at the time of the incident and the actions carried out would not have changed the outcome however there was learning identified.

  The early learning identified for WHT is professional curiosity, discharge planning, feeding assessments in maternity services, voice of the child, inquisitive inquiry and record keeping. The safeguarding team supported and worked closely with divisional leads with the internal review process.

- The learning following the child deaths, is monitored at the WHT internal CSPR/SAR/DHR/LeDeR Group. This Group continues to meet bi-monthly to review and update all actions aligned to the Organisation.

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

- There have been no adult scoping referrals submitted to Walsall Practice Review during Q2.

- WSP have commenced the new subgroup for Child Sexual Abuse as a recommendation following Operation satchel which 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.

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 Q4.
- 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.

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- To ensure any case action plans are completed within timescale.
- 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.

Q2 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 Q3 information across the Trust in regard to new cases or actions.

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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 2023. Data provided accordingly. Annual report for 2023/2024 will be presented in Q4.

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.
Q2 Update: **Childrens and Maternity Update** • During Q2 the Safeguarding Children Team received 127 contacts (in Q1 89 contacts received) from practitioners requiring advice, support, and guidance these requests are increasing month on month. Themes included children with mental health concerns; pregnant young person; children living in home's where domestic abuse is featured, female genital mutilation concerns; poor home conditions and the recurring theme of children not being brought to their appointments. Parental concerns included mental health and substance misuse. • During Q2 the Safeguarding Children Team supported staff with 24 court statements (in Q1 it was 25), maternity Safeguarding Lead has supported with 3 court statements. These requests were from the 0-19 Service: the acute paediatrics and midwives. 25 requests were from Walsall Metropolitan Borough Council Legal Services and 1 from Shropshire Legal Services and 1 from Bolton Borough Council Legal services. • There has been a slight decrease (13%) in the number of high domestic abuse cases heard at MARAC. 145 MARAC cases were discussed in Q2 involving 187 children (126 cases were discussed in Q1 which involved 229 children). The MARAC process is under review by Walsall Community Safety Partnership and West Midlands Police there is a plan to introduce a weekly MARAC triage process.

- Daily Domestic Abuse Triage in MASH remains a key part of the safeguarding children team's work. During Q2 1194 cases were discussed where children were either present in the property or known to reside in the property. This compares to 1175 cases during Q1.

- There were 15 pregnant females discussed in daily Domestic Abuse triage, this is a 50% increase when compared to Q1 which was reported as 7. DA triage is led by the safeguarding children's team the Named Midwife for Safeguarding cross checks data daily to support the midwifery service.

- During 2022/23 Q4 the new Black Country ICB KPI for MASH was introduced. In Q2 the number of RED health checks completed in timescales was 73 (93%). Compared to 77 (100%) in Q1.

- During Q2 648 out of 763 (85%) amber and information checks were completed within timescales in MASH. This compares to 685 out of 835 (82%) completed in Q1. The completion of checks is internally monitored and when required escalation process is evoked, in Q2 this was done on 1 occasion.

- There was a reduced number of strategy discussions held in Q2 which were all attended by the Named Nurse. There were 51 strategy meetings compared to 69 in Q1.

- During Q2 16 there were 16 disclosures of FGM comparted to 19 in Q1.

- During Q2 Lead Nurse for Safeguarding Children lead on the Maternity clinical update day (MCU) which are 1 hour monthly safeguarding training sessions available to all maternity staff. Themes covered in Q2 are Walsall Partnership key priorities; training, Multi agency audits; Local CSPR/rapid reviews learning on information sharing and professional curiosity.

- The maternity clinical update is linked to a case scenario, which focuses on documentation; information sharing and professional curiosity. From Q3 the Named Midwife for Safeguarding will deliver the MCU.

- In Q2 the "All age safeguarding Champions programme" delivered a session on MCA & DOLs, 3 members of the maternity team attended.

- The Named Midwife for Safeguarding worked jointly with the ICB, WSP, and the ICON Group in supporting ICON week (25th-29th September). A display of up-to-date information was launched in all clinical areas for clinicians and parents. Daily events occurred within the hospital atrium to raise awareness and all staff were invited daily to attend the webinars shared by ICON. All discharge packs within maternity contain an ICON leaflet along with a QR Code Sticker, within the child's red book to link to the ICON website.

Adults update.

- 124 DoLS applications were submitted during Q2. The Safeguarding Adults Team have continued to provide regular ward support through daily floor walks which includes supporting staff to complete DoLS applications, ad hoc training regarding mental capacity

assessment processes throughout Q2. MCA and DoLS is also covered in Level 3 Mandatory Safeguarding Adults Training for all registered professionals.

- An MCA/DoLS plan (post CQC visit October 2022) has concluded the final MCA survey conducted Q2 will be presented to TSG in Q3. The results of the Q2 survey will support work and the progress will be reported to the Trust Safeguarding Group on a monthly basis.

- Since Q2 the RESPECT audit has been completed by ward managers who will continue to lead on this audit.

- In Q2 there was no Prevent referral (Q1 there was 1 Prevent referral).

- Prevent returns (to NHSE) has been completed within timescale for Q2.

- From Q3 all Trust staff are required to complete level 3 Prevent e-learning.

- During Q2 the safeguarding team were notified of 43 safeguarding adult referrals (the figure is lower due to less concerns from WM Ambulance Service and back log from local authority). Safeguarding adult referral themes during this quarter were unsafe discharge, pressure ulcers, medication errors.

- The All-Age Safeguarding Champions Programme continued in Q2. The programme provided bespoke safeguarding events for identified champions across the Trust (including community staff.) In addition, the programme also incorporates safeguarding supervision sessions for the champions.

  In Q2 the event focussed on MCA & DoLS and was opened up more widely to include staff from across the Trust who are not champions but how have an interest in learning more about MCA & DoLS.

- Learning Disability and Autism team Business case was clinically approved in Q4 funding sources from partner agencies to support the proposal is to be established as next phase prior to implementation.

- From Q4 the Trust has commenced the roll out of Oliver McGowan Learning Disability and Autism, the training consists of two tiers. Both of the tiers require the completion of an eLearning session but will also require the completion of a face-to-face session. The face-to-face session is currently not available, and the Trust are awaiting guidance from the ICB on how this will be delivered. Compliance for the eLearning element is 54%.

  Oliver McGowan Learning Disability and Autism was 54% in Q2 slight increase from Q1 data. The compliance will be monitored and reported 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. ICB, WHT and GPs are working together to finalise a sharing of information agreement for the GPs to share their learning disability registers to enable

the flagging on the electronic patient records. This will be monitored and reported to the TSG monthly.

- The Trust can flag autistic people who use WHT services. Flags are being added by the paediatric consultants as part of the diagnostic pathway.
- The development of a Trust wide All Age Learning Disability Policy has commenced in Q2 to present to the Trust's Policy group in Q4.

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.

Q2 Update:

- Following ICON week in maternity services during Q2 the ICB have requested the completion of an ICON audit. This requires clinicians to complete a survey and all antenatal and postnatal women are asked to complete a survey on discharge. The Named Midwife for Safeguarding will monitor the results which runs until Q4 feedback will be provided to the TSG.
- During Q2, WHT responded to the Walsall Safeguarding Partnership request to undertake a peer review of their services for both children and adult areas. This was aligned to the Children Act (1989) and Care Act (2014). The review focused on leadership, training, supervision, audit and client feedback. This resulted in the Trust rating themselves as 'good' overall and was endorsed by the partnership stakeholder event in June.
- Throughout Q2, the safeguarding development plan has been presented at the TSG for monitoring and oversight. (Appendix 3). The work is progressing positively in relation to previous concerns raised in 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.
- Following a review of the RESPECT audit this is now being completed by ward managers in Q2 onwards.
- NHSE have started commenced a task and finish group to implement Phase 2 roll out of Child Protection Information System (CPIS) Walsall 0-19 service are early adopters.

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.
Q2 Update: • The LD business case provides an opportunity assure that the Trust is working with RWT to address gaps in provision (as part of the collaboration across both organisations). • There is a forthcoming CQC inspection of adult social care planned in Walsall. WHT have been requested to lead on MCA/DoLs to support preparation of this programme. The date for this is unclear, but likely to be Q3 onwards. • There was 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. The outcome of the inspection will be provided to the TSG when available. **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)
Q2 update. • During Q2 WHT reviewed attendance at all key Walsall Partnership meetings and present actions to the TSG, WSP and ICB. • In Q2 WHT are working with the ICB, WSP and Community Safety Partnership to review the meeting structure and WHT contributions to maximise meaningful intervention to the priorities of WSP and Community safety Partnership.

- During Q2 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 partnership feedback form is now presented to the TSG monthly to capture actions pertinent to WHT.
- The new ICB Dashboard and the challenges of inputting data effectively has now been resolved. The Dashboard is now completed by the Safeguarding team Business Support manager and presented to the TSG (attendance from ICB noted) for approval prior to submitting to CQRM.

- WHT do not attend MAPPA meetings currently however this has been escalated to the ICB by the Head of Safeguarding and is liaising with MAPPA to manage risks when patients who attend WHT. In Q2 2 cases came to the attention of the safeguarding team.

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.

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Appendix 1 - Safeguarding Service
Safeguarding Policy Document – updated OCT 2023

No.	Name of Policy	Approval Date	Review Date	Commence Review (3 months prior to review date)	Lead Practitioner	Notes/Progress
1	Prevent Policy - OP110 V2 March 2021	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	LR	**01/11.23 Policy completed final adjustments requested by Policy Group. To be presented at Policy Panel in Dec 23.** 02/10/23 Policy needs final read by Safeguarding children lead and Named Midwife prior to submitting to Policy Panel.
3	Staff Domestic Abuse Policy V2 Under review: October 2022	May 2023 TBC			SS	**01.11.23 & 02.10.23 – Actions from policy group in progress.** **1)** Liaise with HR re alterations to 121/IPDR paperwork to be agreed and referenced. **– 04.10.23 attend HR subgroup to discuss policy and requests for routine enquiry.** 2) Liaise with medical directorate due to separate PDR paperwork. **28.09.23 discussed with Marsha Belle form HR re IPDR and Health and Wellbeing checks to include routine enquiry. Marsha agreed to set up meeting with divisional directors to discuss including universities for students.**

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						Liaised with safeguarding team to produce bespoke training package to support managers to ask routine enquiry questions. **Raise awareness at Safeguarding Champions meeting November theme DV/DA.** **3)** Reference and contact with universities to inform students of this new policy and what the new policy entails for students and mentors. **As above.** 4) Conformation from the Safeguarding Committee Group, that they are happy with the level of assurance that will be received from directorates re dip sampling audit reports. **To present at TSC when recommendations completed.**
	Safeguarding Patients Domestic Abuse Policy V6 – WHT OP981	5th June 2023	June 2026	March 2026	SS	26.06.23 – policy approved and on the intranet.
4	Safeguarding Supervision Policy (Children and Adults). (Safeguarding Children and adults' policy are being combined). Policy will be referred to as one policy.		October 2022		DF/JJ	**01.11.23 Policy progressing to complete for December Policy Group.** 02.10.23 Policy being reviewed by adult and children team aim to complete for December Policy Group.
5	Safeguarding Adults at Risk Policy Policy will no longer be combined with Childrens policy to	Sept 2023 TBC	April 2023	January 2023	JL/LR	**01.11.23 Policy under review for completion December for Policy Group 2023.** 02.10.23 Policy under review aim to complete by December 2023.

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	ensure policy can be completed.					
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	**01.11.23 Policy delayed due to reduced capacity in the team. Policy to be prioritised and presented to Policy Group in December 2023.** 02.10.23 Policy under review and requested to be prioritised. For completion in November presented to Policy group December.
7	Managing Allegations Against Staff (new policy)	July 2023 TBC	December 2022	September 2022	JL	**01.11.23 Delay in discussion with LA to align processes. To discuss with HR and present TSG December for Policy Group January 2024.** 02.10.23 Policy requires LA discussion to align process – LA contacted confirming meeting. Liaising with HR policy delayed presenting at HR policy group (06.10.23) due to LA.
8	Deprivation of Liberty Safeguards (DoLS) Policy	June 2023 TBC			ML/JL	**01.11.23 Policy completed and on the agenda for Policy Group on 13.11.23 for approval.** 02.10.23 Submitted to Wendy James and distributed for wider feedback prior to being presented at Policy Group in October.
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.

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10.	LD & autism policy		January 24		EW	**01.11.23 policy being developed.**
11.	Restraints Policy		October 23			**01.11.23 Lead identified at October TSG. Policy to be removed from Safeguarding policies proforma December 23 as MH leading on policy.** 02.10.23 waiting for decision who will clinically lead on policy.

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Appendix 2

Safeguarding Dashboard – please see attached.

Appendix 3

Safeguarding Assurance Development Plan – November 2023

	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
1	**Safeguarding Service & Team Resource (October 2023)**	1.To carry out a review of the current resources within the Safeguarding Team (Adults, Children and Children in Care) 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. Ref: *Black Country & West Birmingham Assurance Framework.* 2. **June 2023**: Review the BCWB Service Level Agreement (2023-2026) for Children in Care to ensure WHT has service provision in place.	~~January 23~~ ~~July 23~~ ~~Oct 23~~ **Jan 24** (To conclude recruitment process) Head of Safeguarding	**07.11.23/02.10.23** **Children Team: Team review/recruitment in progress. Awaiting confirmation of budget for B7 team vacancies.** **Adult Team: No change to staffing** **LD Team: Awaiting funding for business case.** **Children in Care Team: B6 vacancy (1.0wte) to be recruited to during November.** **Contingency planning in place to cover workload.** **Admin: B5 post to be advertised in November.** **Named/Nominated Adult Medical Lead post to be confirmed.**	**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 23~~ Nov **23** Head of Safeguarding and Team Leads	**02.10.23**/05.07.23/07.06.23 **Policy in development – see proforma to be concluded by Q3.**	**In process** Evidence: (*Copy of Supervision Policy*)

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	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
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)	• Phase 2 (NHS England roll out to be considered nationally/locally to include 0-19 service access to CP-IS. • WHT to co-ordinate service areas cited within the proposal	~~April 23~~ ~~July 23~~ **Dec-23** Head of Safeguarding/ Safeguarding Children Team Lead	**07.11.23/ 02.09.23** **Phase 2 of CP-IS to be rolled out April 24. WHT group meeting to be set up to consider the implications of extending the work, and to review current system and process in ED/Maternity/Unscheduled care. Meeting for WHT key leads/service areas to be organised by December.** 02.08.23 NHSEngland/ICB and Walsall Partnership meeting held 1.8.23. CP-IS Phase 2 roll out now in process (to be completed by March 2024. The plan is to extend specific service access to (CPiS IT platform) to include GPs, ED, Maternity, 0-19, Sexual Health, SARC, Dental Services and Community Paeds. Task and Finish meeting to be set up with service leads who will be asked to attend/contribute. TSOG to be updated on the details as soon as dates confirmed. To discuss at WHT Children Strategic Group too. 05.07.23/07.06.23 0-19 Service and safeguarding service to consider roll out into HV/School Nurse service. Update expected from NHSE in July/August.	**In process** Evidence: *Audit findings & action plan.*
4	**Safeguarding Training Programme to be reviewed.** **(From October 2023)**	• 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.	~~April 23~~ ~~July 23~~ ~~Oct 23~~ **Jan 24** Deputy Head of Safeguarding	**07.11.23/02.10.23** **Training programme amended from October. Training compliance reporting process being scoped within the Trust due to anomalies with data. Staff groups being reviewed in November.** 02.08.23/05.07.23/07.06.23/01.05.23 TNA to be presented at TSOG August.	**In process**

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	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
		• WHT to offer more training dates whilst the review is in place. *For WHT to email directly all staff who are outstanding with their training.* • TNA for new training programme to be presented to TSOG in July 2023.		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 been scoped. Regular communication and targeting of staff outstanding with all training has been highlighted at senior meetings across the Trust. 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. **LD development Plan/Framework (From October 2023)**	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 • Funding to be finalised for LD team.	~~April 23~~ ~~June 23~~ **Oct 23** Head of Safeguarding/ LD Lead	**07.11.23/02.10.23** **LD Action Plan in development. Liaison noted with BCPFT. Monthly reporting agreed to be presented at TSOG from November 2023, including training compliance for OM training.** 02/09/23 LC to liaise with Walsall Together to clarify if funding available. Update October. /02.08.23/05.07.23/07.06.**23/**01.05.23 Business Case completed and sent to respective team at WHT. Referred to ICB (Sally Roberts) for funding consideration. EW/FP have met with BCHFT on 04.07.23 and agreed to work collaboratively with LD service	**In process**

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	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
				leads to meet the needs of WHT and BCHFT teams as interim. Monthly meetings to be set up, key performance indicators to be agreed. Flagging of records (LD/Autism diagnosis) has also commenced. Oliver McGowan training in place. (E learning level 1) Compliance to be added to the safeguarding Dashboard from May 23. Meeting held with WHT and BCPHT 30.5.23 to clarify role and remit of service model. **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	
6	**May 2022** **Liberty Protection Safeguards known as LPS (from Oct 2023 tbc) and Mental Capacity Assessment/Deprivation of Liberty Safeguard system work.** WHT to be fully prepared for the forthcoming changes within legislation and implications for practice in regard to MCA/DoLS systems and processes.	Review of national (and local) documentation around the intended introduction of LPS and the impact and implications for WHT. • WHT to work with ICB and key partners at Walsall LA re future changes to legislation • 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	~~April 23~~ ~~Oct 23~~ **Feb 24** SG Adult Lead	**07.11.23/02.10.23** **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. Review progress in Q3.** 03.04.23 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	**In process**

DRAFT

	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
		• Identify a Trust 'Lead' for LPS • Set up a Trust Group with relevant stakeholders to support this work		seek any learning in regard to work regarding MCA and DoLs applications in readiness too.	
7	**JANUARY 2023** **Walsall Joint Area Inspection (JTAI)** *Inspection undertaken in November 2022.* *Final feedback received January 2023* **(Updated Walsall action plan from October 2023) to consider IT data base for information sharing.**	Review the final report and ensure any actions for WHT are completed. • Review and finalise actions following JTAI, including roll out of MAST project across Walsall.	~~April 23~~ ~~Sept 23~~ ~~Oct 23~~ **Jan 24** Head of Safeguarding	**07.11.23/02.10.23** **All actions aligned to the JTAI are in review. Forthcoming meeting in regard to the use of MAST for information sharing across Walsall (November 23). WHT IT system (in ED). Further update to TSOG in Q3.** 01.05.23/03.04.23 JTAI action plan circulated to respective service areas from Walsall LA. Forthcoming focus on information sharing systems and processes for accessing health data. Review progress update in Sept. 03.02.23/05.01.23 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**
8	**February 2023** **Safeguarding Adult Referral Process** WHT Safeguarding team/Walsall Local Authority to work together on communication process to ensure cases resolved.	1.For SG Team to review the current process with Walsall Local Authority to ensure that information/request for information (on case referrals) is being directed to the correct service area within the Trust. 2. To review WHT internal process for distributing cases that are referred by Walsall Local Authority 'front door' to ensure the appropriate service or team within the Trust receive detail and updates in a timely manner.	~~April 23~~ ~~Sept~~ 23 **Jan 24** Adult SG Team	**02.09.23** **Number of outstanding S42's have now reduced. SG Adult Team planning in Q3 to review their IT system which populates open cases. Review December 23.** 07.06.23/01.05.23/03.04.23 The safeguarding team are meeting with Walsall Local Authority to oversee the S42's and to work on referral/communication model internally going forward. Cited within the Adult SG team monthly report. Update September 2023. Plan to meet with WHT quality/governance teams during July to progress.	**In process**

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	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
9	**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. • For WHT to finalise any outstanding safeguarding policy work and present updates to TSOG and Walsall Partnership (PQA committee) from November 2023.	~~May 23~~ ~~Oct 23~~ **Feb 24** Head of Safeguarding	**02.10.23** **Walsall Partnership meeting convened in August to address all responses. WHT submission rated as 'Good'. Outstanding actions to be progressed and outcomes submitted to Walsall Partnership Quality and Assurance meeting. Main action is completion of policy work.** 02.08.23 Walsall Local Authority meeting set up on Wednesday 9th August to review WHT submission. Action: to feedback results to TSOG. 07.06.23 S11/Care Act data returned to WLA. Awaiting outcome. 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.	**Completed June 2023. Awaiting outcome.**
10	**June 2023** **Review of WHT Paediatric Safeguarding Medical process requested (by BCWB ICB).** **The key focus will be:** • **Attendance at Strategy Meetings**	• For WHT to meet with Designated Doctor for Walsall to confirm future actions. • For WHT Named Doctor for Safeguarding/HOS/Director of Nursing to meet every 3/12 to ensure oversight of safeguarding actions are in place.	~~Sep 2023~~ **Oct 2023** Named Doctor/Director of Nursing/ Head of Safeguarding	**02.10.23** **WHT Named Doctor update: Medial safeguarding SOP completed and signed off by Chief Nurse. COMPLETED** 02.06.23 Meeting convened with BCWB Designated Doctor and WHT to clarify work to progress. The guidance for CP medicals to be used (within WHT) to benchmark current practice.	**To commence June 2023**

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	Issue	Action required	Timescale for Update & Identified Lead	Progress Update	Evidence/RAG rating
	• **Benchmarking WHT paediatric service in line with national child protection medical documentation and local safeguarding procedures.**	• MASH process to be reviewed to ensure paediatrician attendance is evidenced/documented. • WHT Named Doctor/Safeguarding Team/Paediatric Div to review service in line with national guidance for undertaking child protection medicals.			
11	**July 2023** **To review incident forms to identify key themes/learning for WHT**	• For WHT safeguarding children and adult team to report on themes identified following receipt of incident forms • To ensure that relevant safeguarding incidents are sent to the Team in box.	**Dec 2023** Safeguarding Leads	**02.10.23** **Internal process within safeguarding team being reviewed. Incident forms being received by both adult and children service teams.** **05.07.23** For Trust Group to receive data on key themes from September. To be agreed at Trust Group in July 2023. Review process in October 2023.	**Internal process to be confirmed**

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

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Paper to the Trust Board Meeting - to be held in Public 13 December 2023	
Meeting Date:	
Title of Report:	Annual Report 2022-2023 – Spiritual, Pastoral and Religious Care The Royal Wolverhampton NHS Trust & Walsall Healthcare NHS Trust
Action Requested:	To receive and approve the annual report
For the attention of the Board	
Assure	The data capture assures that the SPaRC provision at both sites is relevant, valued and impactful
Advise	Note the planned production of a SPaRC Enabling Strategy 2023-2025
Alert	
Author and Responsible Director Contact Details:	Garry Perry Associate Director Patient Relations, and Experience Tel 01922 727438 garry.perry1@nhs.net Debra Hickman, Chief Nursing Officer RWT Lisa Carroll, Chief Nursing Officer WHT
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 in the percentage of staff who feel positive action has been taken on their health and wellbeing b) 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
Resource Implications:	'none'
Report Data Caveats	'none'
CQC Domains	**Safe:** Service users, staff and visitors are protected from abuse and avoidable harm **Effective:** People's care, treatment and support achieving good outcomes, promotes a good quality of life and is evidence-based where possible **Caring:** Staff involve and treat people with compassion, kindness, dignity, and respect. **Responsive:** Services are organised so that they meet people's needs
Equality and Diversity Impact	No negative impact
Risks: BAF/ TRR	No known risks
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	
References	The NHS Chaplaincy Guidelines 2015 Promoting Excellence in Spiritual, Pastoral and Religious care – Updated August 2023 https://www.england.nhs.uk/long-read/nhs-chaplaincy-guidelines-for-nhs-managers-on-pastoral-spiritual-and-religious-care/

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:	Annual Report 2022-2023 – Spiritual, Pastoral and Religious Care The Royal Wolverhampton NHS Trust & Walsall Healthcare NHS Trust
Item/paragraph **1.0**	**Detail** Please see report below.

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

Spiritual, Pastoral and Religious Care (Multi-Faith Chaplaincy Department)

Annual Report: 2022 - 2023

Rev Linford Davis, Head of Spiritual, Pastoral and Religious Care (RWT & WHT)

Rev Joe Fielder, Chaplaincy Team Lead (RWT)

Rev Edd Stock, Chaplaincy Team Lead (WHT)

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10. Conclusion

1. Introduction

Reverend Linford Davis

Head of Spiritual, Pastoral and Religious Care

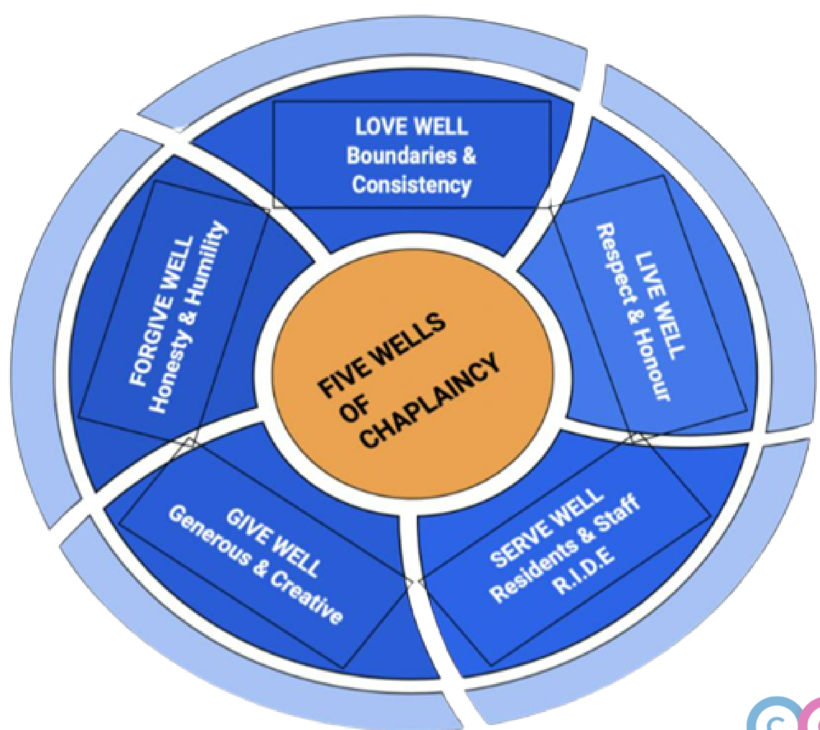
The Royal Wolverhampton NHS Trust & Walsall Health Care NHS Trust

The Chaplaincy - Spiritual, Pastoral and Religious Care (SPaRC) Department has continued to be about its core business of providing spiritual, pastoral, and religious care and support across all parts of our hospital and healthcare communities; whether this has been an inpatient encounter at the bedside, supporting worried relatives, conducting a funeral service for grieving parents, or supporting staff as they face challenging work situations.

As an emerging team we are building on the foundations of the past to develop our strategy for the future. Through this report we capture our development through the year, and trajectory of travel as we seek to develop a shared strategy between the Royal Wolverhampton Trust and Walsall Healthcare Trust. This report details the Spiritual, Pastoral and Religious Care annual activities for the period April 2022 – March 2023.

2. Vision and Values

Our vision is to engage, inspire and empower patients, staff, and visitors to grow in character, overcome challenges and develop holistically through spiritual, pastoral, and religious care. We continue to work from the foundation of our newly implemented "Five Wells" values



Care Colleagues
Collaboration Communities

2.1 Team and Roster

We are a SPaRC team providing compassionate support to those who are affected by illness, injury, trauma, and distress. We are committed to serving our diverse community and all who are part of the Royal Wolverhampton Trust (RWT) and Walsall healthcare Trust (WHT) community. Consequently, our support and involvement are also offered and accessed by visitors, relatives and increasingly staff across the Trust.

At RWT, we have successfully recruited and onboarded to our five vacant positions (administrator, Ecumenical chaplain, assistant Roman Catholic, assistant Anglican, and Team Leader). The new team is benefitting from the experience and support of Rev Joe Fielder as Team Lead following his move across from Walsall Healthcare Trust (WHT).
We have recruited an additional Roman Catholic Chaplain and six bank chaplains at WHT.

Following an assessment of the needs of our provision at RWT and given the collaborative partnership with WHT we took an innovative step towards alignment by exchanging the Team Leader of WHT and RWT. This has brought experience and stability to the newly forming team at RWT, and reinvigoration and reframed insight to the team at WHT as we work towards a new shared vision and strategy.

Role	Name	Hours
Head of Spiritual, Pastoral and Religious care (RWT & WHT)	Rev Linford Davis	37.5
Chaplaincy Team Lead (RWT)	Rev Joe Fielder	37.5
Chaplaincy Team Lead (WHT)	Rev Edd Stock	30.0
Team Administrator Bank (RWT)	Mr Richard Matthews	15.0
Team Administrator (WHT)	Miss Cath Smith	25.0
Assistant Anglican Chaplain (RWT)	Vacancy	15
Bank Chaplain	Rev Ebenezer Asaju	7.5
Bank Chaplain	Rev Eddie Boampong	11.0
Bank Chaplain	Rev Clifton Campbell	TBC
Bank Chaplain	Mr Gopal Gill	As required
Bank Chaplain	Rev Martyn Jinks	As required
Bank Chaplain	Rev Conrad Miller	TBC
Bank Chaplain	Mrs Helen Richards	7.5
Bereavement Officer (WHT)	Mr Tim Mortimer	37.5

Role	Name	Hours
Ass. Bereavement Officer (WHT)	Mrs Denise Lloyd	32.0
Bereavement Admin Ass. (WHT)	Mr Mohammed Kassim	21.0
Chaplain (WHT)	Rev Anthony Swaby	37.5
Ecumenical Chaplain (RWT)	Rev Laurel Woodstock	15
Hindu Chaplain (RWT & WHT)	Pandat Sharad Bhatt	3.5 6.0
Muslim Chaplain (RWT & WHT)	Imam Ahmed Salloo	15.0 8.0
Assistant Roman Catholic (RWT)	Rev David Williams	15
RC Chaplain (WHT)	Fr Chris Ugwuakposim	7.25
RC Chaplain (WHT)	Fr Jobin Mathew	5.0
Sikh Chaplain (RWT & WHT)	Giani Shyam Singh	5.0 12.0
URC Assistant Chaplain (RWT)	Angela Gemmer-Snell	Sessional

3. Training and Development

The Chaplaincy team members are engaged and empowered to take ownership of their development and training, through maintaining compliance with mandatory training, and taking opportunities for personal reflection on professional practice and progress.

Internally, we have supported several team members to participate in training courses covering topics of mental health, strategic planning, and a post graduate certificate in Chaplaincy. The learning gleaned from these courses will be shared amongst the cross-site team. The team continues to prioritise participation in the orientation and integration of international nurses.

2022 was a year of significant change in the personnel of the Chaplaincy team. This has meant the need to establish new connections with the various staff teams and departments across RWT and WHT. We are very encouraged with the warmth of welcome we have received and the training opportunities and engagements these have provided. We particularly note the strong and growing relationship with Bereavement Services team, the Palliative care team, the NNU Clinical team and the Bereavement Midwives.

All Volunteers were stood down at RWT since the beginning of the COVID pandemic in March 2020, we have initiated the process of reintegration, and will have our volunteers new and returning on board shortly. WHT has greatly benefited from the commitment and dedication of our volunteers, and volunteers have become part of the paid team through a program of 'on the job' training and formal training courses held jointly with Birmingham & Black Country area chaplaincy teams.

As we develop our team to better meet the needs of the community we serve, we continue to actively engage with our community and faith groups to recruit more volunteers, and give volunteers a pathway into further development in healthcare chaplaincy, this is a key focus for us in 2023.

4. On-Call Service

	Wolverhampton (RWT) (*data for Aug- Mar)						TOTAL CALL OUTS
	Christian	Hindu	Muslim	Roman Catholic	Sikh	Other	
2022	71	5	32	24	51	Data not available	183
2023*	78	3	41	41	52	22	355**
							**scaled up for 12 months

	Walsall (WHT)						TOTAL CALL OUTS
	Christian	Hindu	Muslim	Roman Catholic	Sikh	Other	
2022	61	0	28	19	5	0	113
2023*	90	0	25	22	9	0	146
							**scaled up for 12 months

We currently have x1 Hindu, x1 Muslim and x1 Sikh chaplain covering RWT and WHT on-call provision as such we need greater capacity to allow for 24 hr on-call coverage. We have started the process to recruit additional chaplains especially of Hindu, Muslim, and Sikh bank chaplains to allow us to provide an equitable and safe on-call provision.

5. End of Life Support

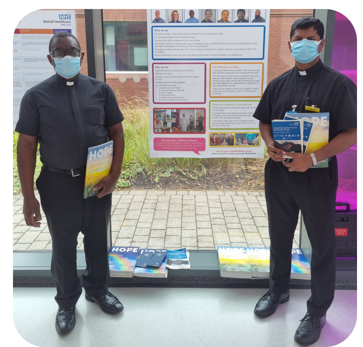
The holistic SPaRC we provide is very much about 'the Living' and the 'Getting Better' but of necessity we are also a key team that is involved in providing compassionate support and professional care when people reach the end of their lives, and in all the care that follows a person's death.

We seek to provide appropriate religiously aware and culturally informed care before death, care at death and care after death. From the provision of digital/electronic Sikh, Hindu or Muslim prayer devices so prayers can be played to a dying person, to the urgent call out provision maintained 24/7 to ensure a chaplain is present alongside a dying person and their loved ones in their final moments, as well as organising and facilitating emergency marriages. Rev Edd Stock conducted the wedding of a palliative care patient in the patient's house, which attracted positive media coverage.

Respectful, informed, and compassionate person-centred care makes a significant difference to the experience of those dying and to those who look on. We are humbled and grateful for the many positive comments and thanks we receive from family members and staff because of our quiet, calming and yet caring presence at such times.

The End-of-Life Support we offer is expressed in the care that follows a patient's death in the following ways:

Supported Viewings



Together with the excellent Bereavement Nurses we have helped many family members and close friends visit their loved ones in the Trust Swan Suite as part of the Swan Supported Viewing programme. On each occasion, where requested, a chaplain (often but not exclusively of the same faith background as the deceased patient) attends to support those who have come to say a final goodbye. We provide service cards and often lead a short service of prayer and pastoral support. Along with the Bereavement Nurses we have been thanked for the care offered and received. At RWT, from April to March, we helped with between 40-45 Supported Viewings.

Adult Funerals

Most Adult funerals organised by the Trust are direct cremations of deceased patients who died within the Trust premises and have no family or kin able to organise their funerals. However, chaplains are requested to conduct either prayers for the deceased before they leave our Swan Suite or are asked to conduct a funeral at our local Crematorium at Bushbury (RWT). Throughout 2022/23 we conducted 7 contract funerals, RWT. We conducted 6 contract funerals at WHT, and 4 private funerals (for patients who had received chaplaincy support whilst in hospital, where the family requested a chaplain lead the service). Fees for private funerals are paid to the Trust.

Pregnancy Loss

Chaplaincy provides an extensive amount of support for families and staff who are affected by pregnancy loss. Thanks to the past good working relationship between the previous chaplaincy department team members and positive early interactions with the new chaplaincy team members we are frequently contacted to provide support to parents facing the imminence of or experiencing pregnancy loss.

Our support is offered to all – to people of faith and to those of no faith. Often there are requests for religious support from families that reflect our local and diverse religious faith communities. These are supported by the faith specific chaplains who are part of our team, and liaison with local faith and belief communities where applicable.

Our support is frequently requested by those who wouldn't describe themselves as 'particularly religious' but 'spiritual' and know they have need of pastoral and spiritual support at these intensely painful times. The Maternity Departments know and trust that we are chaplains who are a help, comfort, and source of strength in very difficult and challenging times, and our input makes a significant difference.

The support takes the form of faith specific religious prayers, baptisms, Naming and Blessing services. On average we are called to either the Delivery Suite or Neo Natal unit 2-4 times per month.

Baby Funerals

It is a very sad but also a humbling and precious experience to be alongside parents and family members as they say goodbye to their little ones. Each of our chaplaincy team members has conducted several faith specific baby funerals throughout 2022. In a change to previous practice, our new standard approach is to conduct individual baby funeral services rather than shared services. From April 22 to March 23, we conducted a total of 167 individual baby funerals (89 RWT & 78 WHT). We also conducted 3 Manor Baby services (a joint service for a maximum of 2 babies).

In addition, we held both RWT and WHT annual Baby Memorial/Time to remember Service's in October at St Patricks church (RWT) and St Luke's Chapel & Prayer Room at the Manor Hospital. They were both well attended by parents and families who had lost babies in the last 12 months and previous years. We also led the Bushbury Christmas memorial event in December at Bushbury Crematorium attended by over 200 people.

6. New Initiatives

- Chaplaincy everywhere, every week' - We have engaged with more clinical and non-clinical areas by redeveloping our visiting rota, this has allowed us to offer our services to more people, whilst also seeking to get a deeper understanding of the needs of those we serve.

- We are in the planning stages of developing a ward-based religious and cultural training program, especially providing education and information on key religious practices and requirements relating to 'end of days' care "imminent death, at death and after death". This was raised as a need following feedback received from our heads of nursing and matrons.

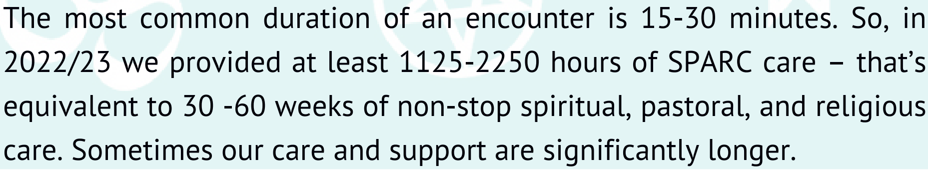
- The implementation of the SPaRC tool (a web-based method of recording pastoral encounters) which was developed at WHT has now been introduced at RWT (August 2022). This tool has enabled us to have a greater depth of insight into the scope and impact of our provision.

- We have entered a new partnership (SLA) with the Chaplaincy team at Compton Care. Our mutual support mirrors the many other cross pollination and cross site forms of care expressed by the Palliative care teams and therapists. The partnership is the culmination of several months of discussion and planning and commenced 1st May 2023.

7. SPARC Data

In 8 months of collecting data (Aug- March) at RWT, we had made 3004 significant pastoral encounters. Scaling that up to 12 months that is 4506 encounters over the year. That's equivalent to 375 encounters per month, or approximately 15 encounters per working day.

At WHT, we had made 7463 significant pastoral encounters. That's equivalent to 621 encounters per month, or approximately 20 encounters per working day.



The most common duration of an encounter is 15-30 minutes. So, in 2022/23 we provided at least 1125-2250 hours of SPARC care – that's equivalent to 30 -60 weeks of non-stop spiritual, pastoral, and religious care. Sometimes our care and support are significantly longer.

7.1 Who Was Supported?

At RWT, 78% of our support went to patients.14% of our support went to Staff. This is a significant area for Chaplaincy and for the Trust. Staff need care and support too, and Chaplaincy ought to be finely placed organisationally and in terms of skills set to meet, support and care for the staff who provide the care to the patients. At WHT, 82% of our support went to patients and 14% of our support went to Staff, with 7% of our support also being offered to relatives and visitors.

Our support has been varied – from a quick chat on the corridor, to gently checking in over a period of weeks, to supporting individuals and departments following traumatic events or the sad and sudden deaths of staff members. Over the past year we have led 3 memorial services for staff members.

7.2 What Support Was Provided?

Over half (53% RWT) and 39% (WHT) of our encounters had a religious/faith specific component. This should not be rushed over. We care for people of faith; we work with people of faith.

Almost 70% of our encounters had an element where people wanted some form of Spiritual support at RWT. Whereas 58% of WHT encounters had an element where people received spiritual support. In addition, 82% of encounters had a Pastoral care element (RWT) and 97% had a pastoral care element WHT. Although the specific content of the encounters remains confidential, themes of the encounters consist of professional and relational needs, fears, worries, and hopes.

7.3 Who Asked Us To Help?

How do you really know if the SPaRC provision is relevant, valued and making an indomitable impact on the organisation?

Answer 1: Ward staff know them and trust them and contact them!
Answer 2: Patients ask the chaplaincy team to return and provide more support.

At RWT, over the 6-month period we have collected data we have seen an increase in referrals from ward staff. Just over 46% of our requests for support for patients are now coming from ward-based staff. In addition, we have seen an increase in the number of requests for ongoing support rise from approx. 11% in early autumn to approx. 19% in the final quarter of the year.

At WHT, 18% of our requests for support for patients are now coming from ward-based staff. 12% of requests are from patients self-referring. 7% of referrals are from relatives/carers. 1% of referrals come from the patient's community.

8. Patient and Staff Feedback

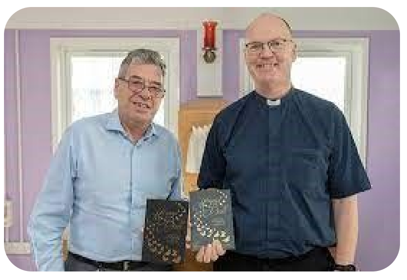
Patient Feedback is one of the ways we measure and develop our SPARC provision. Below are a few excerpts of patient's feedback:

"I can confess I am not a big religious person but having Joe around did feel right and his ways and words calmed the atmosphere. Joe has been there for us from the beginning and is still heavily involved as he will be doing our daughters cremation and burial of ashes services... People of New Cross hospital truly are in good hands with Joe on call."
Bereaved Mother and Father

Dear Laurel and Joe
"We just wanted to say thankyou for the wonderful service and comfort which you provided for us last week. It was such a hard time for us all, but your support, prayer and peace really helped us to get through...you both do a fantastic job and we are eternally grateful."
The words of a husband following support offered on ICCU as support was withdrawn.

"Dear Ahmed
Well done and thank you. Thank you for continuously leading Friday prayers for so many years, which I have benefitted from. I have found your talks spiritually very uplifting. "
A consultant staff member (RWT)

"Dear All,
I wanted to thank you all for your support with the blessing on C21 on 11/2/23.
The family were so grateful to everyone from the chaplaincy team who completed the blessing.
The clinical photographers who were able to take some family photos.
Also, to the ward team who managed to get the patient in a shirt and tie.
The family were so grateful and felt it was something they would treasure during such a difficult time.
I just wanted to pass on my thanks for making it all possible
Thank you.
Amy Lawley
Palliative Care CNS
New Cross Hospital "



“Following on from this, I could not write without a heartfelt thank you to the staff of the Chaplaincy at New Cross. We were first met by Rev Laurel. We are informed that she is relatively new in post, we would never have known, and it is a role she seems perfect for. She spent time offering support to my Nan and offering prayers and words of reassurance to the family. Her visit gave comfort to my Nan and despite him being in a coma provoked a small reaction from Gordon.

In the minutes after his passing, ... Staff also arranged an urgent visit from the Chaplaincy and on this occasion, it was Rev Joe who came to us. Like Laurel, he provided prayers and comfort but also added a sensitive amount of humour which lightened the situation in an appropriate manner. Rev Joe took time to learn about Gordon and his life and speak in detail to my Nan which was greatly appreciated. Our thanks go to both for their support at a very difficult time. “
Bereaved family email of thanks December 2022 (RWT)

“We both felt that you were the perfect person to provide the lovely service for our baby yesterday, and we would both like to thank you for your kindness, and for being a part of our journey and memory when we think of our precious baby.”
Bereaved Mother and Father May 2022

I just want to say Thank you for conducting a beautiful service for my baby last week, it was a difficult day but you made it so heart-warming. Please could you pass on a sincere thank you to Denise for getting everything organised, honestly you all do and amazing job.
Bereaved Mother June 2022

Alhamdo lillah all well. Mom is well Alhamdo lillah, Jazah kallah for visiting her, we really appreciate. May Allah (swt) reward you.
Patient’s daughter June 2022

Just to say thank you for the support you gave the family of BH on AMU. They said how comforting your words were and were so grateful that you helped them during this time.
Message from SNP End of Life Care July 2022

9. Events and Celebrations

- Easter 2023
- Ramadan 2022/23
- Vaisakhi 2022/23
- Diwali 2022
- Bandi Chhor 2022
- Annual Babies Memorial Service 2022
- Babies Christmas Act of Remembrance 2022
- Christmas Service 2022

10. Conclusion

With the implementation of our vision and the increase in our visibility in and around the hospital, the response has been encouraging, with growing numbers of ward referrals and a flow of positive feedback from patients and staff. With a growing team we aim to greater serve the SPaRC needs of those who are within the hospital and surrounding communities we care for, but also build partnerships with the surrounding community. To ensure we do this cohesively, and to the best of our ability, we want to facilitate more teambuilding activities and provide regular wellbeing check-ins.

Peer Review of Maternity Departments within the Black Country Integrated Care System.

Walsall Healthcare NHS Trust
Manor Hospital Visit

August 2023

Black Country Integrated Care Board

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Black Country Maternity Department

Peer Review Report

1.0 Introduction and Executive Summary

In recent years there has been significant national attention on NHS Maternity services. This has included the Donna Ockenden report into Maternity care provided by Royal Shrewsbury and Telford NHS Trust and associated recommendations, the Saving Babies lives programme, continuation of NHSLE standards and more recently the Independent Review of Maternity Services at Nottingham University Hospital. (Also led by Donna Ockenden).

In order to gain local assurance on the key recommendations from these key reports and investigations, and also following a number of locally reported serious incidents, The Black Country Integrated Car Board (BC ICB) agreed to facilitate a Peer Review Visit to each Maternity Unit located within the Black Country Integrated Care System. These visits were scheduled to be undertaken between the months of February 2023 and August 2023. The Peer Review Team, consisted of representatives from the Integrated Care Board, The Local Maternity Neonate System (LMNS) and Black Country Integrated Care Providers.

The aim of the Maternity Peer Reviews is to support the BC ICB and LMNS in commissioning consistent, high quality and safe maternity care provision across the Black Country Integrated Care System, ensuring that there are appropriate resources available and to facilitate the opportunity for supporting collaborative working, observation of practice and the ability to learn best practice from each provider and to highlight common themes and area requiring improvement. The reviews also aim to provide assurance that the recommendations from national reviews / publications have been implemented, or to highlight any areas still requiring further work and support.

The Maternity Peer Review Visits focus on the following key areas / lines of enquiry:

- Safeguarding practices
- Governance / Incident Reporting
- Environment / Equipment and Medicines Management
- Workforce / Competency
- Leadership and Culture
- Patient Experience and Compassionate Care Provision
- Clinical Practice and Outcome.

It is acknowledged that even within the compact geographical footprint of the Black Country, there are significant differences in demand, culture, levels of community deprivation, healthcare provision which unfortunately results in the creation of pockets of inequality, which places unique demands on the Maternity Departments and Community services within the four places across the Black Country System. However, despite these differences, there are opportunities to learn and to install principles of best practice.

The identified areas for improvement will be able to be addressed using appropriate service improvement approaches and will require a collaborative approach to improvement from all stakeholders in each Place, it is very clear from this review that it is not merely improvement

within a Maternity Department that will bring about the change required for improvement, but multi-Trust and LMNS led improvement work to deliver equitable services across the Black Country geographical footprint. It is the expectation that any work required will be overseen by the Local Maternity and Neonatal System (BC LMNS) with the Black Country Integrated Care providers having overall responsibility for acting and monitoring this through their usual governance mechanisms. The BC LMNS is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with regular reporting and escalation to the ICB Quality and Safety Committee and risks appropriately reflected on the Integrated Care Board (ICB) Risk Register.

2.0 ACKNOWLEDGMENTS

The Black Country Integrated Care Board (who facilitated the Maternity Peer Reviews) would like to thank the staff and service users and carers of all the Black Country Integrated Care Providers for their arduous work in preparing for the review and for their kindness and helpfulness during the visit. Thanks, are also due to the visiting team members and their employing organisations for providing their time and expertise in contributing to this review.

3.0 ICB Peer Review Finding and Observations

3.1 Leadership and Culture

3.1.1 Leadership and Culture

The leadership and culture in existence within the Maternity Services was shown to be highly effective, knowledgeable, and approachable. The Director of Midwifery (DOM) had not been in post that long but had been able to build on the processes used by her predecessor and draw on her own personal knowledge of the unit from her previous role as Head of Midwifery to ensure that the change had happened smoothy and without negative consequences. Staff appeared to respect the DOM and found her to be approachable and trustworthy. There was noted good multi professional working and good triumvirate.

The DOM described how the Trust had been on a 4-year improvement journey to reach where they currently are. Initiatives as part of the journey included the following areas:

- Increased patient experience and involvement of patient views in service redesign including MPV and patients who they work closely with.
- Undertaking the 15 steps initiative through induction of labour process and MPV.
- Regular audits of BSOTs.
- Building a strong relationship with the Trust Board and gaining their support and oversight on key issues.
- Trust CEO has been very supportive particularly in regard to the environmental challenges faced by the service.
- Improving communication methods with staff and using various methods to maximise effectiveness.

- DOM attends both private and public Board sessions and has slots on both parts.

- DOM works a clinical shift at least once a month to maintain clinical skills and increase awareness of challenges faced by the workforce.

- CQC 2021 outcome meant that staff were demoralised but were very determined to improve. There was time out sessions held with staff and meetings, which included staff from MSW to 6 postholders. A lot of the initiatives mentioned were as a result of these sessions.

- The funding required to appoint a consultant midwife has not yet been agreed – this is a known risk and the service is working towards resolving this.

- There is a Vision for Improvement / Strategy currently in development, which has been co-produced by services users and staff the vision includes, MPV and service users, increased staff supervision and support, and addressing inequalities.
  There is strong evidence of partnership working , including community hubs and EDI leads.

- Obstetric and Midwifery Staffing is seen as a recent success – this was previously a risk on the Trust risk register but there has been a concerted recruitment drive and improved retention of staff.

- There is a support bleep in operation which allows newly qualified staff to get immediate support on anything they are unsure of.

- The QUAD is still in development but the DOM is aware and will be starting in October 2023.

- RWT and WHT looking to increase collaborative working arrangements, which will improve staffing and opportunities for shared learning.

- There has been a strong focus on making the community teams feel included – all team meetings are now recorded which allows community staff members to listen to them at a time best suited to their diary . There have also been forums held with the staff members.

- There had been an issue in regard to 10-week bookings, with the team not adhering to NICE guidance -this had now been resolved.

3.1.2 Addressing Inequalities

The service has a dedicated and passionate Equality and Diversity lead, as well as a lead for the fellowship midwives (internationally educated). The work undertaken by the EDI lead supports both the local communities and workforce. This has included work to introduce an Outreach clinic where the most deprived communities can be supported beyond their pregnancy needs, for instance with housing issues, as well as work to support digital poverty within the communities. Looking also to the wider inclusion with the commencement of the LGBT+ weekly group session. Work has been undertaken to support staff to recognise a deteriorating patient from the global majority groups, as the tools we use are focused on white skin, for instance an Apgar score looks for pink skin, which is not relevant.

The fellowship lead midwife has introduced a holistic package of support for colleagues, not only to support their practice, but also to support their cultural and social neds as thy join from other countries. This has included a bleep system held by senior staff when extra support is needed, not only for the fellowship midwives but also for new starts and preceptees, this is a good demonstration of compassionate and supportive community of practice.

3.2 Community Midwifery Team

During the review, the BC ICB Peer Review Team held a remote Teams Meeting session with some of the senior members of the Trust's Community Midwifery Team. The following areas were discussed:

- The team stated that there were approximately 18 home births – the Team members keep their skills and knowledge up-to date by undertaking periodic shifts on delivery suite and through their skill drills training.

- The team came across as being very enthusiastic, energetic, and showed a real passion for their work. They were keen to always try to support the needs of the patients and often went out of their way to maximise engagement and were flexible in meeting people's needs.

- The community team members showed in -depth knowledge of safeguarding processes and requirements and there were no concerns flagged by the ICB Peer Review Team.

3.3 Infection Prevention and Control /Environment / Equipment / Medicines Management

Infection prevention and control, the overall environment, equipment, and medicines management was reviewed as part of the visit by the ICB Peer Review Team. The following points provide a summary of the areas that were noted by the team:

Antenatal Clinic –

- Monthly environmental, hand hygiene and uniform audits were routinely and effectively carried out by the Matron.

- Environment was found to be clean and uncluttered.

- The Furniture in the waiting areas was observed as being all intact and wipeable.

- The vaccination fridges all have cleaning and rotation rota's/checklists.

- There were daily and weekly cleaning checklists for the clinical rooms and clean/dirty utilities.

- There were no breaches in uniform, BBE or PPE observed.

Issue identified:

- There were no wall mounted hand gels along the ante-natal corridors.

Ward 25 (Primrose) – 19 bedded, x2 ensuite rooms.

Ward Context

The general ward environment appeared to be worn out and somewhat outdated. A full refurbishment is planned for 2024-25, but in the meantime, they have obtained £50,000 from funds for a small refurbishment to take place this year. They have prioritised three patient bathrooms which are accessed most frequently for these funds. Other funding has been secured for the Discharge lounge which is being decorated and having furniture purchased to make it feel a more welcoming, pleasant environment.

- The last annual Infection Control audit for Primrose Ward was carried out in June 2023 and achieved a 92% overall score.

- Two members of the Domestic service staff, clean the ward twice a day (morning & afternoon).

- Room 3 checked as this room was empty and prepped to accept a new patient into it. Low and high level dark grey dust noted on several areas checked, in particular on top of the wall light above the patient's bed.

- Lovely new Treatment room and Dirty Utility and Nursery room that will be shared with MLU. There was also a specimen fridge stored in here, but this was not in use at the time of the visit.

Issue Identified:

- Flooring and skirting boards are worn, and damaged, adhesive tape applied over damaged flooring between corridor and bathroom door entrances.

- Wooden crash bumpers along the corridors are chipped and damaged with wood splintering exposed.

- The patients board opposite the nursing station is old, wooden, and non-wipeable so cannot be cleaned effectively.

- One of the bathrooms showers has a low-level door screen that has a brush strip along the bottom, this brush is highly contaminated and damaged. Staff are aware and have raised this but say it is unable to be replaced without removing the whole screen due to how old it is.

- The larger bathroom towards the bottom of the ward has flooding problems when the shower is used. There is also a low-level doored shower screen in this bathroom, but it has a rubber seal strip instead of a brush strip which cannot be decontaminated effectively. Waterproof curtains are being used as a shower curtain which are left hanging to dry. Recommended that as not waterproof or changed after every use when wet that an alternative/waterproof shower curtain should be considered.

- Temporary medication/storage room (normally a side room) where the medication fridge is stored. The room itself is very warm which has affected the fridge causing a build-up of ice at the back which then defrosts and water pools in the base. There were boxes of medication on the bottom of the fridge which were sodden due to sitting in this water. Advised to remove and ensure medication is not stored on the base. Daily fridge temperatures all up to date and within range. This room is cluttered but this is a temporary fixture due to the refurbishment taking place and storage space is limited.

- There was high level grey coloured dust located on the ward which is indicative of this being old dust particles.

- The patient information board was made of a material that was not wipeable and therefore poses and IPC risk.

Delivery Suite

- The area was noted as being a bright, clean, and spacious environment.

- The birthing room/pool area was also observed as being clean and hourly temperatures were clearly logged for the pool when in use. All equipment within the room was observed as being clean and the room appeared to be uncluttered. Staff were able to describe how the pools are cleaned after every use and have a deep clean once a week. The Birthing Pool is only used once a month on average.

- Leads/Managers have a weekly walk around which has helped to identify any issues and good practices.

- Staff described how they receive weekly updates from the IPC Team who they said are always approachable, supportive, and visible.

Issues identified:

- Paint/wood on skirting boards have areas that are chipped.
- Bathroom has whirlpool baths with jets. Ward Manager not aware of these baths or the cleaning/maintenance schedule for them. It has been highlighted with the IPC team who will discuss with facilities.

- The specimen fridge is located within the dirty utility, which is a locked room, but the fridge is unlocked due to the key missing – this had been reported.

3.4 Governance / Incident Reporting

As part of the visit, clinical staff members and representatives of the Trust's Maternity Quality and Governance Team were spoken with. The following points were raised / discussed:

- There is a very effective process in place for the timely review of reported incidents, which is undertaken in an MDT manner.

- There are clear processes for Duty of Candour and there was documented evidence of this having taken place with the full involvement of patients who were fully and compassionately supported.

- There was clear evidence of shared learning, for example the Maternity Service Bites. shared via closed media pages and read out in handovers.

- Learning Vignettes were sent to all staff on email and closed social media pages.

- There was evidence of learning and improvement through the use of effective clinical audits.

- The Governance Team did have a staff who were absent due to annual or maternity leave, but the team were very enthusiastic and passionate and were keen to utilise new communication methods and technology to help learn lessons and promote patient safety.

- The Team was able to describe in detail the top 5 themes and risks and the associated mitigations that are in place.

3.5 Clinical Areas

During the ICB Peer Review visit. Time was spent within the clinical environment on the wards, interacting with staff, observing practice, and speaking to patients and relatives. The points below are the key observations made by the Peer review team members:

- Staff described how overall they enjoy their jobs and feel that the Trust and the Unit is good place to work with a good support network. They are aware of most of the issues and stated that they consistently raised these or added them to the risk register. Most issues noted are related to the tired general environment.
- Staff seem to work well together and are clearly very proud of how they have managed flow and capacity even with some areas having been closed for the purpose of refurbishment.
- During the visit, some members of the leadership team unfortunately were unable to identify the top 3 risks or the birthrate and could not describe outcomes from recent HSIB reviews.
- There was an effective “Handover of Care” process , to support those patients who move out of or into the area during their pregnancy.
- The Trust had a lone worker policy in place that utilised staff badges as a locator.
- There are specialist midwives in post but not for drug / substance misuse and there was no perinatal specialist midwife .

Antenatal Clinic

- Doctors in clinics and time delays are clearly shown on the screens within the Antenatal clinic assisting staff with knowledge and up to date data.
- The clinic had achieved a very good response to Family and Friends Test.
- There were QR codes visible for staff and patients to access information.
- Staff shout out boards were present, and staff described how they found these to be a useful method of raising concerns or sharing good practice or news.
- Staff rescue box for any essentials required whilst at work (biscuits, tights, sanitary products etc).

- There had been a recent change of the BCG clinic day as previously fell on prayer day, uptake has increased since changing this.

- There is a midwife vaccinator available every day.

Ward 25 (Primrose)

- Leads/Managers have a weekly walk around which has helped to identify any issues and good practices.

- ICB Peer Review Team members spoke to the Bereavement Midwife and Clerical/Admin staff on Delivery Suite who both said they enjoyed their work and feel very supported by the management team / leads.
- Transitional care has 4 beds, these are funded but if there are more than 4 TC beds then the baby is reviewed by a consultant neonatologist and if TC criteria is met on just one thing it may be that they care for the baby on the ward.

- The Trust have implemented a training programme where midwives on Primrose are trained to do neonatal Antibiotics, this stops delays in treatment and is also being expanded to train midwives on delivery suite so that the initial dose of antibiotics can be delivered within the golden hour.

- The resusitaire that is on the ward was ready for use and had been checked daily, the staff described how they are trying to get funding for new resusitaire's, and this is currently on the risk register as they are over 10 years old. Since the visit, the Trust now report that this has been secured.

- ICB Peer Reviewer spoke with 2 care assistants who felt that the ward manager and matron were really visible and available if they needed them which they felt was important, they enjoyed their job and felt that they had the right training for it. They were also excited that the HEE MSW pathways was starting, and they described how they really wanted to progress to a band 3 post.

Delivery Suite

- The unit was observed as being very quiet during the visit.

- There were a large number of information boards in delivery suite (and indeed throughout the unit as a whole.) the Boards were full of information but appeared very busy and could possibly mean information could not be understood / digested by staff.

- Staff were very proud, enthusiastic, and demonstrated strong bonds and teamworking.

- Spoke to Bereavement Midwife and Clerical/Admin staff on Delivery Suite who both said they enjoyed their work and feel very supported by the Leads. They stated that the unit has activity of approximately360 births per month.

- Ther suite had recently achieved a medicines management compliance score of 93.4% and this was clearly displayed on the entrance door.

- There was a great initiative where the Local Authority have a desk located within the atrium area where babies' births can be registered and support and advice for social / care issues can be quickly obtained.

- The suite had a "Rescue Box" which contained useful products that staff could use to help them through their shift.

- There were vaccine clinics in operation and consideration had been given in regard to the timings of these – having moved to another day due to conflicting with Friday prayer sessions.

- The emergency trolley was checked during the visit and was found to be clean, tidy, and up to-date.

- Midwives have a staff base where they take phone calls, this is also where women come to if they want an update on their stay. The staff talked about a new call waiting system where they will be able to see on a screen how many calls are waiting, response times to calls etc. This has been piloted in ANC and has evaluated really well.

- Staff were able to show ICB Peer Review Team where the folder was kept that had the national alerts for pregnant women and talked through how they would use this and follow up, this also started a conversation about express booking for any woman that turns up to triage that is either not booked or not booked with Walsall, this process has been really useful in supporting women new to the country and also identifying complex safeguarding women who may need wider MDT involvement.

- There was an email located on a notice board in the office that gave a brief overview of a woman's social history was not only visible to staff but also any patient/family member that came to the door. This was immediately taken down by staff.

- Wordskii is used for all women that do not speak English. Staff have good awareness of this.

- The ICB Peer Review Team asked about clocks on Delivery Suite, they are digital and used throughout the unit, the one exception was in obstetric theatres where everyone used the anaesthetic machine clock. The ICB team asked if this clock was calibrated the same way as the digital clock or if there was a time difference. Staff stated that there was a time difference, but that this was considered. This started a discussion about clocks and standardisation, why have the digital clocks to not use it in observation theatre where timings are equally, if not more critical in some cases?

- There was a staffing and vacancy sheet displayed, this was also sent to staff via email and gave a staffing position including forecasting when new starters are due to commence in post. This was referred to by a couple of staff throughout the day.

Triage

- The ICB Peer Review Team felt that there was a robust and effective Triage system in operation that was well known and understood by staff.

- There were both analogue and digital clocks in the area , however these were showing different times (2-3 minutes difference) and need to be calibrated.

3.6 Safeguarding

The following observations and comments relating to Safeguarding was made by members of the ICB peer Review Team during the course of the visit:

- Supervision sessions were very well implemented and high numbers of staff were getting robust supervision sessions – staff feedback how supportive they found these sessions to be useful and managers described the sessions as being a fundamental requirement for staff to allow them to get the support they need to fulfil their duties.

- There are specialist Safeguarding Community Midwives who can offer support and expertise to community midwives as required.

- Staff were able to describe their duties in relation to Safeguarding and stated that they would contact their line manager and safeguarding team for any queries or concerns they may come across which they are unsure of how to safely manage.

- Records management was inconsistent , with different methods of documentation used at different stages of pregnancy – for example BadgerNet is the main patient record system, but paper-based notes are still used in consultant clinics – there is a danger of key information being missed as a result.

- In regard to staff Safeguarding Training compliance, managers told the ICB Peer Review Team how they received regular updates on their staff training compliance numbers and that any staff who have Red or Amber status are supported / chased by their managers.

3.7 Workforce and Competency

The ICB Peer Review Team spoke with the Trust's Research Midwife (RM). She worked split shifts, working 15 hours in Delivery Suite and 15 hours as a Research Midwife. She stated that she enjoyed her job but sometimes found it hard to balance the two roles and to achieve home / work life balance. She was extremely passionate about both aspects of her role and spoke of how she enjoys influencing her peers and getting them involved with research projects. The ICB Peer Review Team feel that there should be a dedicated training slot on research included within the mandatory training programme. The RM expressed how she was keen to link in with the BC LMNS on joint research projects.

The ICB Peer Review Team also spoke to a Band 5 Midwife that had trained in another NHS Trust and then moved to Walsall Healthcare. She said that she was loving working at Walsall, that the team were welcoming, she was very complimentary about the induction week that is put on by the practice development team, this is a week-long and the newly qualifies all get to know each other, get change to go round and spend time in each area and start mandatory training. This was then followed by a rotation programme. It was evident that mandatory training was rostered in, and time allocated and that there was a competency package that was used. All staff attend the staff brief at the beginning of the shift and this included safety bites which a few people said was useful as it gave rationale to feedback.

The team also spoke with a band 5 preceptorship midwife who was very complimentary of the support she receives.

3.8 Patient Experience and Compassionate Care

The ICB Peer Review Team had the opportunity to speak with patients and their relatives as part of the visit. All the patients and relatives spoke with were happy with the care they had received. One patient we spoke with in Triage had used the service 3 times previously and was happy with each visit.

We also talked to a lady who was in triage and awaiting a medical review. She said that she had been to triage a few times, always felt welcome to call and that her problems were being heard and she was always invited in. She said that if triage was busy, she would be asked to sit in the waiting room until someone was free to see her, there was no mention of being seen initially as per the BSOTS pathway. The only thing she said was that sometimes she had more questions about her pregnancy but wasn't sure if she could ask them in triage.

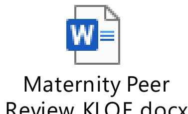
There was evidence that patients provided feedback through Friends and Family Test and that the Trust reacted to feedback provided .

The service had also received compliments, and these were also used to help share positive lessons and improve practice.

4.0 Summary of Recommendations / Areas of Improvement

- IPC - issues relating to the environment on Primrose ward and Delivery suite to be reviewed and addressed / mitigated (see pages 8 and 9).
- Wall Mounted Hand Gels to be installed in Antenatal corridor areas.
- Consultant Midwife Post to be funded and recruited to as soon as possible.
- Arrangements for QUAD leadership team to be implemented as soon as possible.
- Community services – 10 week booking / Nice compliance issue to be monitored following changes implemented recently by the Trust.
- Resusitaire equipment issue to be addressed / replacement machines purchased and installed.
- Calibration of digital and analogue clocks to be immediately undertaken and consideration for all clocks to be digital in theatres.

Appendix 1 – Key Lines of Enquiry



Trust Board Meeting on 13th December 2023		
Title of Report:	Chief Pharmacist Report	Enc No: 10.6.1
Author:	Sonia Chand, Interim Director of Pharmacy Sonia.chand3@nhs.net	
Presenter/Exec Lead:	Manjeet Shehmar, Chief Medical Officer manjeet.shehmar@nhs.net	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐

Recommendations:

The Board is asked to be informed and assured of this report.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: 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. On Risk Register: Yes☒No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
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.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details:
	NHSE	Yes☒No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- It is through the Medicine Management Group that audit compliance is being monitored and escalated to Divisions where necessary.
- Continued work through the Medicines Management Improvement Group (MMIG) is showing a growing positive culture around medicines management.
- Insulin improvement workgroup has commenced.
- Have been able to review off contract purchasing.
- All clinical fellows are now registered on the BPS site for the prescribing exam - we now have all the licences

Advise

- The Trust plans to implement an EPMA system and a project manager (non-pharmacy) is addressing the legal requirements for procurement, business case and timelines. This was approved by Trust Board in October.

Alert

- There is the need for an increased pharmacy establishment to continue to manage medicines across all wards.
- Medicine reconciliation levels have reduced over the past month due to staffing issues. There is now a plan to increase this.
- A business case is planned for submission to Investment Group in November 2023
- The ward audit of medicines management continues to show some gaps in compliance.
- Nitrous oxide management – there is a process to move to cylinders.
- Controlled drugs management on ward 14.- action plan
- Aseptics workforce capacity- is over capacity- staff are being recruited to support this.
- 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. Delay in recruitment due to no candidates, out to advert again.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • 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	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Chief Pharmacist Report

Report to Trust Board Meeting on 13th December 2023

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 reports directly into the Clinical Effectiveness Group on a quarterly basis.
There was a CQC engagement call scheduled for the 8th of September 23 around EPMA and Insulin. The current progress with the Frontline Digitalisation Strategy and the work around insulin was discussed.

Medicines Management Improvement Group key updates:

1. **Medicine Policy review**

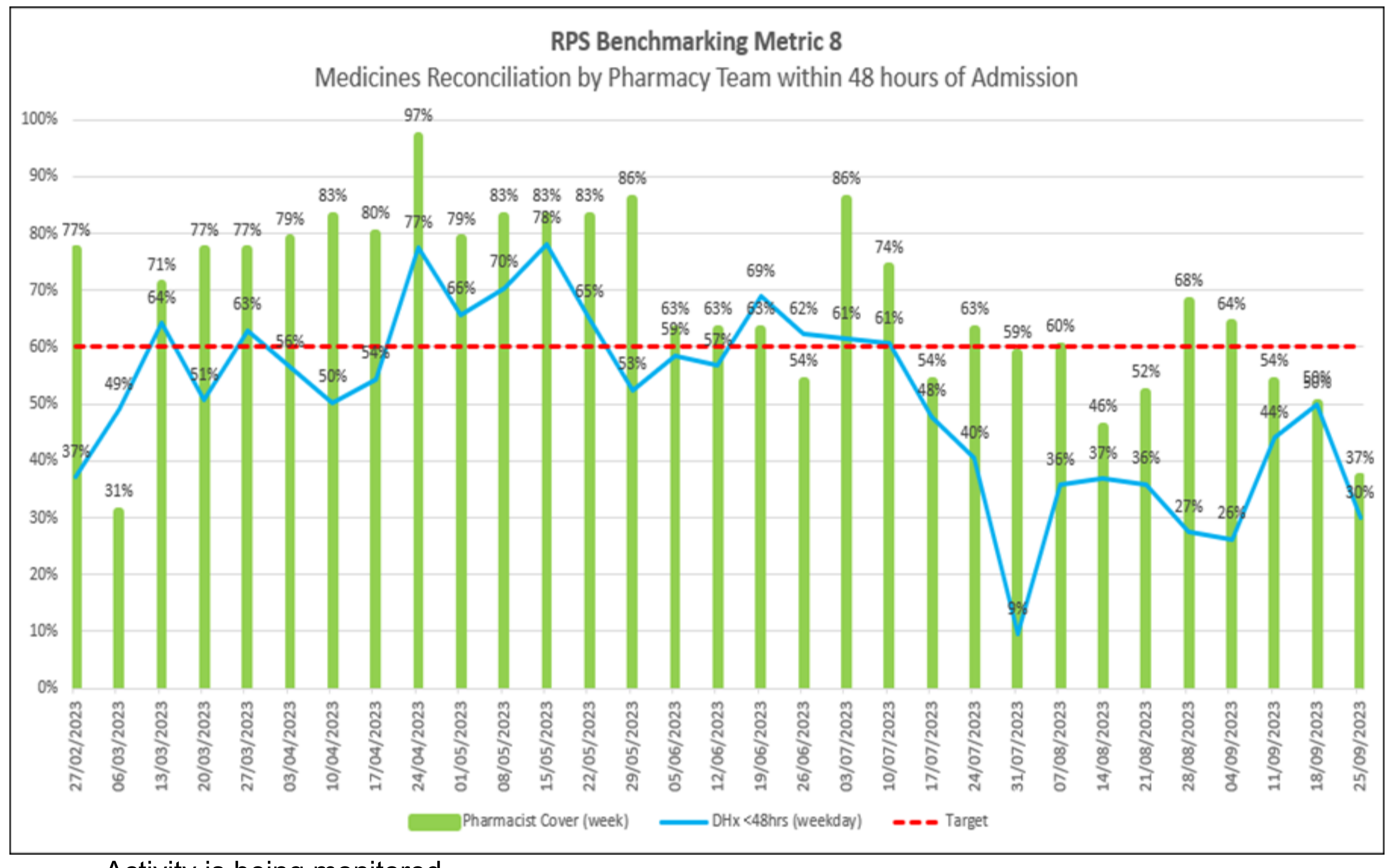
   There is currently a short life working group set up to manage the review of the Medicines Policy in line with the recommendations from the specialist advisor in response to the Section 29a notice. Due to be completed by November 23. There is also a joint approach taken to this review by WHT and RWT.

2. **Education and Training**
   FY2- training is being planned.
   Existing staff to be managed via the local induction at ward level.

3. **Insulin workstream**
   A new insulin working group has been set up to address the issues around insulin prescribing and administration across WHT. Immediate actions are to devise a consolidated insulin audit tool across the trust, to then audit and from the findings to develop a quality improvement programme.

Escalations October 23

1. Pharmacy staffing the staffing levels remain low, recruitment is in progress, agency staffing is being sought to meet the staffing requirements until staff are in post. Expected duration = 3 months.
2. Medicines reconciliation levels are not reaching the threshold due to staffing



Activity is being monitored.

3. Nitrous oxide- currently usage is greater than what can be accounted for. There is work to move to cylinders in theatres to mitigate any risks against loss. This being progressed in conjunction with the anaesthetics team.
4. Controlled drugs management on ward 14 – further losses have not been reported however, there is still some further work that is being undertaken.
5. Aseptic workforce capacity- this is exceeding the recommended capacity- have advertised band 3 assistant and band 7 pharmacist to support the workload in this area.

Pharmacy workforce

The business case for pharmacy staffing is planned for submission to investment group in November 23. In the meantime, key pharmacy ward-based roles have been identified and submitted to the Director of Finance to continue the temporary spend required to support.

New appointments:

3 x Band 6 pharmacists- due to start Mid-October- requesting agency to support the gap.
1 x band 7 ward services- commenced.
ED Pharmacist 8a (1 WTE)- due to start Nov 23
Medication safety officer 8B (1WTE)- due to start Jan 24

Advertised posts:

Band 7 (1WTE) x 3
Aseptics band 8b (1 WTE)

Agency spend- this is on a downwards trajectory and some of our locums are being transferred on to bank contracts.

Business cases

Pharmacy establishment business case due to go to investment group November 23. This has been approved by the WCCSS division.

EPMA Business case- approved by trust board. Next steps are to go NHSE.

Financial

There is currently work being undertaken around reviewing off contract purchases for medicines. To date £50K has been identified that be claimed back from suppliers due to delays in the supply of medicines to the trust. Pharmacy is working to claim this back.

Medicines Management Dashboard

A dashboard of key medicines management metrics has been set up on the Trust Intranet. Data update due early December 2023 due to delay in transfer of PowerBi license.

Risk Register

Current risk score has been reduced to 12 Severity x4 Likelihood x3. Forecasted risk score for this month will remain the same. The corporate risk was reduced as per planned trajectory end of September 2023. Evidence: All divisions have reviewed their risk scores, and all divisions are aligned to risk score 12. Monthly divisional meetings continue.

New risk entered onto the pharmacy risk register.

3285 Risk of drug diversion due to no written Standard Operating Procedures for ward automated medicine cabinets (Pyxis devices)- due to be completed end of October 23.

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.

Audits

The following national audits are in progress and percentage compliance will be reported monthly.

RPS Audit- from Nov 23 onwards.
Annual Audit Procurement
Future: for all audits to go onto tendable.

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 – last inspected May 23 no inspection due.

4. RECOMMENDATIONS

It is important to note that the work around the medicines management improvement group is continuing however, this urgently needs financial investment of the pharmacy establishment to sustain the current developments and further improvements.

The above measures will also improve accountability, especially through the Divisional governance structures, and the newly formed Divisional Medicines Management Groups.

Paper to the Trust Board to be held in Public on 13th December 2023		
Title of Report:	Safe High-Quality Care Oversight Report	Enc No: 10.6.2
Author:	Christian Ward – Deputy Chief Nursing Officer christian.ward@nhs.net	
Presenter/Exec Lead:	Lisa Carroll – Chief Nursing Officer lisa.carroll5@nhs.net	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The Trust Board is asked to note the contents of the report and, in particular, the items referred to the Board for decision or approval.			

Implications of the Paper:			
Risk Register	Yes ☒ No ☐ Risk Title: **208** - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks (Risk Score 12). **2245** - Risk of suboptimal care and potential harm to patients from available midwives being below the agreed establishment level (Risk Score 16) **2325** – Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes (Risk Score 15). **2439** - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety' (Risk Score 12). **2540** - Risk of avoidable harm going undetected to patients, public and staff due to ineffective safeguarding systems (Risk Score 12). **2581** – Internal risk for patients awaiting Tier 4 hospital admission (Risk Score 12). **2587** - Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks (Risk Score 9). **2601** - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6 (Risk Score 8). **3043 –** Suboptimal paediatric staffing - Paediatric nursing establishment is currently maintaining minimal compliance to expected national standards for paediatric nursing. This is further exacerbated by increased demand on service and sickness/maternity (Risk Score 16).		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
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.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Registration and licensing Well led.
	NHSE	Yes☒No☐	Details: Related standards
	Health & Safety	Yes☒No☐	Details: Health & Safety Act

	Legal	Yes☒No☐	Details: Duty of Candour, Claims and Litigation
	NHS Constitution	Yes☒No☐	Details: Constitutional Standards
	Other	Yes☒No☐	Details: Professional registration issues
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	None identified within the report		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: TMC 26/10/2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- Safeguarding adult and children's training is achieving the Trust target for levels 1 and 2 training.
- Falls per 1000 bed days were 3.46 in October 2023. Weekly falls accountability meetings are continuing, identifying lessons for shared learning.
- Agency cessation plans continue to see a reduction in the usage of agency nursing staff, with a robust risk assessment process in place for the agreement of agency usage.
- The timeliness of observations for October 2023 was 82.52% (September 2023 89.10%), including ED and 92.24% (September 91.73%), excluding ED. Results have dipped below 90% for the first time in 5 months. A significant issue with vitals did affect compliance on 14 September 2023.
- Data from October 2023 demonstrates a consistent level of pressure ulcer incidents.
- Within the Emergency Department (ED), 81.96% of patients received antibiotics within the first hour in October 2023.

Advise

- Mental Capacity Act data has been collected via the Tendable Audit (Respect) since June 2023, and results for October 2023 are 84.94%.
- LocSSIPs compliance figure across the Trust stands at 93% in October 2023 (an increase from 86% in September 2023), the latest available results.
- For adult inpatients, 67.14% of patients received antibiotics within the first hour in October 2023, a decrease from 75% in September 2023.
- The nursing and midwifery vacancy rate is just over 4% in October 2023, a slight increase from September 2023 (3.9%).

Alert

- A total of 7 C. *diff* toxin cases were reported in October 2023. Out of the 7 cases, 2 were deemed avoidable, and 5 unavoidable.
- VTE compliance for October 2023 was 90.31%.

- There is considerable pressure on the ED department from Mental Health patients who need assessment and potential treatment. A Memorandum of Understanding has been provided to the Trust from the Black Country Partnership, which has yet to be agreed upon due to the lack of provision for the 'Responsible Clinician'.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing. • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider-collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Reference Pack – SHQC report
Date: 24th November 2023

QUALITY DATA

- The Nursing Quality Dashboard (Appendix 2) provides an 'at a glance' view of ward/department/service performance with regards to structure, process and outcomes and it is provided for information.
- Other nursing quality data can be viewed on the Integrated Quality and Performance Report.
- Trust level quality metrics are provided as trend charts with key actions and mitigations outlined by the subject matter experts. Key points from this month's Trust level nursing quality metrics are highlighted below.

1.0 Excellence in care

1.1 Falls

- The number of Trust falls recorded for October 2023 is 62, an increase from 49 in September 2023 (Chart 1).
- The Royal College of Physicians' mean average performance of 6.1 falls per 1000 occupied bed days has been achieved continuously for the past 34 months (Chart 2).
  - Falls per 1000 bed days was 3.46 in October 2023 (2.93 in September 2023).
- The Falls Steering Group continues to implement an enhanced risk assessment for patients at high risk of falls.

Chart 1 - Total Falls

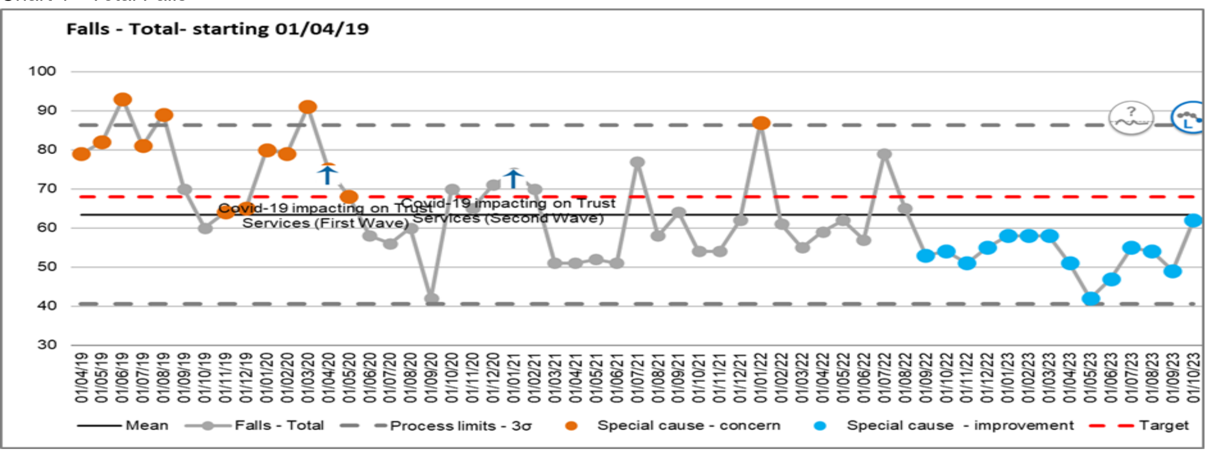
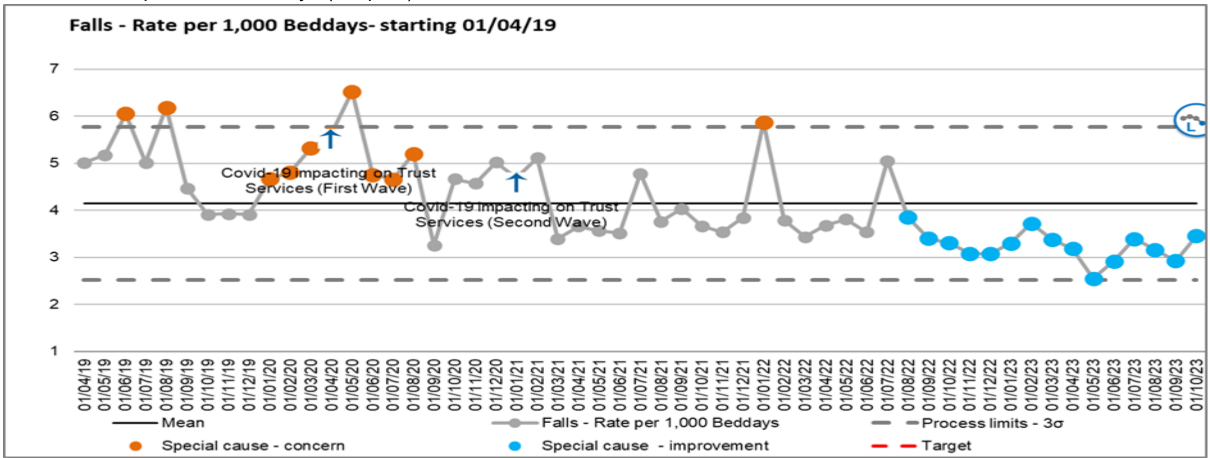


Chart 2 - Falls per 1000 bed days (hospital)



1.2 Tissue viability

- Data from October 2023 demonstrates an increase in pressure ulcer incidents (Chart 3); the hospital data demonstrates an increase in incidents (Chart 5).
- Chart 4 demonstrates a plateau in community pressure ulcer incidents.

Chart 3 - Total Pressure Ulcers Hospital and Community

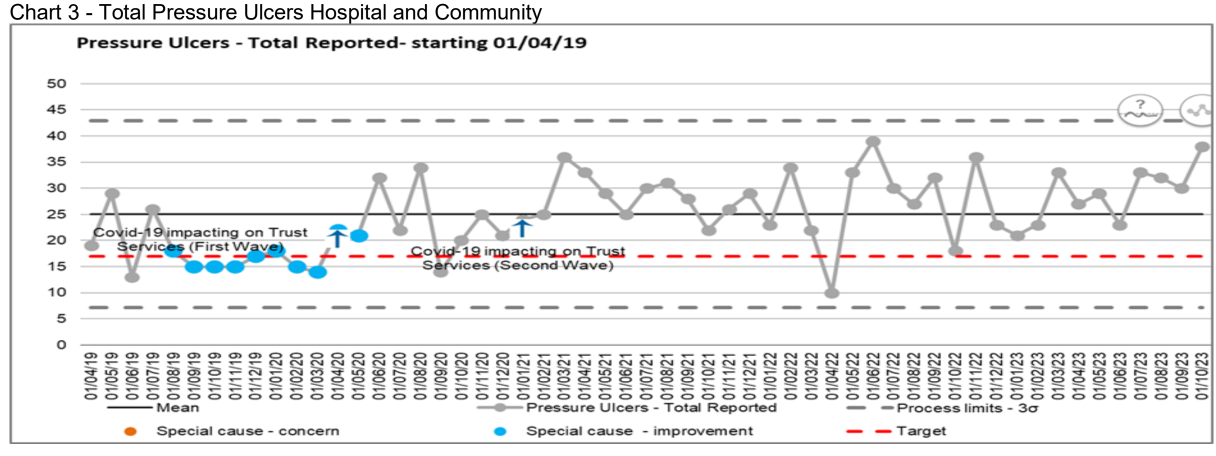


Chart 4 - Community Pressure Ulcers

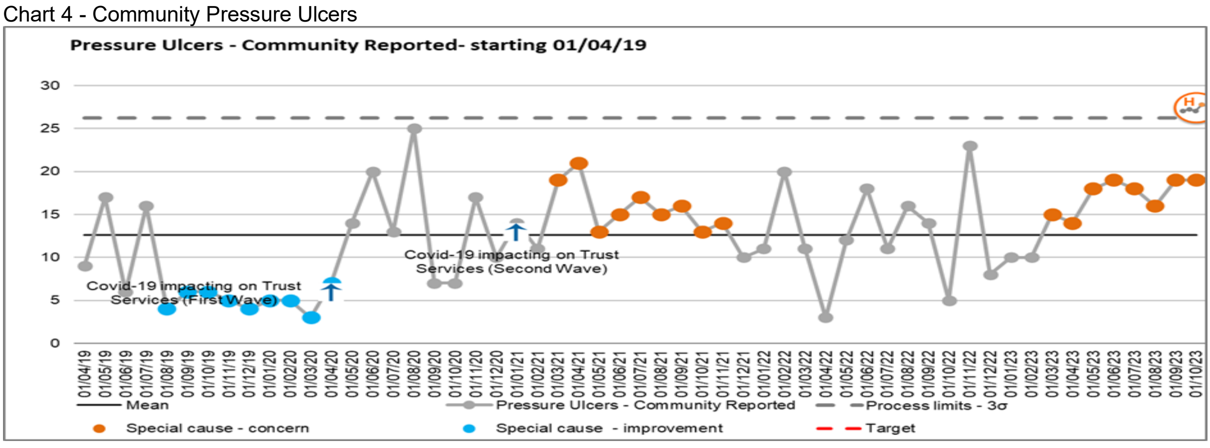
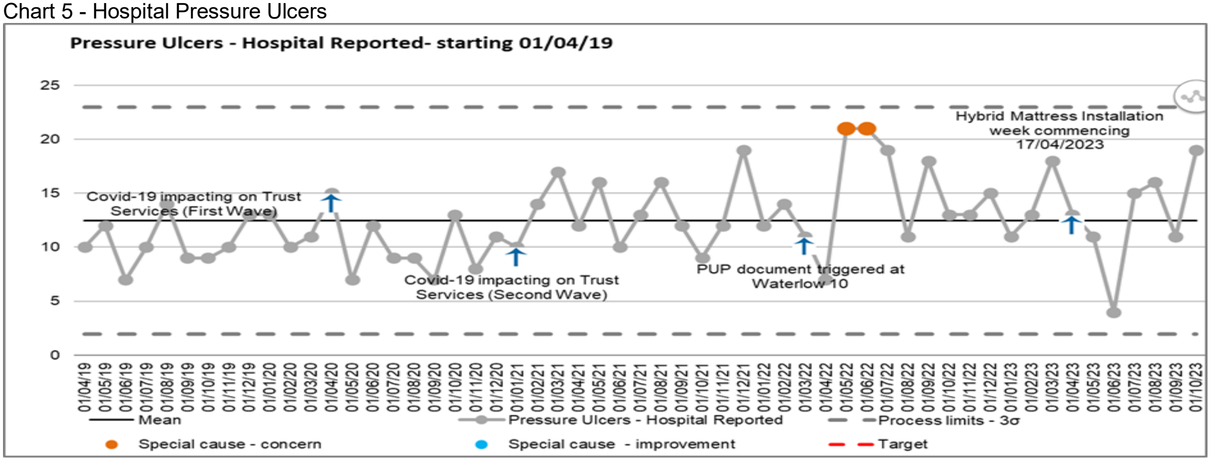


Chart 5 - Hospital Pressure Ulcers



- The main key theme identified through the investigation process is the need to step up the frequency of position changes for the frail patients and recording a different position change. The skin assessment and intervention plan has been edited and is awaiting approval to include darker skin tone guidance. A request has been made to Careflow to update the Emergency Department risk assessment to PURPOSE T. There are a few areas within recently refurbished wards where Hybrid Mattress continue to have electrical supply issues. We are awaiting a decant of the small number of effected beds to provide further investigation by Skanska.

- **Moisture Associated Skin Damage (MASD)**
  - The hospital site has seen a reduction in MASD incidents, after three months of heightened reporting.
  - Education has continued with the use of Contiplan wipes.
  - A Trust produced MASD risk assessment will be piloted to explore the benefits, with an aim to remove the continence assessment within the risk assessment document. Community have seen a positive decline in reported MASD incidents.

Chart 6 - Hospital MASD

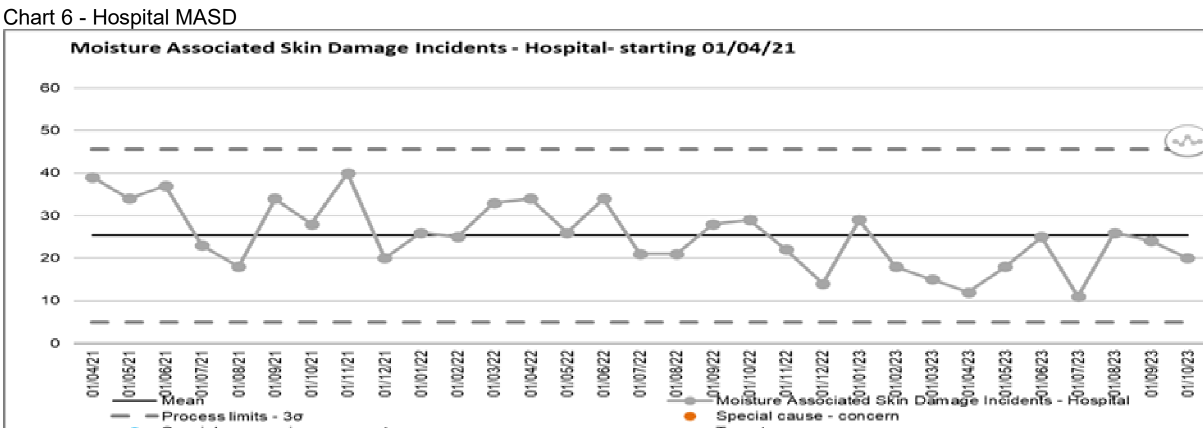
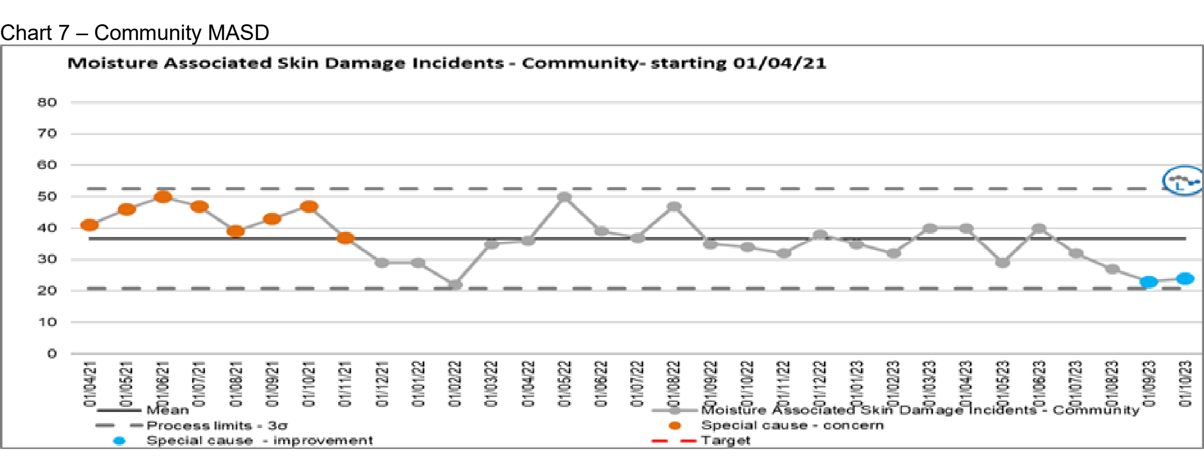


Chart 7 – Community MASD



Wound Formulary

The WHT led Black Country wound formulary has been sent out to each Trust for final comments, prior to sending to the relevant Trust groups for approval. The final stage will be the ICB prescribing approval prior to launch.

Foams and hydrocolloid dressing have been switched in acute care to aim for cost savings from September 2023.

Community

Leg ulcers

- The community tissue viability initial wound assessment began in August 2023 to optimise best practice from admission to aid healing within planned timeframes. Lessons have been learnt from recent incidents and an on-going training program is being delivered.

Community Wound Caseload

- Referrals to community tissue viability have increased since July 2023 to be consistently at or around 150 referrals per month for the past three months (Aug, Sept, Oct).
- To demonstrate the level of demand in terms of caseload on the community see table 1.

Table 1 – Community Caseload

Locality	Leg Ulcers	PU's	MASD	Fungating	Surgical	Trauma	TOTAL
North	51	12	11	3	16	15	115
East	98	47	30	6	8	15	204
South	56	29	27	1	20	15	148
West	84	50	19	0	26	15	194

1.3 Observations on time

- The timeliness of observations for October 2023 was 88.52% (September 89.10%), including ED (Chart 8) and 92.24% (September 91.73%), excluding ED (Chart 9). Results have dipped below 90% for the first time in 5 months. In September 2023 there was reduced availability of vitals due to an upgrade.
- 25 out of 28 clinical areas achieved the 90% target. The quality team are supporting ED, AMU and ICU to improve their compliance.

Chart 8 - Patient Observations on Time

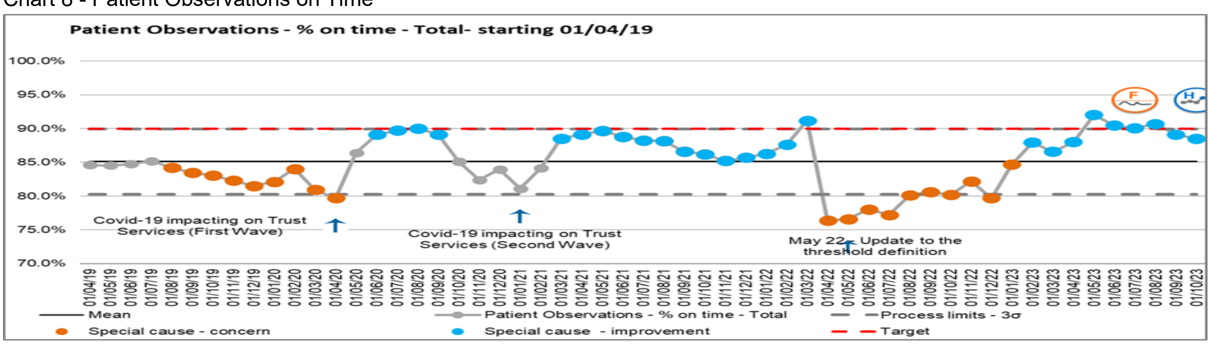
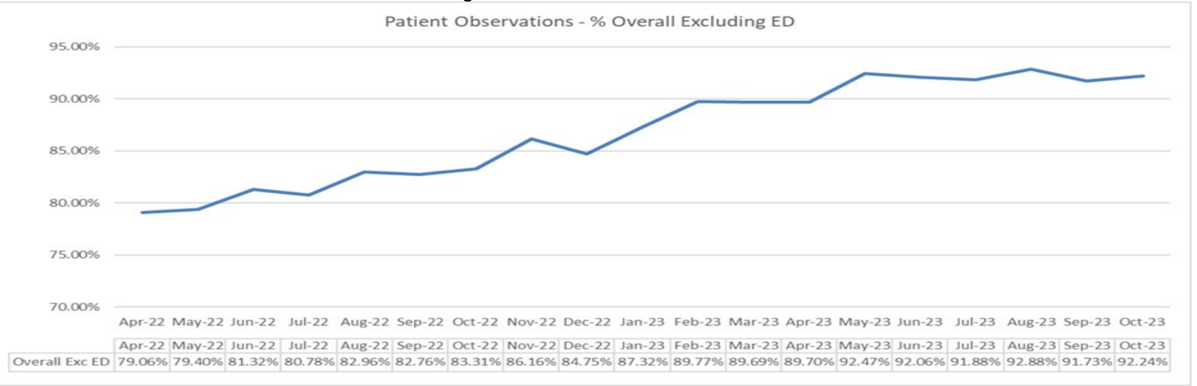


Chart 9 - Patient Observations on Time – Excluding ED



	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	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Overall Exc ED	79.06%	79.40%	81.32%	80.78%	82.96%	82.76%	83.31%	86.16%	84.75%	87.32%	89.77%	89.69%	89.70%	92.47%	92.06%	91.88%	92.88%	91.73%	92.24%

1.4 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 collaborate 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.

1.5 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.
- 18 wards have been reviewed since April 2023 (Table 2). 7 wards have been accredited, 2 ward areas have been awarded Emerald, 5 areas awarded Ruby and 6 areas 'Working Towards Accreditation' to date. 5 wards have received their second accreditation visit. 12 ward accreditation visits await ratification of outcomes at Clinical Accreditation Board.

Table 2 – Accreditation results

Clinical Accreditation WHT		
Date	**Ward/Dept/ Unit**	**Accreditation Level Awarded**
5/4/2023	Ward 1	Ruby
14/4/2023	Ward 2	Emerald
21/4/2023	Ward 3	Working Towards Accreditation
28/4/2023	Ward 4	Working Towards Accreditation
3/5/2023	Ward 15	Ruby
19/5/2023	Ward 17	Working Towards Accreditation
31/5/2023	Ward 7	Emerald
2/6/2023	AMU	Working Towards Accreditation
7/6/2023	Ward 29	Working Towards Accreditation
23/06/2023	Ward 16	Ruby
5/7/2023	Ward 9	Working Towards Accreditation
14/7/2023	Ward 10	Ruby
2/8/2023	Ward 4	Awaiting outcome
4/8/2023	Ward 17	Ruby
11/8/2023	Ward 1	Awaiting outcome
11/8/2023	Ward 3	Awaiting outcome
18/8/2023	Ward 29	Awaiting outcome
6/9/2023	Ward 20a	Awaiting outcome
8/9/2023	Ward 11	Awaiting outcome
15/9/2023	Ward 12	Awaiting outcome
4/10/2023	Hollybank	Awaiting outcome
13/10/2023	Goscote	Awaiting outcome
20/10/2023	Ward 15	Awaiting outcome
01/11/2023	Ward 14	Awaiting outcome
10/11/2023	AMU	Awaiting outcome

Themes from Clinical Accreditation Visits include:

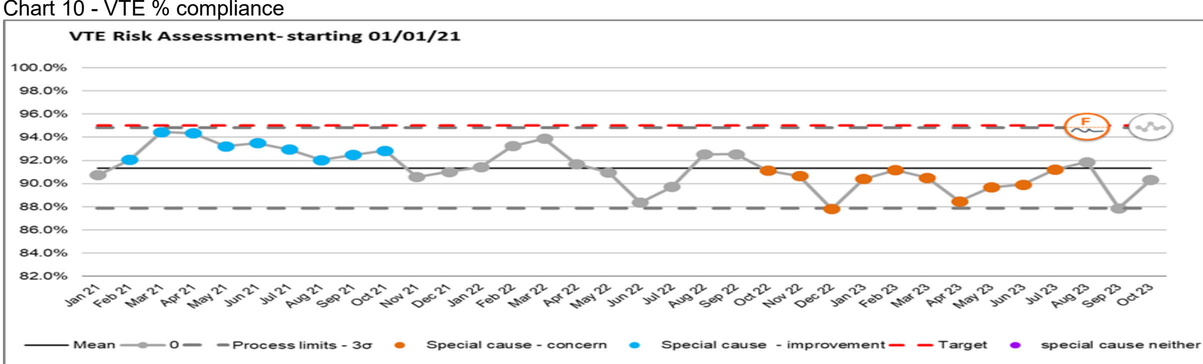
- Storage of medical notes when not in use and quality of storage containers locks often not working.
- NG Competency completion in addition to e-learning package.
- MUST Screening compliance at both organisations.
- Quality of meal service for both organisations.
- Reposition adherence on intervention charts documented relieving pressure points.

Action has been taken to address each of the themes and monitoring will be via the Nursing Midwifery and Allied Health Professionals Group and the Patient Safety Group.

1.6 Venous Thromboembolism (VTE) Compliance

- VTE compliance for October 2023 was 90.31% improved from September 2023 (87.91%). It can be seen from the charts below that compliance has been improving and this improvement should be seen October's results. Divisional results are available in table 3.
- A PowerBI report is sent to the Divisions on a monthly basis and is available on the Trust intranet. The report facilitates deep dives by providing access to underlying data (this data will be relied on for the audit mentioned above). Divisions have action plans in place to increase compliance, and this is reported in the Divisional Quality Board each month and directly to the Deputy Chief Medical Officer.

Chart 10 - VTE % compliance



1.7 Deteriorating Patient

- The critical care outreach team continue to identify all patients placed onto Scale 2 for appropriateness of use.
- A business case is being developed to support a 24/7 sepsis outreach service.
- As of October 2023, 45.48% of clinical staff had completed the Royal College of Physicians e-Learning package (an increase from 41% in September 2023). Historically it was reported 64% in the past but a further 543 members of staff have been identified as required to complete the training.
- All incidents reported as moderate harm related to deteriorating patients are subject to review and oversight by the Deteriorating Patient Group.

1.8 Sepsis

- Within the Emergency Department (ED), 81.96% (Chart 11) of patients received antibiotics within the first hour in September 2023 (83.07% in September 2023).
- For adult inpatients, 67.14% (Chart 12) of patients received antibiotics within the first hour in September 2023 (75% in September 2023). This is a decrease in performance, but previous months data had demonstrated a higher level of compliance. This has been discussed at deteriorating patient group where sepsis performance and actions to improve are overseen.
- Paediatric Sepsis performance for Ward 21 and PAU stands at 85.7% (Chart 13) of patients receiving antibiotics within the first hour in October 2023, reduced from 93.75% in September 2023.
- Paediatric ED Sepsis Performance stood at 52.17% but with an additional 26.09% of patient receiving antibiotics within 61-80 mins. There remains an issue with sepsis checklists being opened but not closed, this data issue contributing to the remaining 21.74% non-compliance. The Lead Paediatric Nurse and Sepsis Team is working with ED colleagues to make improvements to process.

Chart 11 - ED Sepsis Performance

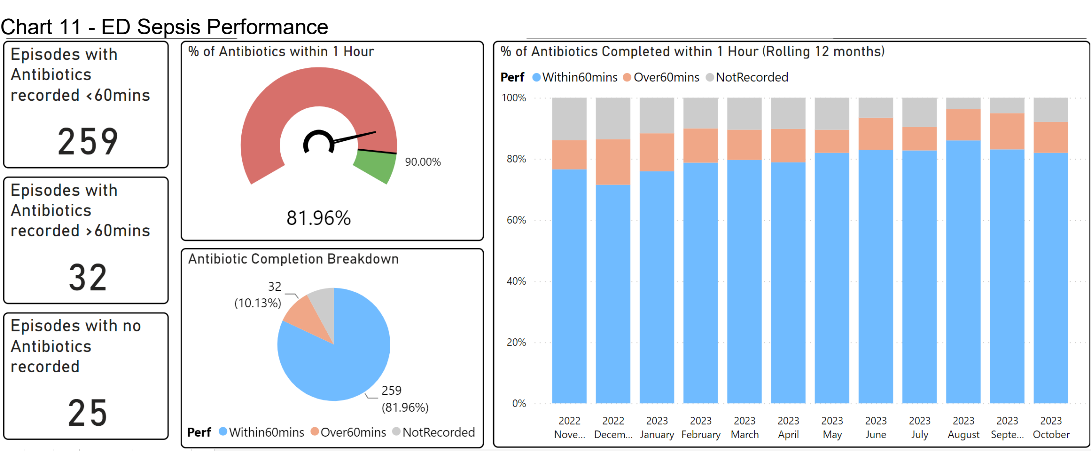


Chart 12 - Adult Inpatient Sepsis Performance

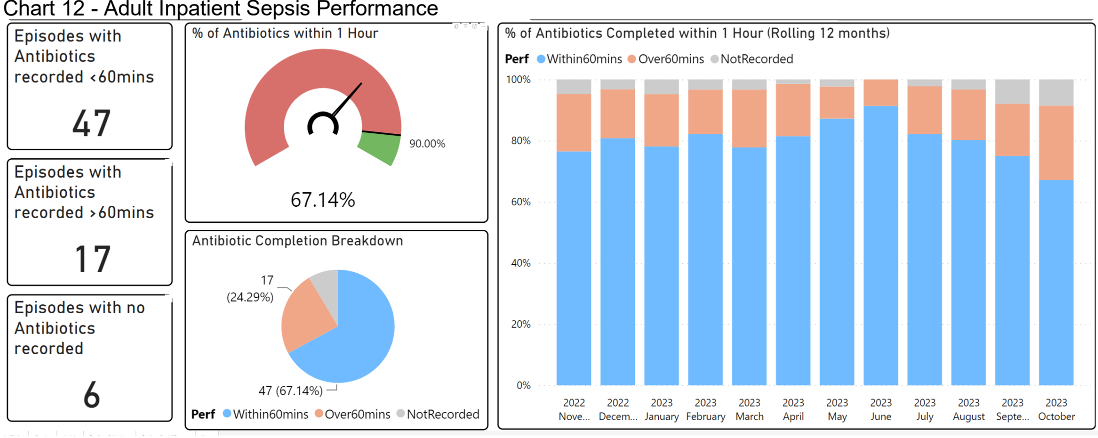
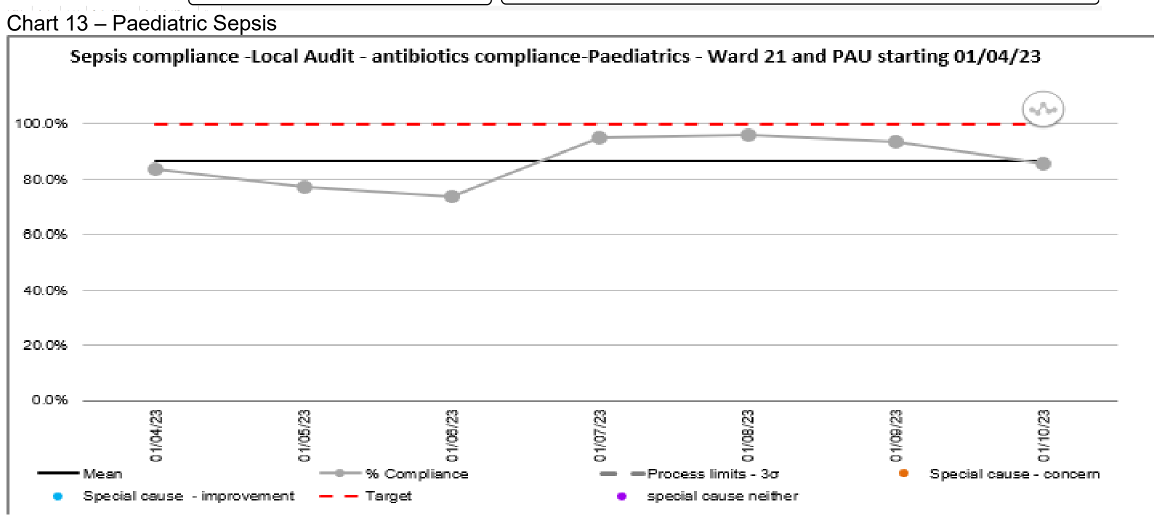


Chart 13 – Paediatric Sepsis



1.9 Nursing Quality Audits

Performance remains relatively consistent and monthly 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. The table below details the audit results from January 2023 to date (Table 2).

Table 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 responsibility)	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	99.6%	91.5%	80.1%	99.0%	88.0%	93.2%	89.4%	95.7%	92.8%	90.5%	91.8%	94.5%	95.6%	84.2%	88.1%
MAY	90.4%	81.5%	77.7%	97.0%	87.3%	91.8%	90.6%	95.2%	93.1%	89.8%	87.8%	96.4%	96.7%	85.6%	91.2%
JUNE	96.9%	85.7%	90.7%	95.8%	92.3%	92.6%	90.7%	95.8%	94.3%	84.3%	95.4%	95.4%	96.8%	77.1%	89.9%
JULY	97.7%	84.6%	89.6%	98.8%	87.8%	94.0%	89.2%	96.5%	95.1%	88.8%	94.0%	95.0%	97.8%	100.0%	94.6%
AUGUST	95.1%	82.6%	92.4%	99.2%	91.7%	95.7%	88.1%	94.9%	95.6%	90.8%	90.6%	93.4%	95.7%	77.8%	96.2%
SEPTEMBER	96.2%	88.7%	84.9%	97.6%	92.3%	95.6%	91.3%	96.9%	95.0%	91.8%	91.2%	91.7%	96.0%	75.9%	98.0%
OCTOBER	89.1%	90.8%	76.9%	98.7%	93.4%	95.1%	90.3%	97.4%	95.9%	86.1%	91.6%	83.8%	96.6%	77.6%	91.7%

1.10 Medicines Management

- A total of 130 medication incidents were reported in September 2023 a decrease of 15 incidents from previous month (August 2023). Most incidents are reported as near misses to no harm (n=93) and 3 incidents caused moderate harm (2) or serious harm (1), these were associated with medication delays.
- Analysis of the data identifies that the reporting for insulin errors remains heightened due to increased insulin audits being conducted on the wards by lead pharmacists. Insulin themes are now being reviewed within the newly formed Insulin working group. Themes and trends will be analysed to formulate an action plan for improvement.
- A total of 129 weekly audits have been conducted in September 2023 by the nursing team across the divisions. Average score is 96%, which remains the same as the previous month's compliance figures.

- Controlled Drug (CD) audits completed by pharmacy: 12 audits took place in September 2023, average compliance 84% an increase of 1% compared to August 2023.
- Themes for improvement continue to be documentation within the CD register, signing receipt of receiving controlled drugs, twice daily stock check, running balance within CD register and patients own drugs being recorded within CD Patients Own Drug (POD) register.
- Work continues with the senior nursing team and pharmacy to ensure the audit tool is reflective of the practice within clinical areas.

1.11 Mental Health (MH)

There is still considerable pressure on our ED department from Mental Health patients who need assessment and potentially treatment. A Memorandum of Understanding (MOU) has been provided to the Trust from the Black Country Partnership which has still yet to be agreed. The MOU needs to adequately provide for the Responsible Clinician (for patients held under a MH Section and MH Assessment) and provide KPIs for the Mental Health Liaison Service on the WHT sites.

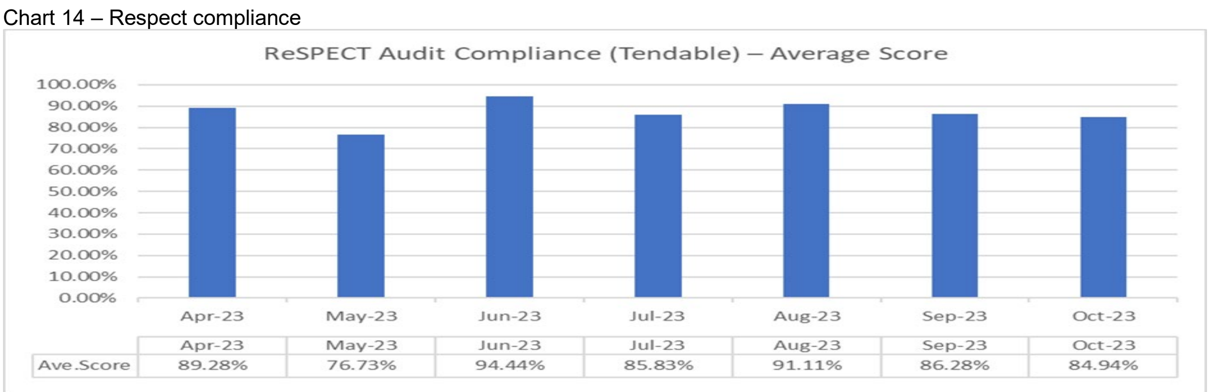
1.12 RESPECT including MCA

When completing a RESPECT form, the Stage 2 Mental Capacity Assessment is used to determine whether the patient has the mental capacity to make decisions about their end-of-life care. This is important because if the patient lacks capacity, decisions about their care must be made in their best interests, considering any wishes or preferences they may have expressed in the past.

Completing a Stage 2 Mental Capacity Assessment involves assessing the patient's ability to understand, retain, weigh up and communicate information relevant to the decision in question. If the patient is found to lack capacity, a best interest's decision may need to be made, which may involve consulting with the patient's family or other healthcare professionals.

The data has been collected in Tendable Audit (Respect) since June 2023 and results for October 2023 are 84.94% (Chart 14).

Chart 14 – Respect compliance



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Ave.Score	89.28%	76.73%	94.44%	85.83%	91.11%	86.28%	84.94%

1.13 Adult and Children Safeguarding and Associated Training

Current Training Compliance – adult and children's levels 1 and 2 remain above Trust target.
Adult Safeguarding Level 3 – 80.50% (80.13% September 2023)
Child Safeguarding Level 3 = 76.97% (76.25% September 2023).

WHT & RWT Training Task and Finish Group continue to meet to review training packages/delivery of training/workforce training needs analysis. RWT and WHT have agreed to align the safeguarding level 3 training as follows:

- Adult services staff groups above Band 6 will complete safeguarding level 3 children's training (4hrs every 3 years). This will reduce the staff mapped from 2444 to 2139)
- Paediatric staff will complete level 3 training plus an additional 2hrs bespoke level 3 training. This training will be yearly and face to face to as per the Intercollegiate document. This will increase the staff mapped from 1101 to 2402.

This alignment will result in a drop in in the compliance figures whilst staff are undertaking training. Divisions have raised concerns that data provided does not align with locally held records. Learning and development are reviewing and working through discrepancies.

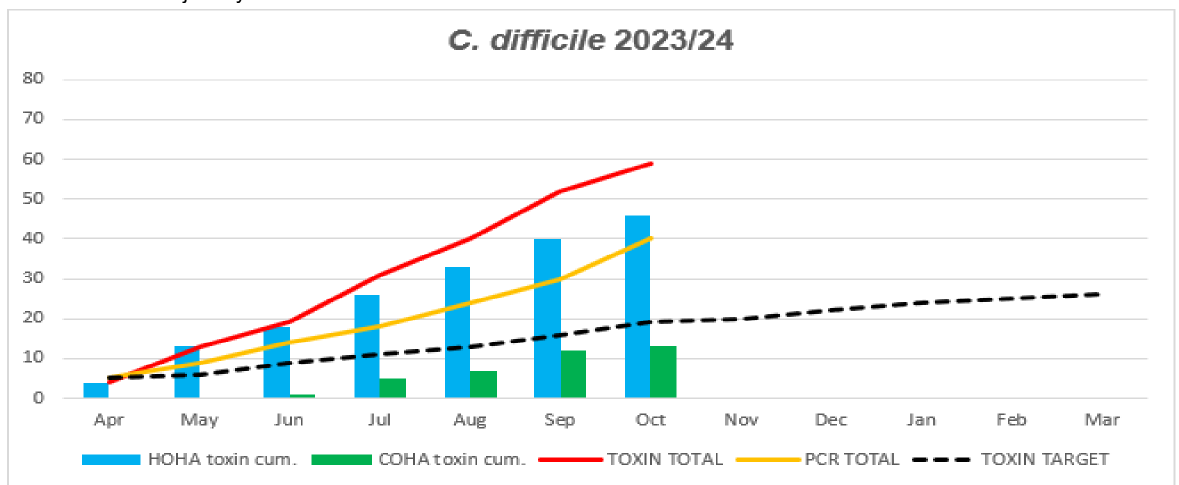
1.14 Clostridiodes difficile (C. diff)

- A total of 7 C. *diff* toxin cases were reported in October 2023 (Table 5). Out of the 7 cases in 2 were deemed avoidable, and 5 unavoidable.
- The National Trust target for 2023/24 has been set at 26 which is a reduction of one on 2022/23 target – Table 3 provides the current trajectory given this new target.
- The graph showing trajectory against cases is illustrated in chart 15.

Table 3 - 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	2
Actual cases per month	4	9	6	12	9	12	7					
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	26
Acute Cumulative actual	4	13	19	31	40	52	59					

Chart 15 – C. diff trajectory



Actions being undertaken:

- The IPC Team, AMS pharmacist, and consultant microbiologist are enhancing infection prescribing practices, including CURB scoring for pneumonia and sampling for Urinary Tract Infections, with progress reported in the AMS report at IPC Committee. Improvements in CURB-65 scoring for pneumonia prescribing are evident. When antimicrobial prescribing errors are found, medication incident reports are filed for prescriber follow-up. Antibiotic time out sessions are conducted among the consultant microbiologist, antimicrobial pharmacist, and IPC team.
- A business case is under review to introduce a Mouth Care Team in areas with high pneumonia rates, aiming to reduce the most common healthcare-associated infection at the Trust and minimize antibiotic use. A review of the last year's 50 C.difficile cases links 20 to antibiotics for healthcare-acquired pneumonia.
- The deep clean programme continues to take place, with Wards 1 - 6, 15, 16 and 17 completed but the plan has required modification following estate incidents and the opening of winter capacity.
- A fishbone analysis reviewing multiple factors into the C.*difficile* cases has been undertaken and shared with IPC committee and Trust governance meetings.

1.15 Local Safety Standards for Invasive Procedures (LocSSIPS)

- LocSSIPs are a set of guidelines developed by the National Patient Safety Agency to improve patient safety during invasive procedures.

- LocSSIPs cover a range of invasive procedures, including surgery, radiology, and endoscopy. The guidelines include a step-by-step process for assessing the risks associated with each procedure, identifying potential hazards, and implementing appropriate measures to minimize those risks.
- The aim of LocSSIPs is to ensure that healthcare professionals have a systematic approach to managing risk during invasive procedures, which will help to reduce the likelihood of adverse events and improve patient safety. The guidelines also encourage communication and collaboration between healthcare professionals involved in the procedure, as well as with the patient and their family or carers, to ensure that everyone is informed and involved in the decision-making process.
- The most recent compliance figure across the Trust stands at 93% in September 2023 (an increase from 86% in August 2023), which is the latest available results (Table 4).

Table 4 – LocSSIPS

Division	Area	Apr Compliance	May Compliance	Jun Compliance	Jul Compliance	Aug Compliance	Sep Compliance
Community	Community - CIT				100%	Not Received	100%
Community	Community - Podiatry	100%	100%	100%	100%	100%	100%
Community	Community - Diabetes-Podiatry	100%					
Community	Community - Children's	100%	100%	100%	100%	100%	100%
MLTC	Cardiac Intervention Suite	100%	100%	100%	100%	100%	100%
MLTC	Emergency Department	48%	43%	63%	40%	54%	31%
MLTC	Endoscopy	100%	100%	100%	100%	100%	100%
MLTC	Gastroenterology (Ward 16)	100%	100%	100%	100%	100%	100%
MLTC	Ward 15	100%		Not Received	Not Received	100%	Not Received
MLTC	Pleural Procedures Clinic	100%	88%	92%	100%	100%	100%
MLTC	AMU	73%	50%	50%	100%	66%	Not Received
Surgery	Chemotherapy	100%	100%	100%	100%	100%	100%
Surgery	Maxilofacial / Dental	100%	100%	100%	100%	100%	100%
Surgery	Intensive Care Unit	74%	80%	94%	70%	100%	100%
Surgery	Ophthalmology	100%	100%	100%	100%	100%	100%
Surgery	Outpatient - Vascular	100%	100%	100%	67%	100%	100%
Surgery	Outpatient - Dermatology	78%	100%	100%	100%	100%	100%
Surgery	Foot and Ankle Steroid Injection	100%	86%	95%	95%	100%	100%
Surgery	Outpatient - Orthopaedic				80%		
Surgery	Urology	100%			100%		
WCCSS	Imaging	94%	90%	94%	95%	97%	94%
WCCSS	Gynaecology		100%				100%
WCCSS	Maternity	93%	86%	65%	100%	66%	100%
WCCSS	Paediatrics/Neonates	100%	100%	62%	100%	82%	50%

Actions taken:

- Results were presented to Patient Safety Group with Divisions taking the lead in reporting on plans and improvements.
- ED - Quality improvement initiative has been commenced, this includes focusing on patients who have Femoral Blocks in ED to ascertain reasons for non-completion, coding of procedures and IT concerns.
- AMU - Have appointed a lead to improve the results, the move into the new build has also provided a procedure room which is a controlled environment and supports the process of LocSSIP completion.
- Trauma and orthopaedics - Are currently in discussion with RWT with regards to the procedures they use for LocSSIPs and are in the process of agreeing the relevant procedures and establishing an audit practice in line with the national patient safety alert.

1.16 Patient Safety Group (PSG) – Divisional Escalations

Reported a month in arrears due to the timing of the patient safety group late in the month (October 2023 PSG escalations).

WCCSS

- Paediatric nursing business case – awaiting outcome re: allocation of funding. Ongoing agreement to continue bank and agency until December 2023. Currently proceeding from agreement in Private Board to ICB system finance group (next sitting in November 2023). Previous agreements to support over recruitment to Paediatric workforce (most recently in Virtual Ward.
- Neonatal Unit – reduced availability of AHPs to provide cover on NNU rota. Division is reviewing risks, potential mitigation and will update.
- Black Country Pathology Service (BCPS) - Activity levels continue to exceed both laboratory`s and Consultant reporting Capacity. There was a slight improvement in month [September] compared to August.

Surgery

- The Review Process into hands and wrist patients has nearly been completed.
- The Colorectal Improvement Programme continues with a new colorectal lead appointed, who will now finalise the improvement plan. Actions completed thus far include LOS greater than 5 days are being escalated to Divisional Leads for review, along with performance data.

- There have been 9 patients breaching 104 days for July 2023 (Latest available data).
    - All 9 cases have been reviewed by the Lead Cancer Nurse with independent support from ICB Lead Nurse.
    - Of the 9 cases reviewed all were referred to tertiary centres for opinion and/or treatment.
    - Of these patients, 6 are Urology cancer pathways, 1 lung, 1 Upper Gastrointestinal and 1 Haematology.
- VTE compliance fell in month [September] to 83% for the Division as a whole, the arrivals lounge compliance fell from 91% to 75% in month.

<u>MLTC</u>

- VTE improvement remains a focus within the division.
- Paediatric sepsis management in ED remains an area requiring improvement.
- IPC oversight and focus the division following C-diff toxin cases identified with 6 avoidable due to inappropriate/prescribing of antibiotic use. Antimicrobial stewardship continues with the IV to oral campaign.
- Medicines reconciliation performance of 33% (WHT KPI 80%). Task and Finish group commenced and with onboarding Pharmacy recruits to ED and AMU underway as early actions.

<u>Community</u>

- Basic life support divisional compliance is 78.06% (↑2.78% from August 2023). Three further community-based sessions held throughout September 2023 which helped to improve compliance. There is however still a significant delay in staff training records being updated following attendance.
- Patient Handling Compliance improved by 1.49% since August to 67.13% still below target of 90%.

1.17 Digital and Innovation

- Following the server upgrade in August the Digital Team is currently planning the upgrade of Vitals from 4.2 to 4.3 in December 2023.
- Digital Team continues to plan for enhancement of our EPR with further System C modules (including Careflow Connect).

1.18 Patient experience

Quarterly Report due in December 2023.
Recent Mealtime Audit work is attached in appendices.

1.19 Guidelines

The number of outstanding guidelines is shown in table 5. Work continues within the divisions to clear the outstanding backlog.

Table 5 – Guideline position

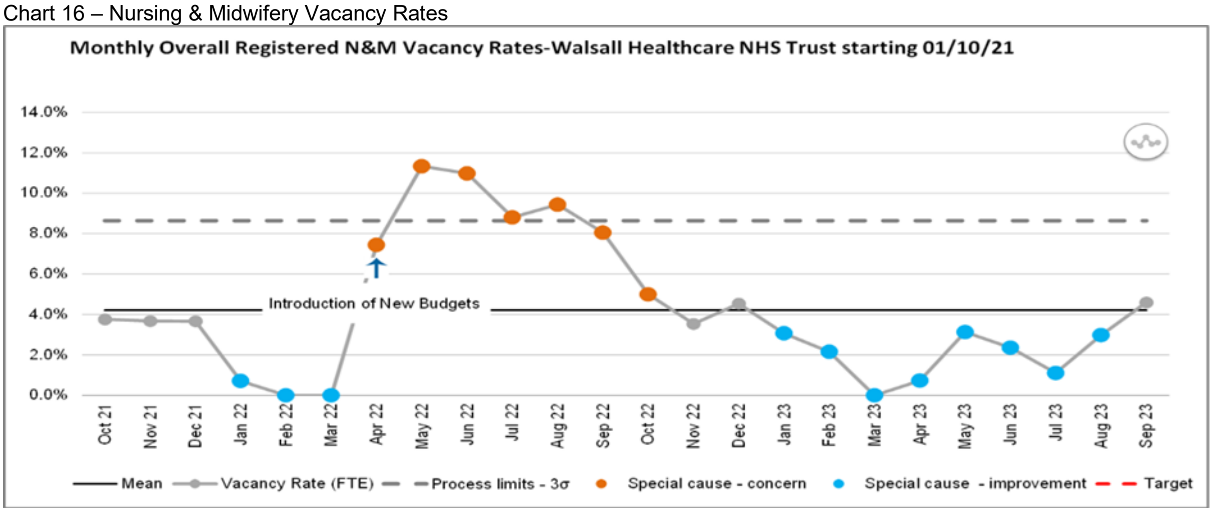
Guideline overview	In Date	Due for Renewal in next 3 Months	Due for Renewal in next 6 Months	Past the review date	**New Guidelines**	**Total**
November – 23	130			102	2	**234**

2.0

2.1 Nursing and Midwifery Vacancies

- In October 2023, the total number of Registered Nurse/Midwife vacancies increased to just over 4% (Chart 16). The increase is due to changes within employed WTE and addition to budget in WCCSS and community divisions (Leavers and externally funded posts).

Chart 16 – Nursing & Midwifery Vacancy Rates



2.2 Agency Cessation

Agency Cessation was initiated across the site from the 1 April 2023.

- There are limited exceptions to allow for specialist areas (ED and Paediatrics) where there are vacancies, Wards 5 (Winter Ward), 9 and 14 where substantive staffing are being recruited after being funded and Mental Health RMN or CSW cover.
- The SPC charts (Charts 17, 18 & 19) illustrate the reduction in agency usage to date.

Chart 17 – Tier 1 agency usage

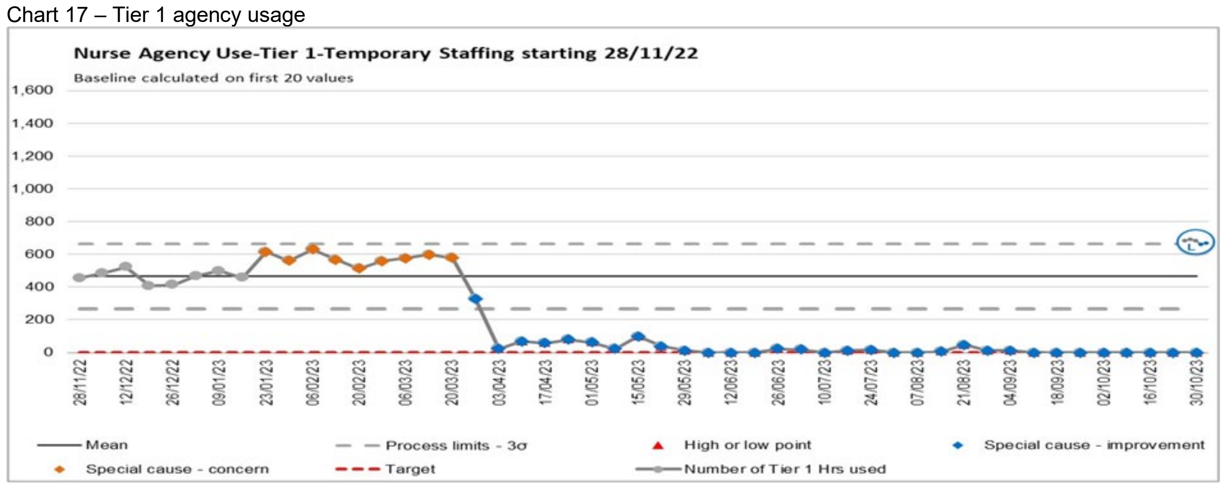


Chart 18 – Tier 2 agency usage

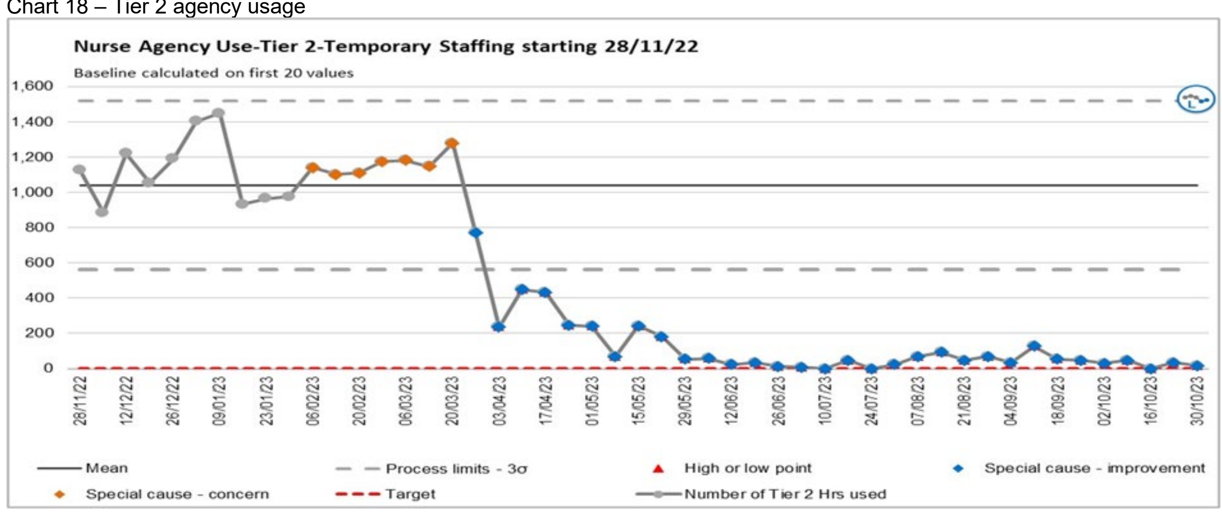
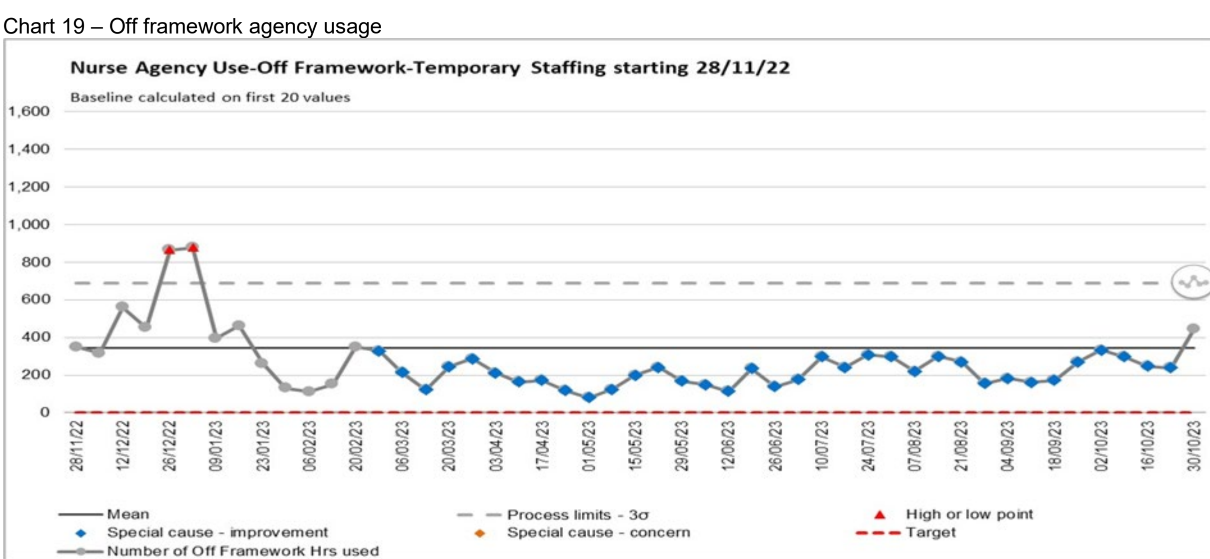
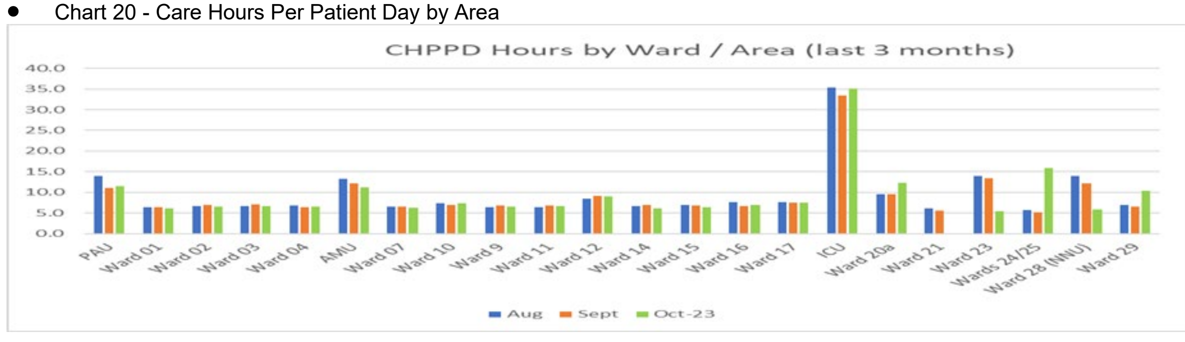


Chart 19 – Off framework agency usage



2.3 Care Hours per Patient Day (CHPPD)

- CHPPD trust average for October 2023 was 9.4 (Chart 20) reduction from September 9.5. This is comparable with the national average of 9.77, which is an amalgam of all NHS inpatient facilities who provide data – including paediatric and mental health units/hospitals/trusts.
- Chart 20 - Care Hours Per Patient Day by Area



2.3 Red Flags

In October 2023:

- There were no open Red Flags reported in October.
- 145 red flags were resolved and closed (Chart 21).
- 114 (79%) resolved red flags were reported in the day and 31 (21%) resolved red flags at night.

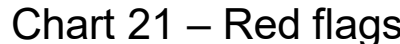
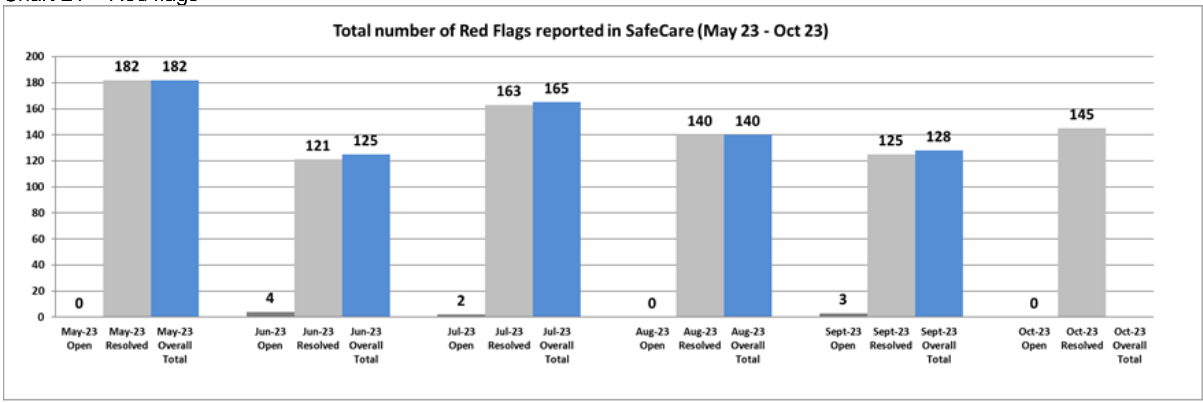
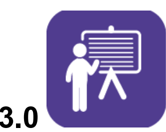


Chart 21 – Red flags





3.0 Education

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

- Standards for Student Supervision and Assessment S(SSA) training compliance in October 2023 at 67%, which is a 1% decrease in compliance. Communication via the matrons has been provided to ensure that staff complete this training.
- Since January 2022, 300 Clinical Support Workers have taken on substantive roles. Of these 300 CSWs, 63% have so far completed a Care Certificate.
- National Education and Training Survey (NETS) action plan in place. Progress being reporting via relevant committees / groups. Current NETS survey underway and available to all healthcare students.

End of Report

Appendices

Appendix 1
QPES Committee Dashboard

Appendix 2
Quality Dashboard

Appendix 3
Mealtime Experience Headline Report and Data Report

Paper to the Trust Board Meeting on 13th December 2023		
Title of Report:	Clinical Fellowship Programme Annual Report	Enc No: 10.6.3
Author:	Jo Duckham – Clinical Fellowship Programme Manager	
Presenter/Exec Lead:	Dr Manjeet Shehmar, Chief Medical Officer	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☐No☒	Yes☒No☐

Recommendations:

The Board is asked to note the contents of the report for assurance of the development of the Clinical Fellowship Programme since its inception at WHT in 2021

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State None if None Risk Description Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') Revenue: Capital: Workforce: Reduction in agency spend Funding Source: Clinical Fellowship Programme		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other – Medical Education Group	Yes☒No☐	Date: 15/11/2023

Summary of Key Issues using Assure, Advise and Alert
Assure N/A
Advise N/A
Alert N/A

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	
Effective Collaboration	• Improve clinical service sustainability • Progress joint working across Wolverhampton and Walsall

CLINICAL FELLOWSHIP PROGRAMME

Report to Trust Board Meeting to be held on 13th December 2023

BACKGROUND INFORMATION

In 2021, Walsall Healthcare NHS Trust (WHT) took the decision to implement the Clinical Fellowship Programme (CFP) across the organisation which would aim to eradicate most of the agency spend and reliance for doctors below consultant level.

Whilst the precise gaps in staffing often becomes known with little notice, it is a practical certainty that there will be gaps, with some areas more affected than others, leading to workforce issues and impacting on patient safety.

It is recognised that the cost pressures incurred by the Trust around agency spend could be mitigated by a coordinated approach to supporting rota gaps through longer term fixed contracts.

This report is to inform of the progress of the CFP for Medical Staff at WHT. The CFP is open to all doctors outside of a formal UK training programme, whether UK graduates or international and provides full support, regardless of their career pathway.

There are 3 levels of Clinical Fellow posts.

- Clinical Fellow – Foundation and Core Trainee level
- Senior Clinical Fellow – Middle Grade
- Advanced Fellow – Pre CCT (pre-consultant)

The posts offer a 1–3-year clinical role (80%), education (20%). All Fellows have an assigned Clinical and Educational Supervisor, access to structured teaching and educational opportunities and comprehensive pastoral support.

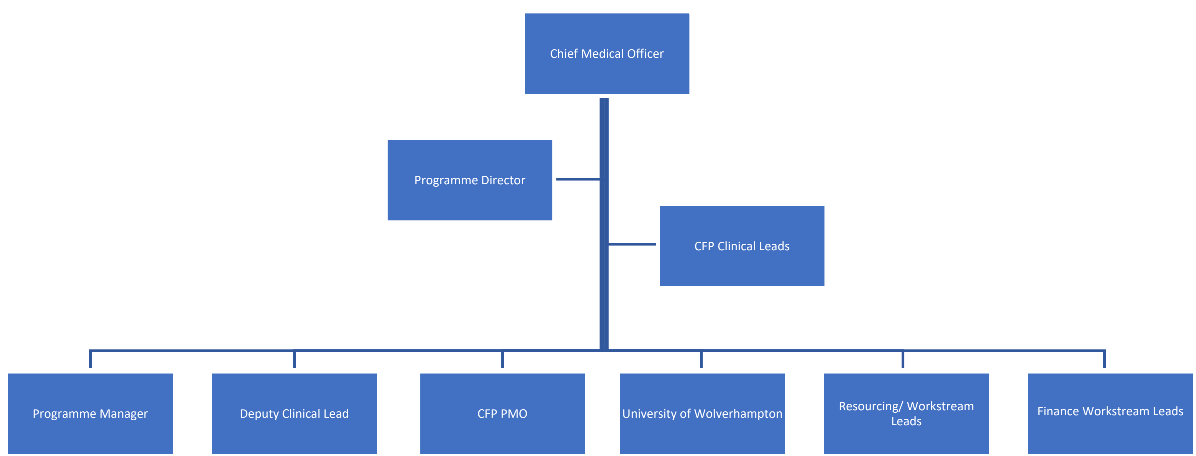
The CFP operates as a shared service function in collaboration with The Royal Wolverhampton NHS Trust, with each Trust contributing to the central core infrastructure.

Benefits, objectives and desired outcomes:

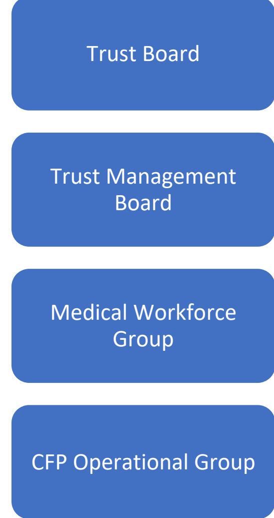
- To replace short-medium term locum appointments with a cohort of longer-term high quality clinical fellow appointments.
- Deliver a high calibre Fellowship Programme for all doctors outside of a formal training programme to support retention and development of medical staff.
- Significantly reduce reliance on agency to fulfil medical staffing gaps.
- Improve patient safety and experience.
- Improve morale of the post graduate doctor workforce.
- Make WHT the employer of choice for our future medical workforce.

PROGRAMME AND GOVERNANCE STRUCTURE

Programme Structure



Governance Structure

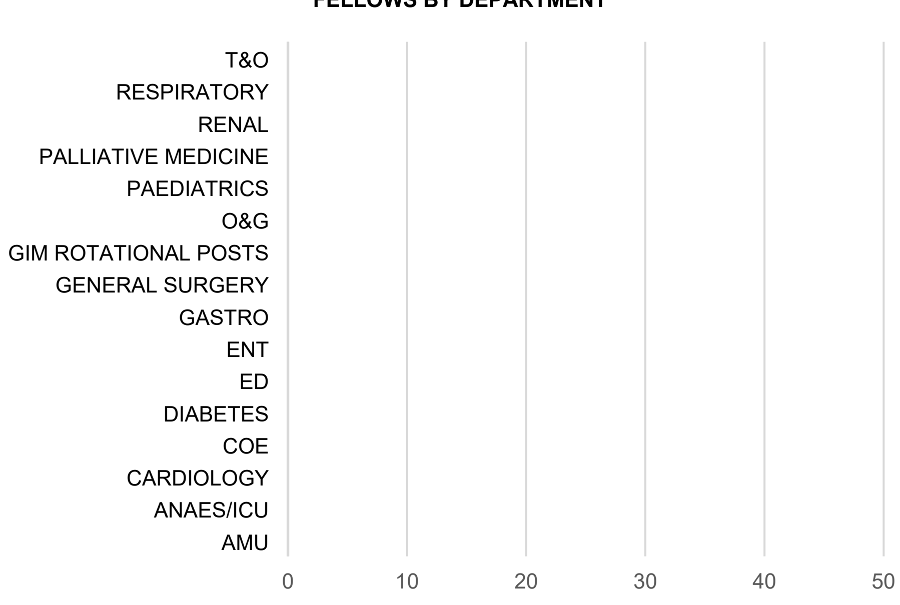


EXECUTIVE SUMMARY

1 RECRUITMENT AND RETENTION

1.1 A total of 91 Fellows are employed by the Trust, this figure includes a natural absorption of previous Non-Training Grades (NTGs) within the organisation.

1.2 The highest proportion of Fellows are those supporting General Internal Medicine (GIM) and Acute out of hours rotas.



1.3 Where it is identified that a division/directorate requires Clinical Fellow(s) to fill vacancies and subsequently reduce locum spend, the monitoring of savings will be the responsibility of the Divisional Team through the Medical Workforce Group (MWG).

1.4 It is acknowledged that monitoring savings is complex and will predominantly be cost avoidance of agency spend.

MTI CPSP SURGICAL PROGRAMME

The MTI Surgery Programme is a joint initiative with the Trust and The College of Surgeons and Physicians of Pakistan (CPSP) and Walsall. The scheme provides international graduates training opportunities within their chosen discipline before returning to their home country.

- Previous cohort left the Trust in July 2023.
- New Cohort of 3 Fellows expected to arrive during December 2023.
- Candidates are provided with the same support and learning opportunities as other CFP Fellows.
- Terms and Conditions of service will be in parallel to other NTGs within the Trust.

2 EXIT ROUTES

2.1 38 Clinical Fellows have exited the programme between December 2021 to 31 October 2023.

2.3 The highest proportion of those exited have successfully entered UK HEE Training Programmes.

DESTINATION UPON EXIT FROM THE PROGRAMME

3 ENHANCED SUPPORT SERVICES

Support Service	When	Frequency
Buddy Support	Prior to and 3 months Post arrival	As required
Pastoral Induction	Prior to and 3 months Post arrival	Monthly
CFP Induction	Prior to arrival	Monthly
Early Support/ Initial EQ Meeting	Month 1 and 6	Twice
Medical On Call Induction	Within the first month	As and when
IT Training and Support	Pre and Post arrival	Monthly
Communication Skills/ Cultural Adaption	Pre and Post arrival	Bi-Monthly
Royal College E-portfolio	Once in post	Monthly
Horus Portfolio	Once in post	Bi-Monthly
Appraisal and Revalidation	Once in post	4 Monthly
PACES Communication	Once in post	4 Monthly
Clinical Fellow Forum	Once in post	6 Monthly

The Enhanced Support Services are designed to support the following principles:

- Initiation of support prior to arrival
- Provision of one-to-one support
- Opportunity for multiple episodes of attendance encouraged.

Support is multifaceted with several components grouped into 3 broad categories:

- Induction and pastoral care.
- Supporting clinical competence.
- Educational support and career progression.

The support provided has ensured:

- Earlier adaptation to life in the UK and the NHS.
- Reduction in time taken to provide effective clinical care.
- Reduction in time taken to participate in on calls.

Chief Clinical Fellow and Pastoral Leads

- The CFP have appointed 2x Chief Clinical Fellows and 1x Pastoral Lead
- The roles play a key part in supporting the design and delivery of the Enhanced Support Services of the CFP.

Support Programme 2023 for HEE IMG Trainees

In addition to Clinical Fellows, the CFP provide pastoral and early support for International HEE Trainees, providing access to the following CFP Enhanced Support sessions:

- Pastoral Induction
- IT training and support
- E-portfolio / Horus support
- Medical on call induction
- Communication and Cultural Adaption Workshops

Peer Learning Group

In view of concerns raised by the CQC concerning medicines management, a Peer Learning Group was established in November 2022.

The initial review of feedback showed results vary but does indicate an improvement overall.

Survey results also indicated this was a welcomed initiative by the juniors' doctors and should continue.

Led by Fellows who have been with the organisation for a significant period and well established within their role, the initiative involves daily visits to the Acute Wards and includes:

- Drug charts review.
- Communication skills.
- Documentation skills.
- Offering support/guidance to Clinical Fellows and HEE Trainees.
- Escalation to Seniors Clinicians in the event of serious concerns.

4 SUPERVISION

All Clinical Fellows should be provided with Educational and Clinical Supervision (ES/CS).

- There are challenges in securing an ES during the initial period of joining the Trust.
- To mitigate this, the Group Supervision Scheme has been developed to ensure a new Fellow is provided with the essential educational support from the onset.
- 11 Fellows are currently being supported through the Group Supervision Scheme.
- All current Fellows have a named Clinical Supervisor

5 CFP TEACHING PROGRAMMES

The programme has 3 arms of protected teaching available for Clinical Fellows:

- **Level One:** Doctors aspiring for IMT /GPVTS Training
- **Level Two:** Fellows aspiring to enter ST Higher Training or pursuing Portfolio Pathway (CESR)
- **Level Three:** Fellows within Surgical Specialties or doctors in advanced stages of pursuing the Portfolio Pathway (CESR)

6 CFP CONFERENCE

The first annual Clinical Fellowship Conference was held on 23 September and was attended by regional and national delegates with excellent feedback received following the event.

The day involved:

- Presentations led by senior leaders within the organisations.
- Career guidance stations.
- Success stories from Fellow’s past and present.
- Personal journeys and reflections from Fellow’s past and present.

7 PORTFOLIO PATHWAY (PP - FORMERLY CESR)

Portfolio Pathway is the route to entry to UK specialist Register and is the alternative pathway for those not employed into UK HEE training Programmes.

The CFP support faculty for PP was established in late 2018 and its main activities include:

A. Support for PP applicants:

The process of providing support is complex and multifaceted and includes:

- Support to meet clinical and non-clinical evidence.
- Training doctors in the application process
- Formal assessment of their progress
- Organising directorate support
- Establishing training sessions

B. Trust-wide and regional PP Training

The table below is representative of those currently pursuing the PP Pathway

Dept	Position	Submitted to GMC	Committed	Expressed Interest
AMU	Locum Consultant	1		
RESPIRATORY	SCF			1
PAEDIATRICS	Locum Consultant (1)		6	
	SAS (5)			
Total:		**1**	**6**	**1**

8 APPRAISAL AND REVALIDATION

As at 31 October 2023, no Clinical Fellows were due appraisal or revalidation.

9 SERIOUS UNTOWARD INCIDENTS (SUI)

As at 31 October 2023, no Clinical Fellows have been directly involved in Serious Untoward Incidents during 2022/2023.

10 CONCLUSIONS

Over the last twelve months the CFP has made significant strides in producing and providing education and pastoral support for Clinical Fellows. This has been achieved without compromising quality or patient safety. It is now an established programme with a good infrastructure to support its ongoing development and sustainability at WHT.

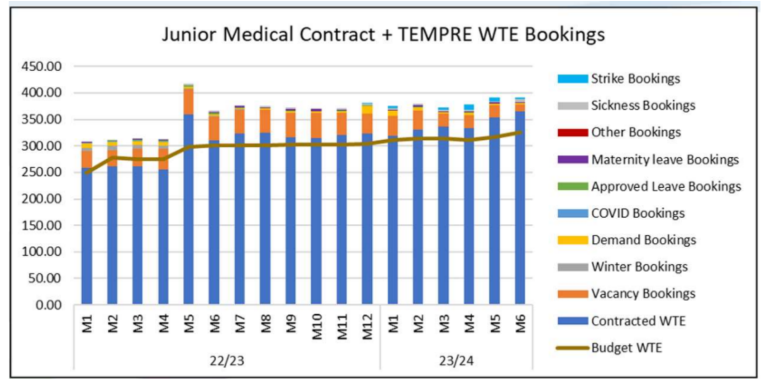
Rotas within the Division of Medicine and Long-Term Conditions are now fully established supported by HEE trainees, Clinical Fellows and Speciality Doctors with almost all agency spend eradicated.

The morale amongst the junior doctor workforce has improved which is evidenced by the Clinical Fellow Forums and Internal Quality visits.

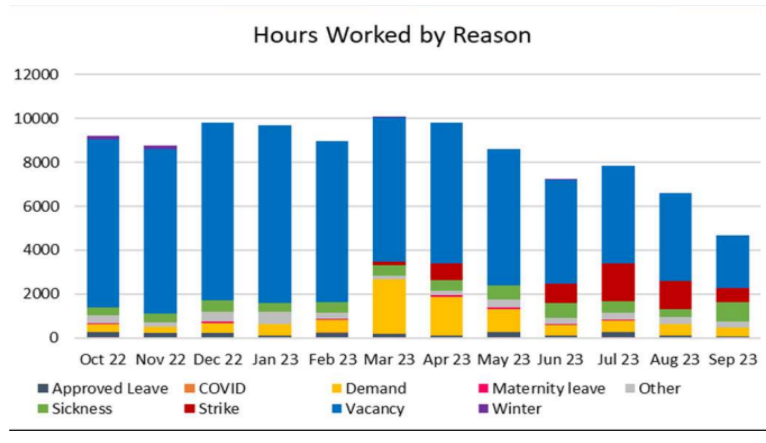
Appendix A

Junior Medical Staffing Spend as at Month 6 (source financial management)

Currently, Trust medical WTEs + bookings continue to track above authorised budgets relating solely to Junior Medical lines.



This has been driven by over establishments as well as bookings to unfunded medical rotas. This by Division is broken down as being MLTC (43.31 WTE), WCCSS (14.32 WTE) & DoS (4.12 WTE).



The majority of shifts in these areas have been booked as vacancies in all divisions. Controls are being put in booking reasons as well as focus on the reasons going forward.

Trust Board Meeting – to be held in Public On 13 December 2023		
Title of Report:	Covid – 19 National Inquiry	Enc No: 10.8.1
Author:	Steph Poulter	
Presenter/Exec Lead:	Kevin Bostock, Group Director of Assurance	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☐No☒	Yes☒No☐
Recommendations: The Board is asked to note the contents of the report and receive as an update.			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State None if None Risk Description Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') None Revenue: Capital: Workforce: Funding Source:		
Report Data Caveats	None		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☒No☐	Details: Covid-19 National Inquiry
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☐	Details: Covid-19 National Inquiry
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration:		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
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. • The Inquiry's current focus is on Module 2 – This relates to core political and administrative governance and decision-making for the United Kingdom (UK).
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 the dates for the next Module 3 Hearings are expected to take place over the course of ten weeks, starting with a second preliminary hearing in Spring 2024 and the public hearings thereafter from Autumn 2024.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement.
Support our Colleagues	• Improve overall staff engagement.
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative. • Improve clinical service sustainability. • Progress joint working across Wolverhampton and Walsall

Covid-19 National Inquiry Update

Report to Trust Board Meeting to be held in Public on 13 December 2023

EXECUTIVE SUMMARY

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.

BACKGROUND INFORMATION

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 continued in October 2023 and is ongoing at the time of this report with an expected conclusion date of 14 December 2023.
'*Module 3 - looking at the impact of the pandemic on healthcare'* on Tuesday 28 February 2023 and another preliminary hearing will be held in Spring 2024.
'*Module 4 - Consider and make recommendations on issues relating to the development of Covid-19 vaccines and the implementation of the vaccine rollout programme in England, Wales, Scotland and Northern Ireland'* this was launched on 13 September 2023 with public hearings to start in July 2024.
'*Modules 5 - which is to examine the response of the health and care sector across the UK in relation to the procurement and distribution of key equipment and supplies, including PPE and ventilators'* will be launched by the end of 2023.

RECOMMENDATIONS

Trust Board members are requested to note the content of the report as an update for the end of the 2023 calendar year.

Any Cross-References to Reading Room Information/Enclosures:

More information can be found at: **https://covid19.public-inquiry.uk/**

Report to the Public Trust Board – to be held in Public 13 December 2023		
Title of Report:	Health and Safety Annual Report 2022 - 2023	Enc No: 10.8.2
Author:	Simone Smith – Head of Health and Safety	
Presenter/Exec Lead:	Kevin Bostock – Group Chief Assurance Officer	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐
Recommendations: The Committee is asked to note the contents of the report and receive it for assurance.			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Trust wide Risk - Ineffectual compliance with Sharps Safety Management system On Risk Register: Yes☒No☐ Risk Score (if applicable) : 12		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	None		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Fundamental Standards of Care
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☒No☐	Details: Statutory Duty - Breaches of statutory legal duties can result in enforcement notice, including improvement, prohibition notices and prosecution.
	Legal	Yes☒No☐	Details: Litigation Claims impact
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration: There are no identified adverse impacts on persons with one or more protected characteristics.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Health and Safety 25.07.23
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- 100% quoracy and convening of Health and Safety Committee achieved during 2022/23
- Reduction in externally reportable RIDDOR incidents by 53% in 2022/23 when compared to previous financial year.
- Conflict Resolution and Load Handling training exceeded the KPI ending the year at 94.62% and 93.44% respectively.
- The number of employer and public liability claims reduced by almost 50% during 2022/23 and paying out £400K less than the previous financial year.
- DHSC Fit-Testing data showed Walsall Healthcare NHS Trust as one of the top performing Trust in the Midlands and 3rd nationally in Quarter 4
- Continued policy development and review in line with organisational arrangements, national guidance and legislation including Sharps Safety Management.

Advise

- Mandatory safety training compliance failed to achieve the KPI ending the year at 87.66% overall.
- Health and Safety incident reporting increased by 3% compared with the previous financial year, with violence and aggression decreasing by 5% for the same period.
- RIDDOR reportable incidents resulting in 7-day incapacitation of an employee were primarily attributed to Slips/ Trips/ Fall accounting for 27% and load handling accounting for 15%.
- Preventing Musculoskeletal (MSK) injuries and Violence & Aggression are key priorities for the HSE. Collaborative work is ongoing to test and assure a current arrangements.

Alert

- Managers engagement and compliance with the Trust-safety management system is low – completed returns for the Managers Health and Safety toolkit is not reaching KPI of 100%. This adversely impacts the assessment of compliance and Trust assurance and required targeted improvement in 23/24.
- Fit Testing and First Aid Training Provision are limited to sole accredited instructors exposing the organisation to a single point of failure.
- Parts of the Trust estate and subsequent ventilation systems are old and operating sub-optimally. This presents a challenge in terms of minimising time weighted exposure to nitrous oxide.
- In conjunction with a full revision of the sharps safety policy; mandatory sharps training, revised non-safe sharp risk assessments and peer audits have all been developed following the HSE sharps safety management planned inspection in January 2023. Ongoing monitoring is required to provide assurance of implementation.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Reduction in the carbon footprint of clinical services by 1 April 2025
Effective Collaboration	• Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Walsall Healthcare NHS Trust Health and Safety - Annual Report 2022/23

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EXECUTIVE SUMMARY

Health and safety is an integral, and important part of everyone's duties. The Trust's commitment to Health and Safety therefore ranks equally with all other aims, objectives and activities. All organisations have a legal duty to put suitable arrangements in place to manage health and safety.

During 2022/23, the Trust edged further away from restrictions brought about by the Covid-19 pandemic. Significant effort has been directed into restoring *all* service activity to a state of 'business as usual'. Health and Safety core business activity gathered significant momentum during this past financial year compared with the previous two years. The predominant focus remained on maintaining compliance with health and safety legislation through robust internal safety management arrangements. Face-to-face training, inspections, assessments and office-based working were all re-established. However, digital benefits brought about during the pandemic has meant some aspects of health and safety training, meetings, and policy consultation; remain virtual. Although largely reduced, working from home has become a long-term viable option for many colleagues, who have adopted a hybrid pattern of work.

The Health and Safety Committee acts as the main mechanism for consultation on work related health and safety matters. The Group Director of Assurance holds current chairpersonship of the Health and Safety Committee, as Director with delegated responsibility for health and safety. This continues to demonstrate strong strategic leadership-commitment to the safety agenda. The Committee convened via MS Teams on 4 of 4 occasions during 2022/23, to execute its primary responsibilities, specifically, promoting the health, safety, security and welfare of all its employees and service users, through consultation and co-operation between management and staff. Quoracy was achieved at all meetings with representation from divisional representatives and specialist advisors. Meeting minutes and actions were disseminated and copies available via the Trust intranet.

The Health and Safety Team have continued to review existing policy documents over the last 12 months. The majority of our existing policies have been updated and ratified with a small number to be reviewed and ratified at year end. Most significantly, the team have developed a new Sharps Safety Management policy in collaboration with our Occupational Health & Well-being and Infection Control & Prevention colleagues as a result of recommendations made by HM Inspector, following a Health and Safety Executive (HSE) Sharps Safety inspection in January 2023. The Trust acknowledges that clear, well-articulated policy documents are essential for the implementation of organisational health and safety structures and arrangements. The Health and Safety Team will continue to collaborate with stakeholders to develop polices where gaps have been identified.

The Trust uses a range both reactive and proactive measures to monitor health and safety performance. The Managers Health and Safety Toolkit is a checklist designed to assist managers in identifying any deficiencies in health and safety management arrangements and a process for proactively developing actions to mitigate risks identified. Divisional self-audit compliance against the Health and Safety Toolkit has been variable over the last 12 months with quarter 4 showing some positive improvement in most areas. Further work is required in corporate directorates to bring them in-line with our clinical service areas.

Fit Testing compliance has significantly improved during 2022-23. The Trust Respiratory Protective Equipment (RPE) Facilitator in conjunction with external Fit Testers provided to us via the Department for Health and Social Care (DHSC), have undertaken almost 4500 tests during this 12-month period. As a Trust, we have implemented the DHSC resilience principles, particularly ensuring staff are tested on at least two FFP3 respirators with year end compliance sitting at 79% for one mask and 53% for a second.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (amended 2013) requires employers to report certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work' to the Health Safety Executive (HSE). The Trust reported 26 RIDDOR incidents over the last 12 months, a reduction of 53% compared to 2021-22. Predominantly these relate to lifting and handling and slips trips and falls, resulting in absence from work in excess of 7 days.

Moving into the next 12 months, the Health and Safety Team will work collaboratively with specialist safety advisors and our counterparts at Royal Wolverhampton NHS Trust, to focus on the suitability of safety management arrangements in preventing musculoskeletal injuries, work-related stress and violence and aggression. There will be a greater emphasis on divisional compliance with proactive health and safety risk management arrangements, training, incident reporting and subsequent investigative management. Re-stablishing our formal programme of audit and improving provision of enhanced safety performance data to divisional teams, we recognise are essential to improving safety culture and measuring performance for the purpose of providing assurance to the Trust Board.

1. PURPOSE OF REPORT

The purpose of this report is to provide the Trust Board with a summary of principal activity and performance relating to the promotion and management of health and safety for Walsall Healthcare NHS Trust for the period 1st April 2021 to 31st March 2023. In addition, this report highlights key health and safety priorities, to be delivered throughout the current financial year 2023/24.

The aim of the report is to provide the Trust Board with **assurance** that there are suitably effective systems and processes in place to ensure WHT executes its statutory responsibilities in line with Health and Safety legislation. Where complete assurance cannot be provided, the report will **advise** the Board on action planned and taken to mitigate any enduring risk. For issues or risks identified as having no assurance, this will be clearly **identified** within the report.

2. BACKGROUND & CONTEXT

All organisations have a legal duty to put in place suitable arrangements to manage health and safety. The Health and Safety at Work etc. Act 1974 is the primary piece of legislation covering occupational health and safety in the UK. This Act defines the general duties for employers and employees to protect both themselves and other service users from significant or avoidable harm. A positive safety culture should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes.

In particular, the act requires organisations to provide and maintain:

- A Health and Safety Policy
- A system to manage and control risks in connection with the use, handling storage and transport of articles and substances.
- A safe and secure working environment, including provision and maintenance of access to and egress from premises.
- Safe and suitable plant, work equipment and systems of work that are without risks.
- Information, instruction, training and supervision as necessary.
- Adequate welfare facilities

It is advocated that Health and Safety arrangements used by the Trust are aligned with the principles and guidance issued by the Health and Safety Executive (HSG65) which is represented by four key components of health and safety management: 'Plan, Do, Check, Act'. Health and safety objectives have been aligned to these four components with an associated Improvement Plan. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced. The key components of the PDCA framework that is being applied within WHT are summarised, as follows:

- **Plan** - determine policy, plan for implementation.
- **Do** - profile health and safety risks; organise for health and safety management; implement the plan.
- **Check** - measure performance; investigate accidents and incidents.
- **Act** - review performance; apply learning.

The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation and this is often enforced in healthcare by the Care Quality Commission (CQC) through a Memorandum of Understanding with the

HSE. The HSE also fulfils a major role in producing advice on health and safety issues, and practical guidance on the interpretation and application of the provisions of the legislative framework.

Regardless of the size, industry or nature of an organisation, the key aspects to effectively managing for health and safety are:

- leadership and management (including appropriate and effective processes)
- a trained/skilled workforce.
- an environment in which people are trusted and involved.

Walsall Healthcare NHS Trust (WHT) accepts this framework to be fundamental in the delivery of safe services for staff, patients, carers and visitors. Health and Safety law places specific duties on organisations. Employers, directors, managers and employees, can be held personally liable when these duties are breached, and members of the board have both collective and individual responsibility for health and safety.

Each section of this report will review the suitability of Health and Safety management arrangements for controlling risk, within WHT based on *Managing for Health and Safety* (HSG65). This will include an evaluation of contributions from specialist advisors and safety-sub-groups reporting into the Health and Safety Committee as described in the Trust Health and Safety policy.

Whilst not included under the Management of Health and Safety at Work Regulations 1999; fire safety remains an essential requirement to ensure the H&S of people present on our sites. The Regulatory Reform (Fire Safety) Order 2005 (RRO) became law in 2006 and covers all fire legislation, alongside the RRO are the Firecode suite of documents and the building regulations. Together these documents form the basis of all fire safety on site and within community premises, including fire safety training and emergency evacuation. Responsibility currently remains with the Fire Safety Advisor under the Chief Operating Officer as Executive Director with delegated responsibility for fire and overall remit for Estates and Facilities. The Trust Fire Adviser has submitted the Annual Fire Safety report and this will be presented to the Trust Board as a separate report. This report will present a summary of key aspects of fire safety performance.

3. Health and Safety Committee and Governance Arrangements

Trust Board

People and Organisational Development (POD)Committee*

Health and Safety Committee

Radiation safety | Water Safety | Fire Safety | Medical Gases | Safer Sharps | V&A & Security

***NB**: The Health and Safety Committee previously reported to POD Committee, following a review of corporate governance arrangements its is now agreed Health and Safety oversight and assurance will be reported through Quality Committee moving forward from March 2023.

Trust Health and Safety Committee

The Health and Safety Committee, (HSC), is constituted under the requirements of Section 2(7) of the Health and Safety at Work etc. Act (1974). Its purpose is to consult with employees on matters of health, safety and welfare in accordance with the Safety Representatives and Safety Committees Regulations (1977) and the associated Code of Practice and Guidance, the Management of Health and Safety at Work Regulations (1999) and the Health and Safety (Consultation with Employees) Regulations 1996.

The Committee has an overarching responsibility for corporate leadership and risk management of health and safety matters appertaining to WHT. The primary role of the Committee is to promote the health, safety, security and welfare of all the employees of the Trust, service users, visitors and any others who may be affected by the Trust's activities and to promote of consultation and co-operation between management and staff. The Group Director of Assurance Chairs the Health and Safety Committee, being the Director with delegated responsibility for health and safety, specifically providing strategic leadership within Walsall Healthcare NHS Trust. The Health and Safety Committee acts as the main mechanism for consultation on work related health and safety matters. The Committee convened via MS Teams on 4 of 4 occasions during 2022/23. Quoracy was achieved at all meetings including representation from Chair, divisional representatives and specialist advisors. Meeting minutes and actions were taken and disseminated by the Governance Administrator and are available on the intranet.

Divisional Health and Safety representatives prepare assurance reports to be presented at Health & Safety Committee. This report is intended to provide the committee with assurance of actions taken to improve compliance within the division in terms of the H&S management arrangements including, risk assessing, training, participation in audit, review, and management of incidents etc.

Divisional Meetings

Health and Safety Divisional proactive and reactive principal activity reports are provided to clinical divisions on a quarterly basis. A Health and Safety Team representative attends these meetings each financial quarter to present and advise on lessons learnt and remedial action required. The report has been updated to include Trust oversight in the main body of the document with Division-specific data contained within the appendices. This allows divisions to view performance data across the Trust and the 4 clinical divisions.

Quality, Patient Experience and Safety Committee (now renamed Quality Committee)

The Health and Safety Committee is accountable to the Quality, Patient Experience and Safety Committee (QPES) which is in turn, as a sub-committee, responsible to the Trust Board. The Health and Safety Committee can at any time take Health and Safety matters directly to the Chief Executive Officer, as accountable officer, and also to the Trust Board. Scheduled reports are provided by the Head of Health and Safety to QPES 6-monthly and a summary report annually.

Trust Board

The Trust Board is responsible for demonstrating the commitment of the Trust to all matters relating to health and safety and for leading the health and safety agenda. The Trust Board receive reports from QPES via the same schedule described above.

4. Health and Safety Management System - HSG65

Source - HSE

4.1 PLAN - Health and Safety Policy

The Trust's overarching Health and Safety Policy remains current following a planned review in 2021. Although the policy is not scheduled for review until 2025; work has commenced with our RWT health and safety colleagues to review and align (where viable) health and safety policy and procedural documentation.

Throughout the last financial year, the team alongside key stakeholders, have continued to review existing, policy documents. The following policy documents have been ratified by Trust Management Committee during the financial year 2022/ 23:

- **Personal Protective Equipment Policy** – Consulted virtually with Health and Safety Committee on 8th April 2022 – Ratified on 26th July 2022
- **Work Equipment Policy** - Consulted virtually with Health and Safety Committee on 8th April 2022 – Ratified on 26th July 2022.
- **Working at Height Policy** Consulted virtually with Health and Safety Committee on 8th April 2022 – Ratified on 26th July 2022
- **Control of Substances Hazardous to Health (COSHH) Policy –** Policy Group Approved 20th December – Ratified at TMC 26th January 2023
- **Display Screen Equipment Policy -** Policy Group Approved 20th December – Ratified at TMC 26th January 2023
- **Sharps Safety Management Policy Including Sharps/ Splash Injury & Post-Exposure Prophylaxis (Pep) -** Policy Group Approved 14th March 2023 – Ratified at TMC 23rd March 2023
- **Security Policy including 'Management of Violence and Aggression' and 'Lone Working' –** Policy Group Approved 11th April 2023 – Ratified at TMC on 28th April 2023.

The Health and Safety Team will continue to review and update topic-specific health and safety policies, procedures and Standard Operating Procedures (SOP's) throughout the current financial year.

4.1.2 PLAN - Health and Safety Objective Performance Review (20222/23)

Performance against the 2022-23 objectives has seen some positive progress specifically in terms of H&S training provision. Health and Safety for Managers and IOSH for Executives and Directors have been delivered as planned. Face to face risk assessment and inanimate load handling training have recommenced also. Further work has taken place to develop relationships between divisional representatives and specialist advisors throughout the year. This can be seen through the evolvement of divisional reporting mechanisms and collaborative improvements made to the sharps safety management system. Over the next year further collaboration between the security team and the manual handling and ergonomics team will focus on the reduction and management of violence & aggression and musculoskeletal injuries. Implementing robust and effective investigation process and embedding an audit programme are key priorities. A full summary of performance against previously agreed and new objectives for the coming financial year, can be found in **Appendix 3**.

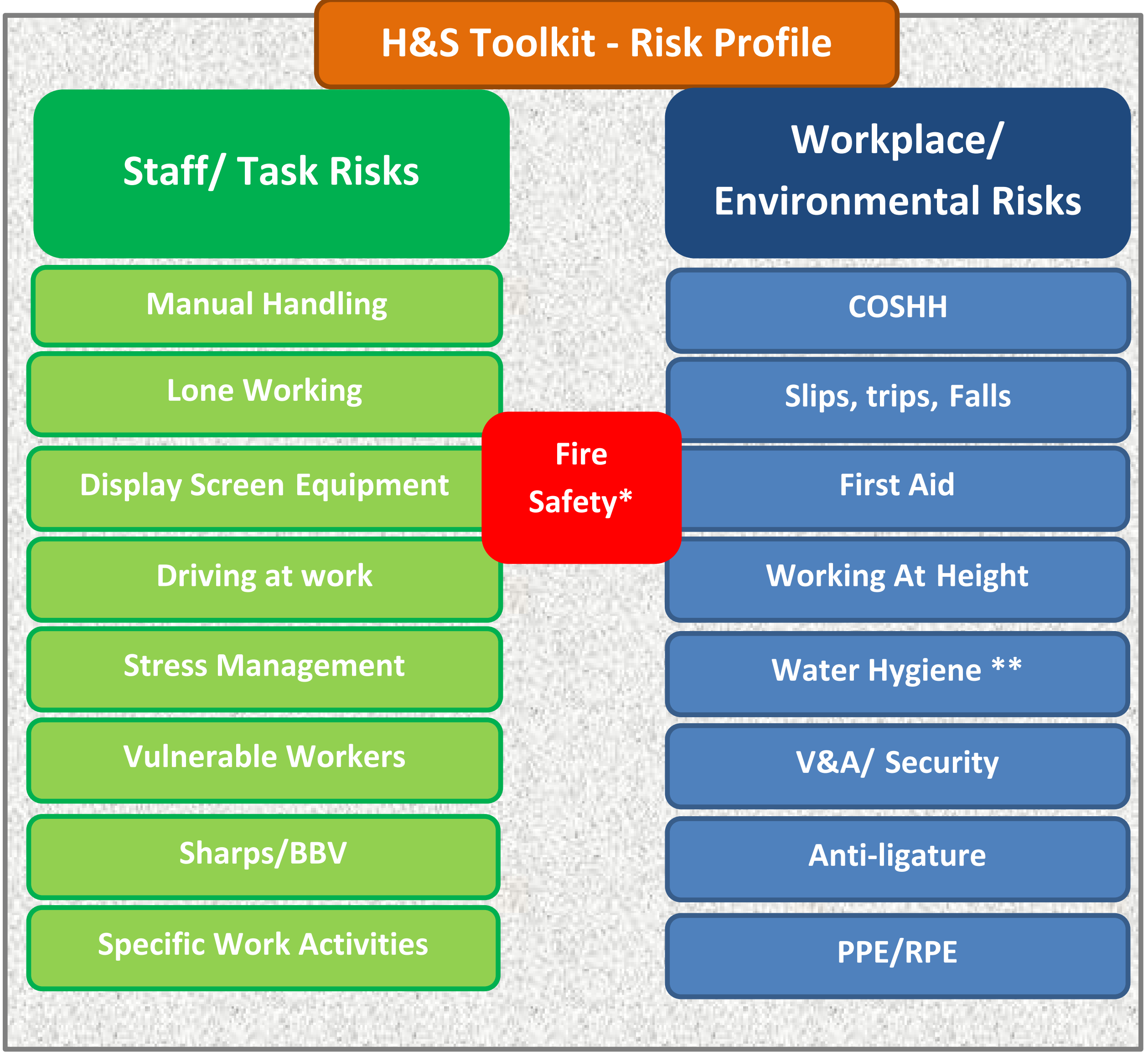
4.2 DO – Assess Risk/ Plan for Implementation

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. Assessing risks helps identify what could cause harm in the workplace, how or what could be harmed, and the likelihood this is to happen. This enables managers to identify and prioritise their biggest health and safety risks and focus efforts on putting suitable and proportionate safety measures in place to mitigate the risk of harm.

To support the risk assessment programme, the Health and Safety Team continues to provide advice and guidance in the implementation of statutory risk assessments through utilisation of the Health and Safety Toolkit. The Toolkit is intended as a health and safety 'one-stop' resource to guide managers through assessing and managing their relevant statutory responsibilities.

The Health and Safety Toolkit has been in place for over 6 years at Walsall Healthcare NHS Trust. Essentially this comprises of a proforma containing 21 sub-sections covering relevant aspects of Health and Safety Law and local policy, specifically risks associated with healthcare work and environment.

4.2.1 DO – Walsall Health and Safety Risk Profile



Note: * Completed by the Trust Fire Advisor
** Specialist Estates staff, engineers and contractors, complete the required risk assessments associated with the maintenance and operation of the estate i.e. asbestos, electrical works, lifts, waste and water.

4.2.2 DO - Organise and Communicate

To deliver the Health and Safety toolkit managers (along with any designated safety representatives) are required to complete a **Self Audit return** which provides a visual summary in terms of compliance against each of the health and safety topics identified within the toolkit. To demonstrate proactive monitoring the **Self Audit Summary Sheet** should be completed and returned to the Health and Safety Team on a **quarterly** basis. Each quarter an email reminder (including deadlines) is circulated to *all* managers requesting toolkit submission. The return position for 2022-23 is reported in section 4.3 – 'measuring Performance'. The health and safety team have met with divisional leads and present monthly data at divisional meetings showing toolkit compliance broken down by care groups. The self-audit inventory has also been shared with divisional leads which identifies wards/ departments with zero compliance where action is required.

The **Health and Safety Planner is** a 'tool' provided to help managers plan, prioritise and implement their health and safety arrangements by organising all risk assessments,

workplace inspections etc into monthly schedules. The planner also facilitates continuous monitoring and review of health and safety progress. In addition a list of myth busters is created to support Managers' most common concerns including prioritising risk assessments, implementing the toolkit, managing local risks etc.

Managers Health and Safety Toolkit Awareness Sessions & Self-Audit Compliance

The health and safety team have provided 3 'toolkit' awareness sessions over the past 12 month, attended by over 40 members of staff; delivered via MS Teams. Our challenge moving forward is including our corporate departments, making consistent progress each quarter, and ensuring the 100% target for compliance is achieved every quarter. Further awareness sessions will be rolled-out in quarter 3 and 4 specifically for corporate teams. We will need to ensure that representatives from each of the corporate functions are identified, trained and an ongoing network/ forum established to aid continuous improvement and collaboration. The role of a health and safety representative requires defining to ensure individual staff, managers and divisional leads understand their objective, role and responsibilities.

Datix IQ Cloud

RLDatix™

The Trust is moving from Ulysses to a new risk management system; Datix Cloud IQ. The launch date for DCIQ is still to be confirmed. An update is expected by end of October 2023.

During the last financial year, the Health & Safety Team have worked collaboratively with the Datix Cloud IQ (DCIQ) Team, to ensure that the configuration within the new DCIQ system will accurately record any Health & Safety related incidents across the organisation.

The robust data capture process will allow the Health & Safety Team to effectively review the adverse outcome (including reporting to the Health & Safety Executive RIDDOR) and will support them to ensure that any staff safety issues are exposed and resolved quickly to enable learning and an improved staff experience.

DCIQ staff engagement events have taken place, supported by representation from the Health & Safety Team in order to further promote and raise the profile of DCIQ and Health & Safety in general.

Health and Safety Resources

Resources are held on the Health and Safety 'Team Pages' on the Trust intranet site. There are over 40 resources including guided risk assessment tools, posters, Standard Operating Procedures (SOP's), inspection tools, checklists, links to committee minutes and helpful videos.

Resources

Welcome to our resources page where you will find our latest Risk Assessments, Health and Safety Toolkits, Health and Safety Committee Minutes and more to help you achieve compliance in Health and Safety.

Manager's Health and Safety Toolkit

The Manager's Health and Safety Toolkit identifies the responsibilities for the health, safety and welfare of staff as stated in the Trust's Health and Safety Risk Management Policy. Through the complexion of the toolkit it will enable you to carry out a self audit and help you identify and manage risks.

Self Audit Summary Sheet

Manager's Health & Safety Toolkit

Health & Safety Toolkit Planner

In Quarter 1 the team updated the following resources and uploaded them to the Health and Safety resources page:

- Public Liability Insurance Certificate
- Managers Health and Safety Toolkit
- Health and Safety for Managers Flyer
- DSE & COSHH for Assessors Training Flyer
- DSE Assessors report to manager's template
- Self-assessment checklist for Homeworking
- Working from Heights Risk Assessment Template (Version 1)
- Ladder, Stepladders; Inspection checklist
- Healthy Back at Work Video

Divisional Health and Safety Activity

Each clinical division has received a quarterly report during this reporting period. Each reports includes a summary of principle activity from both a Trust and Divisional perspective, containing details of proactive and reactive performance, such as:

- Health and Safety Toolkit monitoring,
- Audit progress,
- Policy review,
- Training compliance (including Fit Testing),
- Trust wide & divisional incident activity with comparators
- RIDDOR Reporting
- Employer Liability Claims data.

Training and Competence

Mandatory Health and Safety training is available for staff to complete by eLearning on induction to the Trust. Non-clinical staff renew their compliance bi-annually whilst clinical staff undertake annually (training for both clinical and non-clinical staff have now been

aligned and will be required every 2-years from April 2023). Overall compliance for mandatory training as of 31st March 2023 reported at 87.66%. with overall Corporate Update Training at 86.74% %. Load Handling and Conflict resolution training (as of year-end) demonstrated positive engagement and compliance. Action plans remain in place to increase compliance with mandatory training as per Trust policy. Promotion of training, flexibility in accessing online training and regular compliance reporting are ways in which compliance is encouraged. The Trust now have substantive Fire Safety officers in place to deliver Fire Safety Training and increase compliance with already established mandatory training.

Conflict Resolution	Fire Safety	Health, Safety and Welfare	Load Handling	Patient Handling	Annual Fire Local Arrangement	Overall Core Mandatory Training Compliance
94.62%	**83.87%**	**84.70%**	**93.44%**	**79.32%**	**72.30%**	**87.66%**

Additional Health and Safety Training was provided throughout 2022/23 delivered face-to-face and via MS Teams; courses include:

Table 1 – Health and Safety Training

Training Course Description	Total Delivered Sessions	Total Attendance
Fit-Test Training	247	3957
Health and Safety for Managers (Full-Day, Face-to-face)	15	53
DSE Risk Assessment for Assessors (2-hour)	5	34
COSHH Risk Assessment for Assessors (2-hour)	5	22
Health and Safety Risk Assessment (Half-day) (Face-to-face)	3	11
IOSH for Executives and Directors (1 Day via MS Teams External Provider)	2	20
Health and Safety Toolkit Awareness Sessions (1-hour)	3	41
Health and Safety for Coordinator's (2-hours, 8- Modules)	N/A	N/A

Through April-22 to March-23 the fit testing team supported 3957 colleagues with **Face-Fit Testing**. The Trust maintained its Fit Testing provision with the support of Ashfield who were provided via the Department of Health and Social Care (DHSC). This meant that we were able to facilitate a total of 247 planned sessions throughout the last financial year, peaking at 550 slots per month. Staff were able to book through an online system using a QR code. DHSC worked closely with Ashfield capturing data on the 28 Regional and 100+ National Trusts that Ashfield supplied Testers to. Walsall Healthcare NHS Trust were one of the top performing Trust in the Midlands throughout the contract and competed well with much larger Trusts.

Health and Safety for Managers is a full-day course. Due to Covid-19 restrictions remaining in place until July 2022, some sessions were subject to social distancing rules meaning capacity was limited. However, following removal of NHS restrictions, rooms were open to maximum capacity. The health and safety team have delivered 15 face-to-face sessions over the past 12 months, training 53 clinical and non-clinical managers. This is a much-improved position compared to the previous financial year where we were unable to provide any sessions as a result of restrictions brought about by the pandemic.

DSE and COSHH for Assessors continued to be delivered via MS Teams with Risk Assessment for Assessors re-established in quarter 4 and delivered face-to-face. Attendance at these sessions has improved over the past 12 months.

Although, the **IOSH for Executives and Directors** was sourced and funded in 2022/23, the course was delivered in June 2023 (current financial year) due to winter pressures and staff availability. The accredited training was delivered to Executive and Divisional Directors, with priority given to (non-clinical) divisional directors of operations and their associated deputies. The 2 sessions in June were positively attended with just one cancellation. To gain accreditation, each attendee was required to complete a health and safety commitment. These have been collated and will form key objectives for corporate and divisional health and safety management planning moving forward.

The **Health and Safety Co-ordinator (HSC)** course is a bespoke programme, specifically designed to develop a network of champions across the organisation that have enhanced skills to support the Trust and management in the delivery of its Health and Safety responsibilities. Two full Cohorts of training have been delivered within the Trust prior to the pandemic and the third Cohort cancelled in March 2020 as a result of the Covid-19 pandemic. At present, this course remains suspended due to reduced capacity within the health and safety team. In the current year period it is anticipated that recruitment to a fully established team and revised work plans will enable the re-establishment of the H&S champion roles within the Trust.

Health and Safety Team Resource

The full team establishment comprises of the following members:

- Head of Health and Safety (1.0 WTE)
- Health and Safety Skills Trainer/ Officer (0.6 WTE)
- Health and Safety Officer (2.0 WTE)

A Respiratory Protective Equipment (RPE) Coordinator post was created and approved at Tactical Command albeit not funded from Covid-19 funds but through the Health and Safety Team. Following a management of change process in 2022/23, it was agreed that the RPE portfolio would be integrated into the Health and Safety Officers role. Recruitment to this role is currently in progress.

In terms of combined experience, the Health and Safety Team holds approximately 100 years' worth of public sector experience, at least 70-years of which specifically pertains to safety and regulatory governance. Qualifications held by the team include National Examination Board in Occupational Safety & Health (NEBOSH) Certificate & Diploma, Chartered Member of the Institution of Occupational Safety and Health (CMIOSH), BA (Hons) Law and Social Policy, Preparing to Teach in the Lifelong Learning Sector (PTLLS), Fit2Fit accreditation, Accredited Serious Incident Investigation and PRINCE2 Project Management.

Sharps Safety Management – HSE Inspection

On 11th and 12th January 2023, the **Health and Safety Executive** undertook a planned inspection of the Trust's Sharps Safety Management System. Following the 2-day inspection, feedback provided to the Executive Team highlighted a number of areas requiring improvement. HM Inspector wrote to the Trust following the inspection explaining the material breaches in legislation. The Notice of Contravention outlined 2 key areas of work to be undertaken and agreed timeframe for delivery, specifically relating to non-safe sharps risk assessments and clear roles and responsibilities to be outlined in policy. Not all wards and departments were able to demonstrate non-safe sharps risk assessments and safe systems of work were in place. When present these did not provide details of make/ manufacturer or include written instructions of safe systems of work. The trust policy was unclear in its arrangements specifically roles, responsibilities and strategic and co-ordinated approach to reducing reliance on non-safe sharps.

The theatres sharps risk assessment was reviewed, revised and updated to include greater detail in terms of the make and manufacture of non-safe sharps in use; greater emphasis on safe systems of work (we refer to these as SOP's). In addition to this, a non-safe sharps inventory was created detailing all non-safe sharps devices used in theatres, regardless of ordering modality. This was completed to the deadline of 28th February 2023.

The new Sharps-Safety Management Policy Including Sharps/ Splash Injury & Post-Exposure Prophylaxis (Pep) was developed collaboratively through Occupational Health & Wellbeing, Infection Prevention and Control, Clinical Procurement and Health & Safety colleagues. The newly developed policy was endorsed at Trust Management Board on 23rd March 2023. This policy was significantly rewritten and consolidates the previous two (separate) policy documents:

- Ver 6.0 Safe Handling and Disposal of Sharps and
- Ver 4.0 of Sharps/Splash Contamination Incident Policy.

A residual action plan was developed to outline further arrangements identified during the inspection including the review of local sharps risk assessments in line with the theatre model, procurement arrangements for the wider roll out of safer sharps, training,

sharps performance monitoring and reporting. Both the policy and action plan were submitted to the deadline of 1st April 2023.

On meeting with HM Inspector following submission of the updated risk assessment, feedback was complimentary. HM Inspector agreed with our honest, albeit lengthy non-safe sharps inventory and the residual risk scoring. The Inspector also commented positively on the newly developed SOP which describe actions taken to mitigate the risk of injury associated with specific tasks/ activities.

The HSE case file was closed by the HSE on 27th April 2023. The Trust continues to progress the residual action plan which is monitored by the Sharps group and oversight reported at the HSC.

Timely Reporting of Injuries, Diseases and Dangerous Occurrence

Reported workplace H&S incidents are monitored by the Health & Safety Team who liaise with relevant managers to ensure appropriate investigation and immediate redress actions to prevent reoccurrences. Where incidents meet RIDDOR reporting criteria, the Health and Safety Team, on behalf of the Trust, report any **RIDDOR** reportable incidents to the **Health and Safety Executive** and support managers to undertake the required investigations. Despite strict reporting timescales in place, there were RIDDOR reporting delays encountered during 2022/23. .

During Quarter 1 an internal alert was cascaded to all managers with pertinent RIDDOR advice attached. Managers were required to action the internal alert, specifically:

- Read the alert and understand their responsibilities in relation to RIDDOR reportable incidents.
- Reinforce with their team responsibilities for reporting all workplace incidents.

Increased staff awareness and management focus will continue in the next reporting period since breaching these Regulations is a criminal offence and can lead to enforcement action

4.3 CHECK – Measuring Performance

Monitoring and reporting are important parts of effective health and safety arrangements. Safety Management Systems allow the Trust to receive both risk-specific and routine reports on the performance of health and safety policy.

Checking the organisation is managing risks is a vital to provide assurance that we are doing enough to manage health and safety risks and highlights gaps in our safety systems where we could be doing more, or working differently and more efficiently.

Table-2 - Health and Safety Intervention Monitoring

Health and Safety Activity	Planned interventions – 2021/22	Planned interventions – 2022/24
Display Screen Equipment (DSE) Assessments	44	66
Covid-19 Environmental Safety Inspections	23	1
Lifting/ Handling Assessment Advice	12	21

Workplace Inspections	9	6
Advising on environment/ Space/ pre- and post-move checks/ / COSHH assessments/ equipment	10	47
Trust EPRR Exercise	2	1
Advising on new ED build	2	0

Note: The above figures detail only those interventions that were booked and planned and does not cover reactive/ urgent requests.

Health and Safety Interventions

The health and safety team have continued to support staff through providing expert advice and assessment. DSE assessments, manual handling advice & assessments and advice in relation to space and COSHH have all increased during the last financial year.

Sharps audits

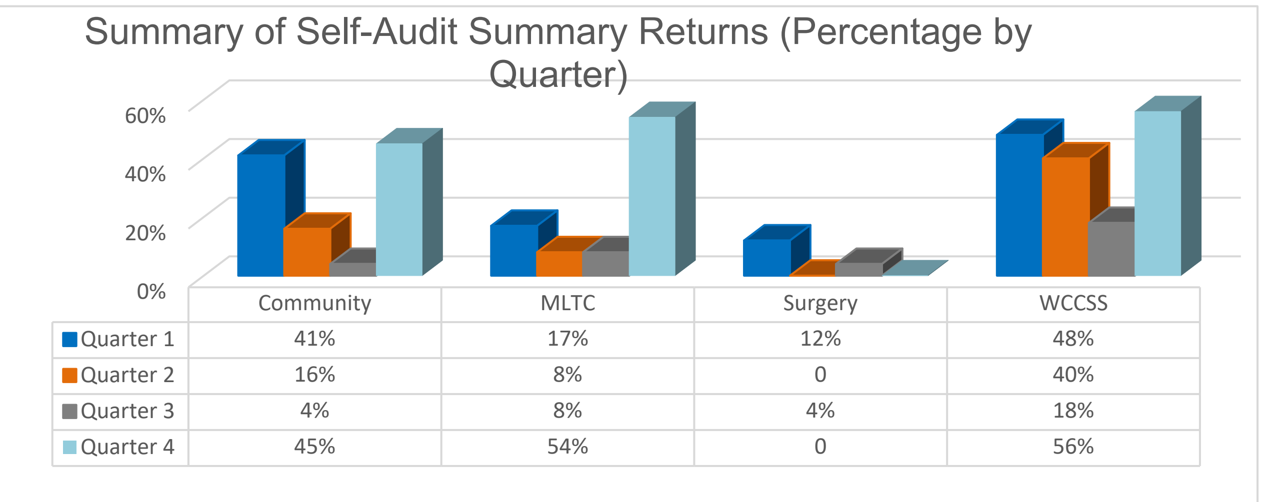
During quarter 2 and 3 the health and safety team undertook sharps safety audits. The audit focussed on 9 key areas specifically; policy, visual aids/ posters, safe practice, sharps bin-safety, needle-safe device availability and risk assessment. Over 35 clinical acute areas were audited this included all acute wards and (outpatient) departments with the exception of wards 24, 29 ICCU and pre-assessment brought about by access restrictions as a result of infection. Initial audit findings showed:

- Lack of awareness of relevant policies
- Inconsistent advice from displayed posters
- Poor medical compliance in terms of taking mobile sharps containers to the point of care.
- Lack of awareness of or no sharps risk assessment
- Reintroduction of non-safe vacuette due to supply-chain issues affecting blood-collection products
- Failure to consider incident reporting requirements.

A number of immediate actions were undertaken which later fed into the HSE post-inspection Sharps action plan. Actions included, policy development, improved procurement practices, safe-practice information sharing, updated qualitative risk assessment with scrutiny, sharps safety forum re-establishment and more.

Self-audit monitoring continued within the Trust. The Self Audit process **(Appendix 3)** provides a visual summary of compliance against each of the health and safety topics identified within the toolkit. Previously, the requirement for self-audit summary submission expected returns 6-monthly, this was increased to quarterly in 22/23 to improve assurance on engagement and compliance.

During the reporting period 2022/23, 124 self-audits have been reviewed and submitted. The Graph below illustrates self-audit summary compliance for the last financial year.



	Community	MLTC	Surgery	WCCSS
Quarter 1	41%	17%	12%	48%
Quarter 2	16%	8%	0	40%
Quarter 3	4%	8%	4%	18%
Quarter 4	45%	54%	0	56%

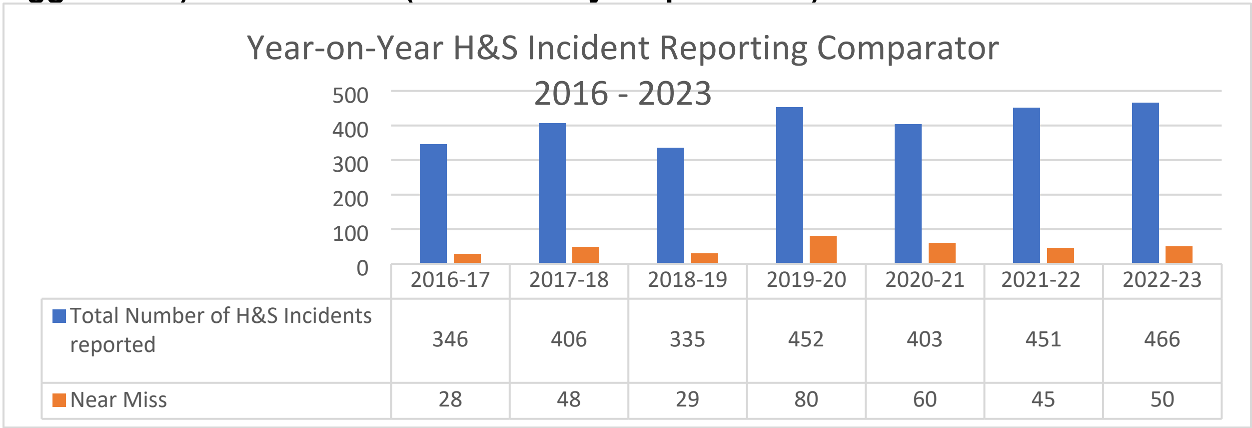
This financial year, priority work will be undertaken to return to pre-pandemic activity with focus on improving engagement and compliance and attention to the inclusion of corporate areas such as; Estates and Facilities, Digital Services, Governance and other key infrastructure functions. Face-to-face health and safety audits will be re-established in 2023-24 to measure performance in terms of suitability of documented risk assessments and sufficiency of practical safety arrangements.

Incident Reporting and Investigation

Health and safety incident investigations form an essential part of the monitoring process. Findings from incident investigations can help identify why existing risk control measures failed, form the basis of action to prevent an incident from happening again, and improve overall risk management.

During 2022/23, the total number of Health and Safety incidents reported in the Trust, increased compared with the previous years. Chart 1 illustrates 2022/23 as having the highest reporting figures when compared with the previous 6-years'. Whilst as a Trust our primary objective is to decrease harm associated with incidents and accidents; incident reporting is actively encouraged as part of our open learning culture. Chart 2 illustrates a reduction in harm incidents compared with previous years. Increased near miss reporting is indicative of a positive learning culture, i.e. incidents are reported even though harm was prevented. These incidents provide beneficial insight into patterns of behaviour and allow early intervention to prevent harm being realised and to encourage early learning opportunities. Whilst near-miss reporting has increased in the last 12 months, we need to encourage all staff to report incidents including ancillary colleagues who are largely low reporters.

Chart 1 – Total Number of Health and Safety Incidents (excluding Violence and Aggression) Year on Year (Extracted by 'Report date')



	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Total Number of H&S Incidents reported	346	406	335	452	403	451	466
Near Miss	28	48	29	80	60	45	50

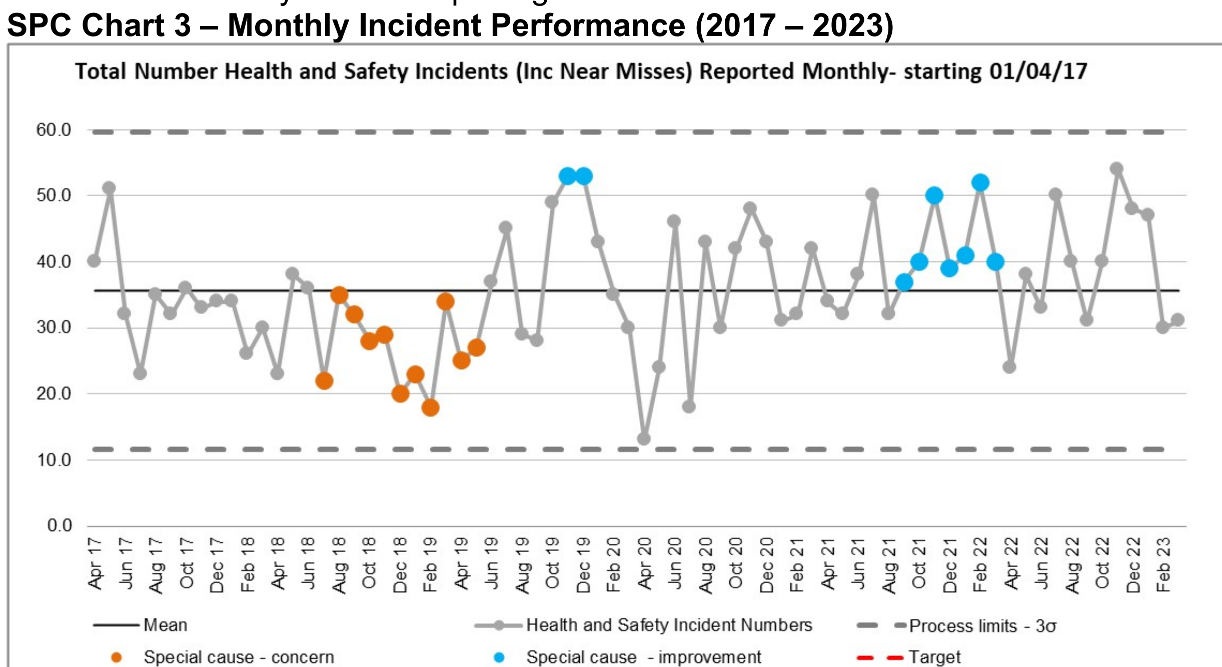
Chart 2 – Year on Year Comparative Health and Safety Harm Data

Total of Harm 3-5 Reported Over 7-years - Apr 2016 - Mar 2023

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Total of Harm 3-5	21	31	14	14	18	18	12

The Statistical Process Control (SPC) Chart 3 below demonstrates a sustained increase in Health and Safety incident reporting from 2017 – 2023.

SPC Chart 3 – Monthly Incident Performance (2017 – 2023)



Under reporting of sharps incidents was identified in the Trust reporting system. **Appendix 2** demonstrates sharps reporting variance when compared with Occupational Health and Wellbeing (OHWB) attendance data. This has been continually monitored throughout the last financial year. Moving into the new financial year, both the Health and Safety and OHWB teams have established a monthly validation process to ensure incident and OHWB data matches. Use of the new sharps investigation tool, which is commenced by OHWB at the injured person's appointment, has aided reporting and investigation processes significantly. As this report is being prepared, Quarter 1 – 2023/24 incident and OHWB data reported a 100% match.

Violence and Aggression

Violence and Aggression incidents have decreased by 5% during the last year, albeit numbers remain higher than pre-pandemic figures, specifically 2019-20 shown in Chart 4. The Local Security Management Specialist (LSMS) function is now undertaken by colleagues from Royal Wolverhampton Trust who manage this portfolio on both Walsall and Wolverhampton sites. During the last financial year, the LSMS has reviewed, and continues to monitor onsite security provision and performance which has seen improvement in the work undertaken by the security team. Following review of the Violence and Aggression Policy, a new Security Policy has been implemented within the Trust which includes arrangements for the management of violence and aggression, lone

working and CCTV. The policy was ratified at TMC on 27th April 2023. Work is ongoing to improve the utilisation of preventative and reactive measures, and zero tolerance processes to reduce the prevalence of violence and aggression.

Chart 4 – Combined Health and Safety and Violence and Aggression Figures – Year on Year

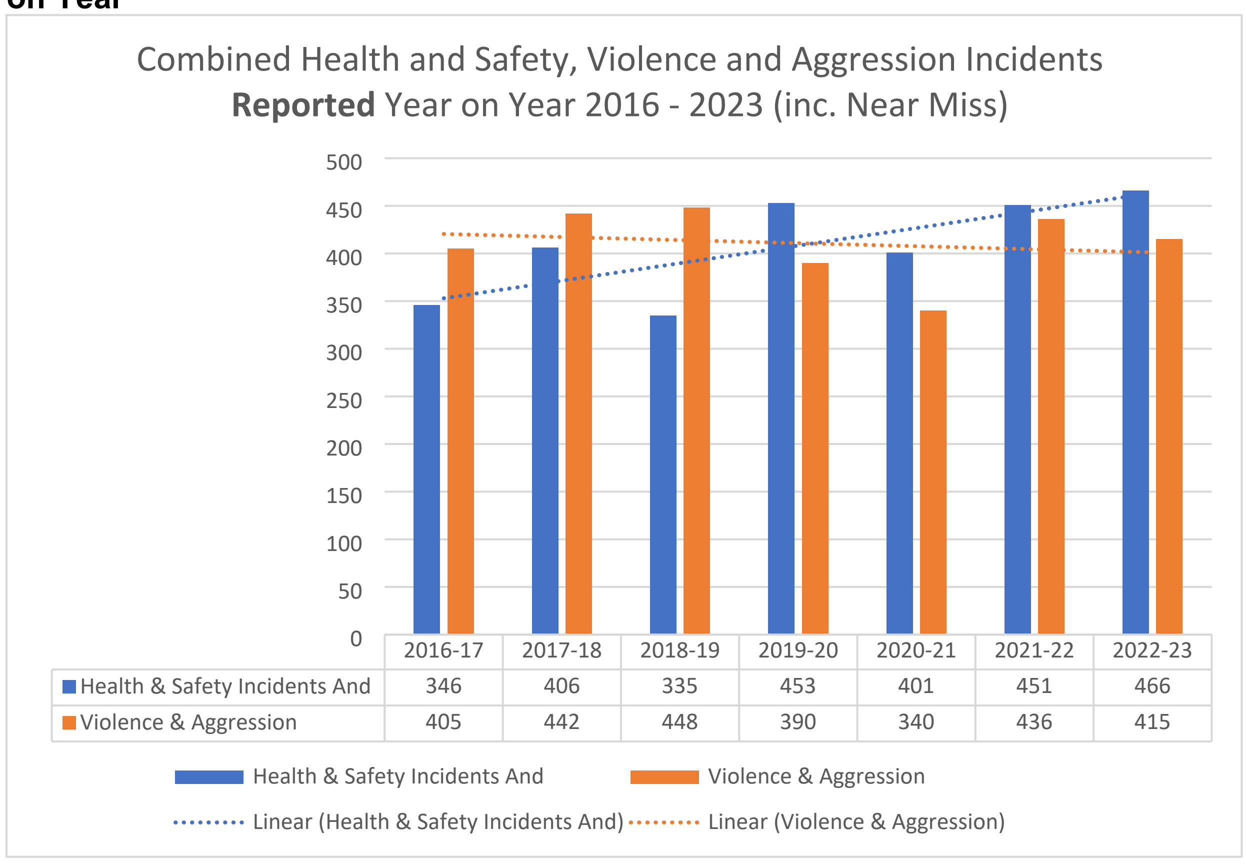


Table-4 – Year on Year Incident Performance

Year on Year Incident Performance	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Health & Safety Incidents	346	406	335	453	401	451	466
Year on Year % Difference	-	+15%	-17%	+26%	-11%	+11%	+3%
Violence & Aggression	405	442	448	390	340	436	415
Year on Year % Difference	-	+8%	+1%	-13%	-13%	+22%	-5%
Grand Total	**751**	**848**	**783**	**843**	**741**	**887**	**881**
Combined Total Year on Year % Difference	-	+11%	-8%	+7%	-12%	+16%	-1%

Most Frequently Cited Incidents

Appendix 1 and Chart 5 below, illustrate most frequently reported causes of incidents. Sharps, Slips/ Trips/ Falls and Manual Handling feature as our most frequently reported incidents. In addition to this, the majority of Violence and Aggression incidents cite the

patient's medical condition being a contributing factor, albeit numbers are reduced compared with previous years. Verbal abuse and threatening behaviour report comparable figures and show incidences reported widely across both acute and community sites. Incident investigation is essential in determining learning outcomes and reducing further incidence. The quality in incident investigation varies from one incident manager to another. The Health and Safety Team provide managers with investigation training as part of the 'managers' role-specific training programme. The manual handling and Ergonomics team have undertaken a raft of initiatives to reduce risk of musculoskeletal (MSK) injuries including:

- Successful introduction of a pilot people moving and handling risk assessment.
- Implementation of a moving and handling return to work risk assessment for managers documentation.
- Introduction of a new role, Ergonomics Assistant with the aim to further explore musculoskeletal health needs of colleagues using a HSE body mapping tool in a risk reduction exercise, raising awareness of the importance of incident reporting and identifying trends that require further investigation.

Work will continue into 2023-24 to further reduce MSK injuries through improved risk assessment.

Chart 5 – Top 8 Most Reported Violence and Aggression Sub-causes

Most Frequently Cited Violence and Agression Incidents by Cause Year on Year 2016 - 2023

VA09 - Verbal Abuse (Pt Medical Condition)
AT09 - Other Staff - Rude
VA05 -Threatening Behaviour Aggression (Pt Med Con
VA06 - Threatening Behaviour Agression (Pt Non-Med
VA02 - Violence Or Assault (Pt Non-Medical Conditi
VA11 - Verbal Abuse (Visitor - I.E. Outpatient)
VA07 - Threatening Behaviour Aggression (Visitor)
VA10 - Verbal Abuse (Pt Non-Med Condition)
VA01 - Violence Or Assault (Pt Medical Condition)
0 20 40 60 80 100 120 140
2022-23 2021-22 2020-21 2019-20 2018-19 2017-18 2016-17

Incivility

Incidents associated with staff-on-staff incivility was a prominent feature in 22/23 and are monitored through regular Pulse surveys, the annual NHS staff survey and divisional performance reviews. The People and Culture Directorate have instigated work to

reduce the prevalence of incivility issues through their health and wellbeing framework. The Trust commenced a pilot civility and respect training programme between June and September 2023. The programme is a three-hour face to face session and covers the important of psychological safety in the workplace from an individual and team perspective as well the role all staff have in creating kind, compassionate and inclusive workplaces with a healthy speak up culture. The pilot sessions have been attended by many stakeholders across the Trust to evaluate and finalise content. The training will also highlight the joint behaviour framework which has been developed with feedback from staff focus groups across Walsall Healthcare and The Royal Wolverhampton and the Dispute Resolution Policy and Procedure introduced in March 2023. Once the 'train the trainer' has been completed a training programme will be published for colleagues to book later this financial year.

RIDDOR Reporting

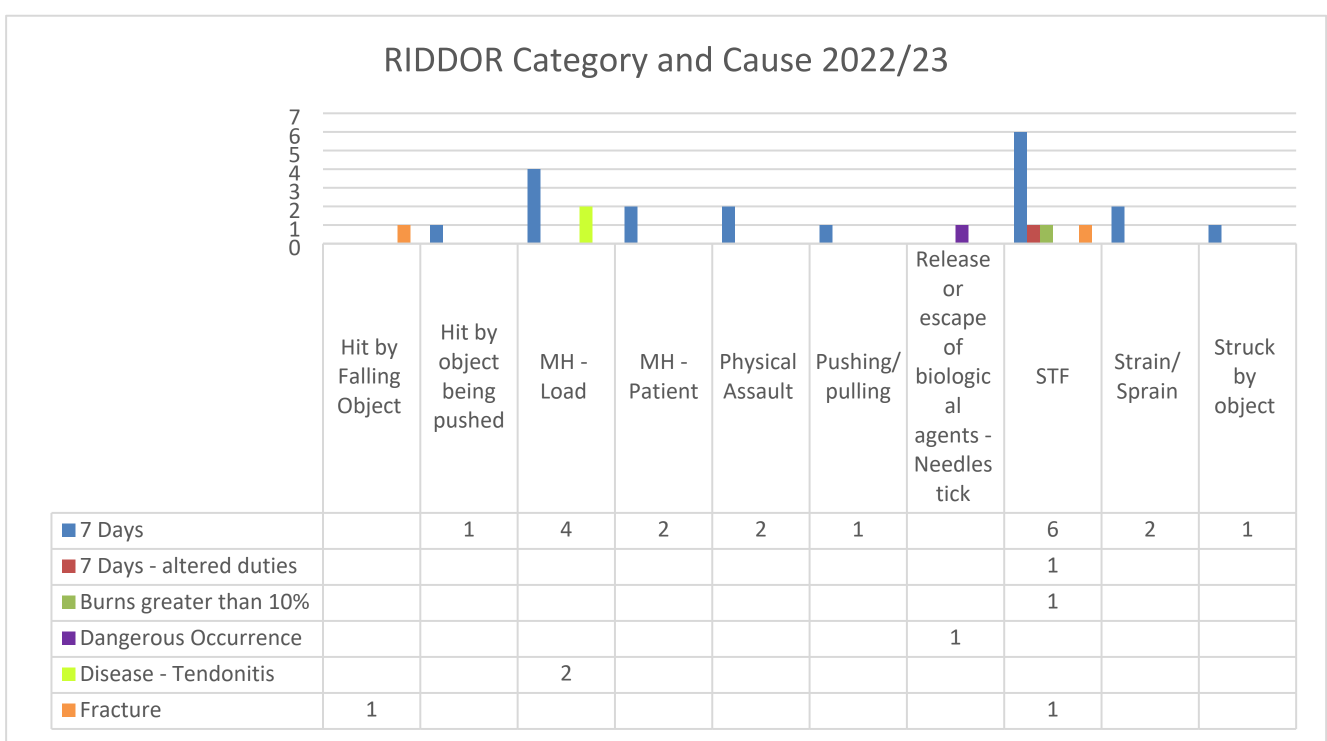
There was a significant reduction in the number of RIDDOR reportable incident in the last financial year compared to the previous financial year. The Trust reported 26 RIDDOR incidents over the last 12 months, a reduction of 53% compared to 2021-22. Predominantly these relate to lifting and handling and slips trips and falls, resulting in absence from work in excess of 7 days. Cumulatively, and in order, Slips/ Trips/ Falls and Load Handling are the most frequent causes of RIDDOR reportable incidents and incapacitation of an employee in excess of 7-days. Slips/ Trips/ Falls contributed to 27% of RIDDOR 7-day incapacitation[1] whilst all load handling account for 15%. The Trust reported one Dangerous Occurrence relating to a sharps incident from a confirmed blood borne virus source. 2 incidents of tendonitis were reported relating to repeated handling activities in the medical records department.

Greater collaborative work is required between the estates and facilities team, NHS property services and our own staff to look at the suitability of risk assessments to prevent slips/ trips/ falls.

Chart 5 – RIDDOR Reporting by Quarter

RIDDOR	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total Incidents Reported to HSE 2021/22	8	12	13	13
Total Incidents Reported to HSE 2022/23	6	10	4	5

[1] Over-seven-day incapacitation of a worker. Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury.



	Hit by Falling Object	Hit by object being pushed	MH - Load	MH - Patient	Physical Assault	Pushing/ pulling	Release or escape of biological agents - Needlestick	STF	Strain/ Sprain	Struck by object
7 Days		1	4	2	2	1		6	2	1
7 Days - altered duties								1		
Burns greater than 10%								1		
Dangerous Occurrence							1			
Disease - Tendonitis			2							
Fracture	1							1		

Employer and Public Liability Claims

During the period April 2022 to March 2023 the Trust received a total of 13 Employer & Public Liability Claims. This has almost halved compared with the previous period April 2021 to March 2022 where the Trust received a total of 22 Employer & Public Liability Claims.

Incident Category	Claims Received April 2020 / March 2021	Claims Received April 2021 / March 2022	Claims Received April 2022 / March 2023
Manual Handling Patient	1	2	2
Manual Handling Load	2	3	1
Slips Trips & Falls	3	3	5
Physical Assault	2	3	1
Body Part Impacting with Object	2	5	1
Burn / Scald	0	1	0
Needle Stick Injury	1	2	3
Operative Procedures	0	1	0
Work Related Stress	1	1	0
Covid 19 Exposure	0	1	0
Total	12	22	13

The Total amount paid out in Claims for the period April 2021 to March 2022 was: **£569,508.33**

The Total amount paid out in Claims for the period April 2022 to March 2023 was: **£167,842.30**

Incident Category	Claims Settled – Paid Out April 2020 / March 2021	Claims Settled - Paid Out * April 2021 / March 2022	Claims Settled - Paid Out April 2022 / March 2023

Manual Handling Patient	£19,699.50	£394,827.44	£14,112.00
Manual Handling Load	£8,485.25	£89,075.39	£8,674.00
Slips, Trips & Falls	£25,992.50	£37,231.00	£21,546.00
Physical Assault	£0	£0	£44,035.90
Body Part Impacting with Object	£12,893.00	£40,998.50	£29,436.00
Burn / Scald	£0	£0	£1,925.00
Needle Stick Injury	£5,058.00	£7,376.00	£10,329.00
Operative Procedures	£0	£0	£0
Work Related Stress	£0	£0	£37,784.40
Covid 19 Exposure	£0	£0	£0

NOTE: *Please note however that this is not the Total amount that the Trust has paid out in Employer & Public Liability Claims.

Employer Liability Claims have an excess of £10,00.00 and Public Liability Claims have an excess of £3,000.00.

On investigation it is found that most Claims are successful due to the following contributing factors:

- Shortage of Staff
- Inadequate / out-of-date training
- Lack of Risk Assessments/ failure to share assessments with Staff
- Needle Sticks / Sharps inappropriately disposed.
- Lack of/ unavailable appropriate work equipment

These areas of learning will inform improvement work activity in the year ahead.

National Patient Safety Alerts

All Health and Safety related alerts issued during 2022/23 were responded to within timescale.

Reference	Alert Title	Originated By	Issue Date	Status	Response
CHT/2023/002	Management of National Patient Safety Alerts	CAS Helpdesk Team	22-Mar-23	Issued	Action Completed
CHT/2023/001	NHS England Estates and Facilities alerts and safety messages	CAS Helpdesk Team	20-Feb-23	Issued	Response Not Required
NatPSA/2023/001/NHSPS	Use of oxygen cylinders where patients do not have access to medical gas pipeline systems	National Patient Safety Alert - NHS England & NHS Improvement	10-Jan-23	Issued	Assessed - not relevant to organisation's services
NatPSA/2022/005/UKHSA	Contamination of hygiene products with Pseudomonas aeruginosa	National Patient Safety Alert - UKHSA	24-Jun-22	Issued	Assessed - not relevant to organisation's services

CHT/2022/002	Changes to alert responses	CAS Helpdesk Team	10-May-22	Issued	Response Not Required

4.4 ACT - Review Performance

On review of overall performance, a huge amount of work has taken place to improve and maintain the Trusts health and safety management system.

Policy development and review has continued throughout the financial year with only two *shared* policies outstanding a review. The Driving at Work and Asbestos policies are currently in the review process supported by our Estates and Facilities colleagues and will be ratified in quarter 3 of the current financial year.

Health and Safety mandatory Training compliance has improved in some subject-matter areas with conflict resolution and Load Handling training ending the year above the 90% Trust target. Fire Safety and Health and Safety training compliance ended the year just under target at 84% and 85% (to nearest denominator) respectively. Patient handling and Local Fire Arrangements ended the year below expected compliance levels. In terms of non-mandated training, the Health and Safety Team have returned to almost pre-pandemic training provision with the exception of Inanimate Load Handling for Assessors targeted at staff who handle non-patient loads and Health and Safety Co-ordinator Training state when will restart. Inanimate Load Handling for Assessors is due to recommence in September 2023. The Health and Safety for Managers training is now mandatory for WHT managers. The course has evaluated well with excellent comments from attendees and increasing attendance. Health and Safety Co-ordinator Training will be reviewed in lightof a requirement to increase divisional safety representation and alignment of practice on both RWT and WHT sites.

The **Managers Health and Safety Toolkit – Self audit summary** compliance has improved significantly when compared to previous reports. We have seen a significant shift in engagement over the last year specifically from our Community, Medicine & Long-term Conditions and Women's, Childrens and Clinical Support Service divisions. Over the next 12-months there will be a focus to ensure all relevant departments are showing activity in this area, specifically corporate services and that overall compliance can be reflected as a percentage.

Analysis of self-audit returns followed by face-to-face (Health and Safety led) audit will commence in Quarter 3 of the current financial year.

5. Specialist Advisors and Specialist Group - Safety Activity and Performance

Fit Testing Activity

Fit Testing Support from Ashfield

From April-22 to March-23 the fit testing team supported 3957 colleagues with face fit tests. Ashfields resilient approach allowed them to supply quantitative and qualitative testers meaning that we could cater for everyone such as the increase of users losing their taste and smell due to COVID-19, a test that didn't rely on the user's ability to taste the BITREX solution, could be offered. Ashfields flexibility also allowed the Trust to offer services to both acute and community teams where bespoke sessions were organised in the community while also continuing with our static bookings approach in the Acute side.

	Attendance
Qualitative Test (Taste)	3338
Quantitative Test (Particles)	404
Tests not completed	215

Independent External Assurance

The Department of Health and Social Care (DHSC) worked closely with Ashfield capturing data on the 28 Regional, and 100+ National Trusts that Ashfield Supplied Testers to. Walsall Healthcare NHS Trust were one of the top performing Trust in the Midlands throughout the contract and even on occasion competed with much larger NHS organisations in terms of staff volumes and fit tests completed; The data did not include tests undertaken by in-house testers it was purely to monitoring Ashfield testing performance.

Fit Test Completed	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Midlands Performance	6th	3rd	3rd	1st
National Performance	No Data	No Data	3rd	3rd

The support from Ashfield was withdrawn in March 2023. significantly reducing testing capacity by two thirds.

Over the coming months, the Trust will need to agree a resilient in-house mode of testing programme which continues to function to meet the needs of the organisation including NHSei resilience principles. Our priority currently is to serve the needs of new-starters, students, locum, bank, agency staff and substantive staff whose competence has expired; on a minimum of two types of respirators. An options appraisal paper has been presented at the Health and Safety Committee detailing the pros and cons of viable modes of fit-testing delivery. A decision on this is being taken by the Executive Team.

Manual Handling and Ergonomics Activity

Summary of and achievement against planned activity/ objectives for the last financial year;

- Raised expectations and shared understanding of patient safety, embedding human factors and ergonomics into all training materials with the aim of our colleagues providing safe high-quality care across all services
- Successful introduction of a pilot people moving and handling risk assessment.
- Implementation of a moving and handling return to work risk assessment for managers documentation.
- Introduction of a new role, Ergonomics Assistant with the aim to further explore musculoskeletal health needs of colleagues using a HSE body mapping tool in a risk reduction exercise, raising awareness of the importance of incident reporting and identifying trends that require further investigation
- Presented three practical workshops at National Back Exchange people handling conference and an article published with findings. The team have been invited to present again this year due to feedback from delegates.
- Use of BI data to prioritise targeted support to colleagues' groups with high musculoskeletal injuries

Ongoing work where there are gaps in overall assurance, or objectives not completed within the time frame:

- Currently not able to identify work related absence relating to MSK injuries at work due to inconsistency of managers completion of the home/work related absence field
- An FOI raised an issue with manual handling people related injuries. During a cleanse of the data there were 203 incorrect entries for injured handling patient. To consult with governance team regarding a possible training programme for managers.

Risk issues which arose within the reporting period:,

- Training KPI not met and stands at 72%
- Current training room holds a maximum of 10 learners and as such induction spaces are oversubscribed with possible interruptions to work force plans/recruitment processes.

Summary of priorities for this new financial year 2023/24

Project to reduce work related sickness absence relating to MSK Injuries by ensuring there is a package in place to facilitate return to work.

Key area of focus are:

- review current processes to ensure managers are identifying sickness absence as work/home related. Further consultation with national ESR team to negotiate the home/work related field in absence reporting made mandatory.
- ensure managers are completing the necessary referral ton Occupational Health and Wellbeing (OHWB) and reporting an incident.
- review current processes to ensure Managers are identifying sickness absence as work/home related in ESR system.
- ensure managers are completing an occupational health referral for these absences so appropriate intervention can be provided.
- ensure managers are reporting the incident in the reporting system so appropriate intervention can be provided.
- update sickness absence policy/process/procedure

Renewing an in house IOSH accredited train the trainer 4-day programme for people handlers. The aim is to increase the numbers of IOSH keyworkers.

Team objectives to continue to feed into the NHS Health and Wellbeing framework.

Understand the musculoskeletal health needs of our colleagues recognising that musculoskeletal health is important to the workplace and employees. Encourage colleagues to think about solutions to the problems they report and provide proactive interventions that empower colleagues to manage their own health and wellbeing, including:

- mental and emotional wellbeing
- physical wellbeing
- healthy lifestyle

To further explore musculoskeletal health needs using the HSE Body mapping tool in a risk reduction exercise, raising awareness of the importance of incident reporting and identifying trends that require further investigation.

Prioritise targeted support to colleagues' groups with high musculoskeletal injuries.

Occupational Health and Wellbeing Activity

The Occupational Health & Wellbeing (OHWB) Service aims to improve and maintain the health, safety and wellbeing of Walsall Healthcare NHS Trust employees; guided by the objectives and values of the organisation. Staff Health and Wellbeing are integral to improving performance and reducing sickness absence within the Trust. The OHWB service offers a confidential and independent service that is available to all staff. Despite challenges, the following activities were delivered this past year:

Key OHWB Interventions

- Provision of various clinics delivering the following to prospective and existing staff: new starter screening assessments/clearances, staff vaccinations, health surveillance, self-referrals (mental health, physiotherapy, skin/face mask problems, sharps/splash injuries, infection control matters, night worker assessments, hand hygiene/skin awareness, etc.) and supporting sickness absence management referrals
- Providing case management advice to line managers and Human Resources to help maintain healthy workforce, providing advice regarding adjustments for individual staff in support of the Attendance Policy
- Work in partnership with Human Resources to encourage management use of Trust stress checklist in line with the Stress Policy (pending update)
- Work in partnership with Infection Prevention Control (IPC) and UK Health Service Agency (UKHSA) to reduce cross infection risks to staff, i.e., outbreak management/contact tracing, public health directives, etc.
- Collect, monitor and distribute monthly staff sharps/splash contamination data for IPC and H&S Committees
- Collaborative partnership work with Black Country Partners to align OHS new starter policies and procedures

Stress/Mental Health Interventions

- Appointment of new OH in-house Counsellor in February 2023, to enhance delivery of tailored counselling interventions; specifically for staff who are experiencing acute and significant mental health problems.
- Provision of EAP 24-hour telephone helpline and face to face counselling service to proactively support staff who are experiencing mainly personal problems, to support staff to remain healthy at work.

- When warranted, encourage managerial use of Trust stress risk assessment tool in line with Prevention and Management of Stress Policy (currently being updated) and Attendance Policy
- Provision of urgent counselling and bespoke team bereavement counselling to support mental wellbeing of staff following critical situations in the work environment, such as sudden colleague bereavements, etc.
- Provision of bespoke Team Stress Management sessions for Teams where stress concerns have been raised.

Physiotherapy Musculoskeletal Interventions

- Designated in-house Occupational Health MSK Physiotherapy service for fast-track referrals, management referrals and functional assessments.
- Early intervention physiotherapy to aid individual recovery from acute musculoskeletal problems/conditions with emphasis to help employees remain fit for work.
- Proactive intervention to assist employees with chronic underlying musculoskeletal conditions.

Improvements/Innovations

- Achieved Safe Effective Quality Occupational Health Service accreditation in August 2022
- Upgrade of bespoke Occupational Health Cohort confidential database in October 2022; with further upgrade to a new Cority system planned 2023/2024 – to interface with ESR system, provide managers/Human Resources direct access to system.
- OHS Cohort database now has facility to improve delivery of staff appointment notifications through mobile telephone text messages/reminders effective May 2023
- Where possible, the OHS continues to expedite staff GP referrals to Walsall Hospital for investigations and Specialist consultations.
- Where possible, the OHS continues to expedite staff skin referrals to Walsall Hospital Dermatology Service

Challenges

- Delivery of quality improvements with reduced staff capacity
- Maintaining KPIs with robust weekly monitoring of appointments, adjusting clinic capacity as required to meet demands of service.
- Awaiting installation of new OH Cority database system, due during 2023/2024 financial year

Summary

Staff Health and Wellbeing are integral to improving performance within the Trust. A robust evidence-based employee health and wellbeing service is key to helping employees to maintain good health and productivity at work. Integral to this are work-based interventions and innovations to help maintain staff safety, prevent and reduce sickness absence levels within the organisation.

Fire Safety Group

The Fire Safety Team of Royal Wolverhampton NHS Trust has been working in partnership with Walsall Healthcare NHS Trust (WHT) formally since 1st May 2022. During that time, the team have conducted a gap analysis against the requirements of the Regulatory Reform (Fire Safety) Order 2005 (FSO), the primary fire safety legislation in England for non-domestic buildings, and the recommendations of the HTM

05 Series suite of documents, issued by the Department of Health which sets out the recommendations and provides guidance for the management of fire safety in healthcare buildings. Key insights are summarised below:

- Fire Safety Training compliance is below an acceptable standard and has been consistently low over the reporting period, averaging 85.5% throughout the year.

- The Trust have a good record of low unwanted fire signals (UWFS), with only 55 occurrences during this reporting period, which is considerably lower than other NHS providers in the Midlands.

- In September 2022, the compliance figure for in-date FRAs was 3%, at the end of March 2023, this figure had increased to 6.1%. Encouragingly, this figure has increased to 15.3% by the end of April 2023.

- RWT has invested in the development of a piece of software for carrying out fire risk assessments and inspections, my intention is to role this out to WHT – this will be further explained in Section 5.

- Following the retirement of WHT Fire Safety Advisor, we are currently out to advert to ensure we can deliver the fire safety programme of work in 2023-24.

- Periodically, WMFS will undertake Fire Safety Audits, in line with the National Fire Chief Council's guidance. WHT have not received any external audit/inspections since before the COVID-19 pandemic and have not been served any notices under the Regulatory Reform (Fire Safety) Order 2005.

- Following a recent meeting with WMFS Hospital Liaison Officer, we are now aware that the Walsall Manor Hospital will be on notice for audit in the summer of 2023. I will keep the Trust updated against this via the Trust Fire Safety Group.

Radiation Safety Group

Annual summary of activity for 2022/23:

Staff Dose Monitoring

Results were obtained for a total of 208 staff members at the Trust. Results were also obtained for 23 finger and 10 eye dosimeters. Doses received by staff are well below levels at which classification should be considered by the Trust due to routine work. Concerns remain due to the number of zero readings for eye and finger dosimeters and several late returns. The Trust is reminded that management of aspects around staff dosimetry is essential for safety and compliance. Nuclear medicine staff have now been classified as per recommendation from last RSG.

Patient Dosimetry

Patient dosimetry has now been completed for CT, Nuclear medicine, and Mammography. The mammography dose survey was undertaken by Physics using their established remote connection to Dose watch and the CT dose survey undertaken by the CT dose optimisation team. Nuclear medicine patient dosimetry audit has been recently undertaken. Patient dosimetry remains out of date for plain radiology and Fluoroscopy. Work is ongoing to establish Dose watch in plain radiology and Fluoroscopy.

Regulatory Compliance
A radon risk assessment needs to be carried out and the Trust must ensure that records of a radon risk assessment are carried out. It was identified during recent commissioning that the X ray radiation risk assessments, except for CT, were not being kept up to date. It is a requirement under IRR17 to risk assess activities involving ionising radiation and there are specific aspects that must be included in the assessment. Improvements in document control is recommended. An exercise was carried out to assess radiation compliance across all Trusts where we provide a physics service. This involved listing areas of concern across the three Trusts and scoring on a RAG rating each Trust against these.

Incidents
There were 17 radiation incidents reported to Radiation Safety Services in 22/23 involving X-ray medical exposures, 3 of these incidents have been externally reportable to the CQC. Incident trends found are mainly in relation to Plain Film with incorrect body parts or sides being x-rayed due to operator and supervision errors. There are also inappropriate referrals that were carried out and CT scanning errors. Key trends are Referral issues, Individual errors (Side and Site), Non-adherence to policy. Education is continuing with radiology staff.

Equipment Quality Assurance
During the 22/23 a total of 47 routine surveys were undertaken by Radiation Safety Services. Of these, 34 surveys required action to be taken. This is a high proportion, often as a result of aging equipment.
Of the 47 surveys, 40 were undertaken within the required timeframe (usually 13 months). Commissioning of new equipment has been carried out for;

- DTC Canon fluoroscopy + Over couch,
- new detector mobile 13,
- x2 Agfa x-ray rooms,
- x1 Fuji digital x-ray rooms
- 2 mobile c-arms and
- 1 Agfa Ge mobile

Recommendation 1:
The effectiveness of the staff dosimetry program must be kept under close review including:

- Radiation risk assessment should be kept under regular review and should identify (by anticipated dose rates) which staff groups should be monitored.
- The Trust should ensure that staff wear their dosimeters. The wearing of dosimeters should be included in audit programs.
- Any delay in return should be investigated to prevent reoccurrence.
- The dosimetry results reports should be reviewed when received and action and investigation levels used to ensure staff doses are as low as reasonably practicable.

Recommendation 2:
Records of the radon risk assessment must be kept at the Trust and contain a suitable review date. It is recommended that the Trust ensure that their policy for radiation safety clearly identifies responsibilities around radon.

Recommendation 3:
Radiation risk assessment (and other radiation safety documentation such as local rules and IRMER procedures) must be kept up to date by regular review. To facilitate this a document control system should be used.

Recommendation 4:
The Trust must complete the setup of the Dose Watch system to enable effective patient dosimetry and dose optimisation, required by IR(ME)R. The setup should be completed across modalities and a system established to ensure its effective use going forwards.

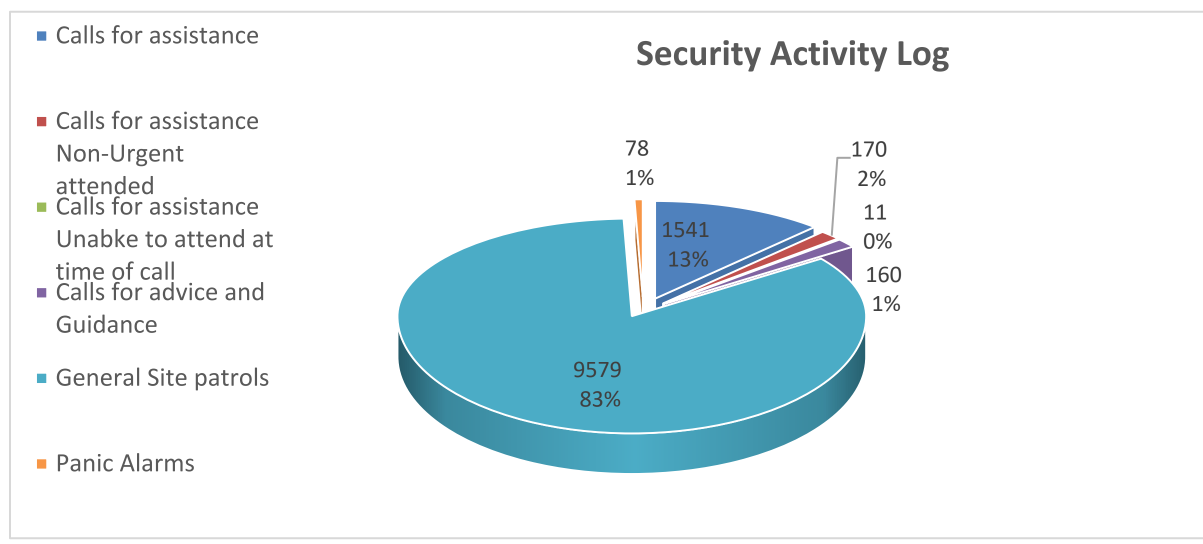
Recommendation 5:
The Trust should set up Image Optimisation Teams within each modality. These teams should include a Radiologist, Radiographer and Physicist. The Department of Health recommend that these multidisciplinary groups meet regularly to support dose optimisation.

Recommendation 6:
The Trust should ensure that they have an effective equipment replacement program in place. The CQC have stated that un-optimised patient doses cannot be justified by continuing use of equipment that is old.

Local Security Management Specialist Activity

During the year we have been working with the Security provider (APCOA) on a daily occurrence to deliver security and car parking to the Trust.
We have introduced a new security reporting log for the duties of the team so that we can capture a reflection of the work that the team complete alongside the violence and aggression statistics we see from safeguarding. This continues to be work in progress, although we haven't been able to capture a full years' worth of data, a summary of information gathered is demonstrated below in the charts.

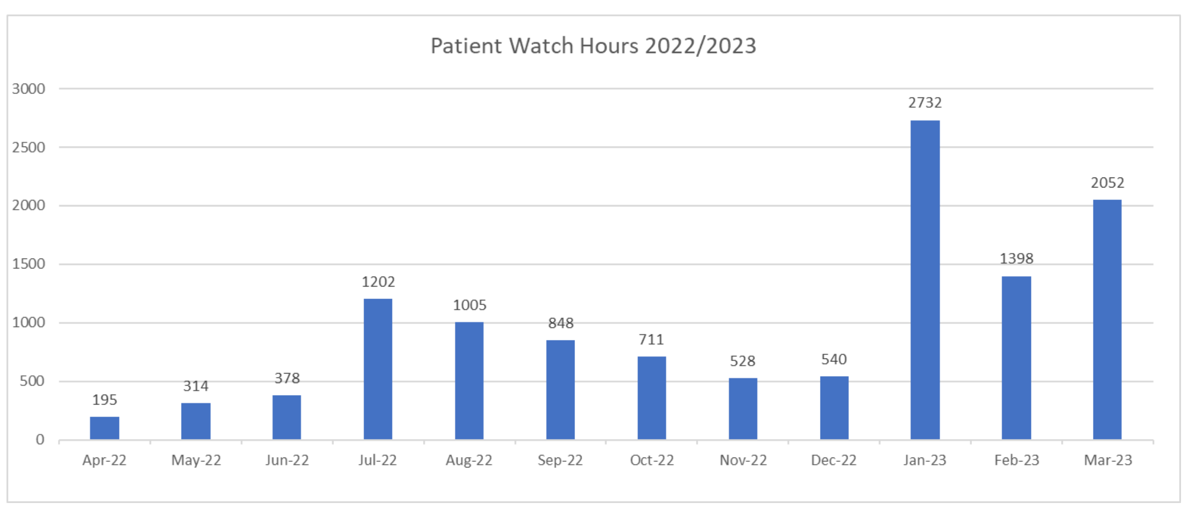
Event	Total
Calls for assistance	1541
Calls for assistance Non-Urgent attended	170
Calls for assistance Unabke to attend at time of call	11
Calls for advice and Guidance	160
General Site patrols	9579
Panic Alarms	78



The security team have also been working with divisions to help understand the requirement of additional security at times. During the year we have analysed how this service was used and where it was being overused which was having financial impact on the Trust.

Working with the heads of service we have been able to implement a new procedure for the booking of additional security which has seen the hours-used reducing rapidly, during this time we have also done more on the wards to assist the staff by increasing patrols, hourly checks and leaving radio communications on some wards should they need a quick response from the team.

Please see the chart below for the patient watch hours.



Water Safety Group - Awaiting Report

Within the last 12 months the Water Safety Group has focused on the following objectives:

L8Guard.

In August 2023 we completed the rollout of l8guard to the whole site and to the community properties under our control this replaces the trusts current paper-based systems such as logbooks, L8guard provides an initiative-taking instant audit trail helping to ensure ACOP L8, HTM 04-01 and HSG 274 compliance.

Version 3 of the software is due out soon and will be tested by the Estates Department before rollout to the whole trust.

Water in General.

Currently, we are continuing to work with Skanska to make sure all water issues are actioned correctly and efficiently.
We are also looking at all our current water assets and making sure that the technology we have on site is being used to its maximum capacity.
Reports on problem areas are being written and will be forwarded to all the relevant managers to advise on what action the trust needs to take.
In April Skanska changed their water contractor to HSL. This has seen an improvement in the quality of the remedial works taking place. They have also put into practice checking the work that HSL have done to make sure it is compliant.
As of August 2023, the Water Management Group will be chaired by a clinician; this will either be the Infection Control Doctor (Dr Aiden Plant) or the Head of Infection Prevention and Control (Amy Bowden) as deputy Chair. Administrative support is currently provided by the executive offices.

The trust Estates department is currently undertaking a case study with Rada about the new IQ TAPS in NNU. This will allow the trust to see what impact they have had in reducing the possibility of waterborne pathogens going into the area. We are aiming to have this completed by August 2024 with a board paper going to the Trust Management Board with the findings and recommendations by November 2024.

When Skanska have been doing their water hydrant checks they have found that someone has been entering the site and putting data loggers on to one of the hydrants. This has happened twice. We have contracted our water provider and the fire service, and they do not have any knowledge of this.
These data loggers have been removed and are currently stored in the Estate's office awaiting some to request then back.

Augmented Care Areas

The group have reviewed the current areas and found that areas that should be classed as Augmented Care Areas were not. After a full group discussion and a piece, a work from the director and deputy director of nursing and director of IPC a new list was drawn up and approved by the group. Currently this is to be reviewed at the next Water Management group to check that the trust is covering everything that needs to be tested.

Testing regimes

Earlier on in the year it was brought up that we need to check what our water testing regime was. This was gone through in the group and with our microbiologist to make sure we are testing to the correct level. This piece of work was undertaken before it was highlighted that we needed to add more areas as Augmented care Areas.
Currently this is to be reviewed at the next Water Management group to check that the trust is covering everything that needs to be tested.

Water Risk Assessments.

The group have been reviewing the progress of the remedial works which was highlighted on the current water risk assessment. They have also asked all the relevant questions

appertaining to the system of monitoring the work undertaken by the contractors in completing this work.
As the Estates Department have only just had the finance approved to undertake the remedial works coming out the back of the last Water risk assessment, this has delayed some of the actions taking place but a tracker is being set up so we know exactly what is being done and when it is being done.
This will be shared with the WMG as soon as practically possible.

Isolations and routine maintenance.

Any water isolations (for whatever reason unless in an emergency) have been brought before the group for their authorisation for it to take place. Any existing 28a jobs concerning water have also been brought to the group for information and approval if required.
Skanska, our PFI partners also produce a report which shows where they are with the routine maintenance and PPM'S

Water testing and Results.

Each month Skanska present information to the group about what outlets have been tested and the results of these. If we have any failure these are acted on straight away by Skanska and key members of the group are informed of this. A full report is then brought up at the next Water Management Group.

Medical Gases Group

The Medical Gases Group meets on a quarterly basis and is chaired by the Director of Pharmacy. During the last 12-months the group have focussed on the following key issues:

Decommissioning of Nitrous Oxide manifold in main theatres
On the 8th of December 2021 NHS England and NHS Improvement released version 1.3 Reducing Environmental Emissions from Piped Nitrous Oxide Products guidance document which outlines what each trust should do to reduce their usage of Nitrous oxide and Entonox. Subsequently following discussions, the Trust have approved the decommissioning of the nitrous oxide manifold in west wing and be replaced with nitrous oxide cylinders. All outlets are to be blanked off and manifold isolated from the pipework. An SOP has been written & submitted to the Medicines Management Group. For added security estates have implemented a bar code tracking system provided by our gas supplier Air Liquide, allowing full audit trail of bottled gases and identification of location. Currently estates are finalising usage figures and have provided assurance on a robust process for delivery & storage.

In-Health and MRI Contract
The Authorised Engineers report submitted in March 2022 highlighted an issue for resolution around the demarcation of the MRI facility for piped gases between 'In Health' and 'Skanska'. This was a contractual issue which has now been agreed. Skanska will be responsible for the piped system outside of the area. In-Health will be responsible for carrying out routine checks inside of Theatre however any remedial work or checks will be contracted back to Skanska from In-Health. Clear operational & financial responsibilities now in place.

Exposure to workplace exposure monitoring for Entonox

The group have received assurances around remedial actions underway which will continue to feed into the Medical Gas Group. Amongst these include reviewing the environment & ventilation systems, consideration of devices that can be used to promote dissipation of the gases and training & awareness of other mitigations to reduce nitrous oxide in the air. All mitigations have been entered onto the risk register.

During the last 12-months the group have also had assurances on the following:

- The group-maintained oversight of planned refurbishment works alongside opening of new UECC centre in early 2023 and any subsequent risks and/or remedial actions required concerning medical gases.
- Both the ToR and Medical Gas Policy have been reviewed and have undergone the Trust ratification process.
- Annual Authorising Engineer Report: No serious issues raised. Piped medical gas systems are being managed in accordance with the HGM.
- Oxygen prescribing audit completed in October & November 2022 – audit findings & recommendation disseminated across all Divisions.

Annual Report Conclusion:

The health, safety and security of everyone who may be affected by Walsall Healthcare NHS Trust's activities including staff, patients, visitors and carers is of paramount importance to us all. The Chief Executive Officer and Board are committed to providing and maintaining a safe and healthy working environment providing and maintaining safe plant and equipment and ensuring safe manual handling practices as well as safe use of hazardous substances so far as is reasonably practicable.

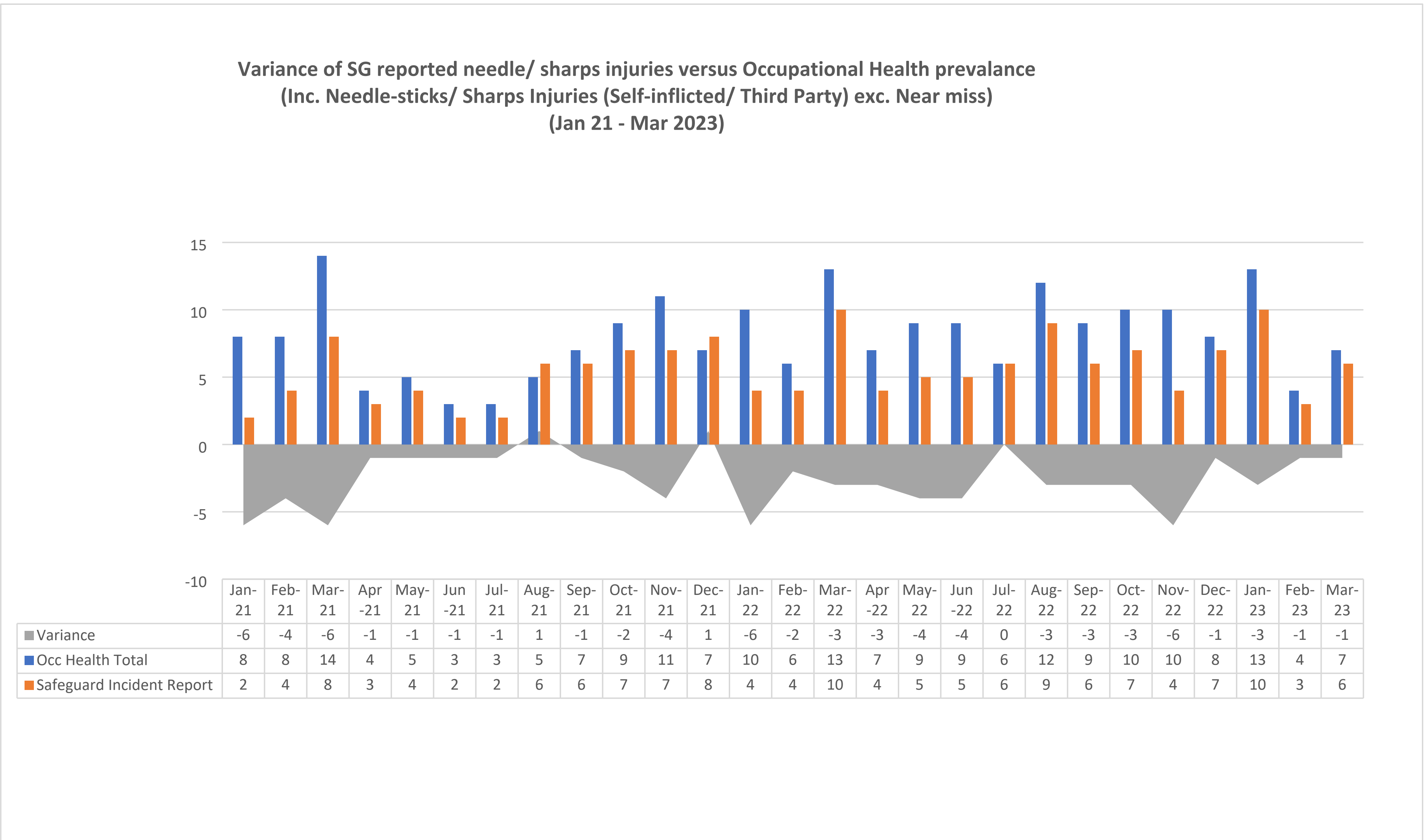
The Trust will strive for continual improvement in all aspects of safety risk management and aim to prevent accidents and cases of work-related ill health whilst recognising its requirements to comply with all relevant health & safety legislation as a minimum requirement. In pursuing these aims, Trust employees are empowered to take all reasonable steps to ensure the highest standards of health, safety and welfare for staff, patients, visitors and any other persons that may be affected by the Trust's activities.

Safety priorities will be driven from the outcome of performance against previous health and safety objectives, new and emerging risks, national steer from regulators and local proactive and reactive activity intelligence.

A review of Existing Health and Safety Priorities and New Objectives for 2023/24 are detailed in **Appendix 3.**

Appendix 1: Incident by Causation 2016 - 2023

Appendix 2: Variance in Sharps Injury Reporting OHWB versus Incident Data 2021 - 2023



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	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
Variance	-6	-4	-6	-1	-1	-1	-1	1	-1	-2	-4	1	-6	-2	-3	-3	-4	-4	0	-3	-3	-3	-6	-1	-3	-1	-1
Occ Health Total	8	8	14	4	5	3	3	5	7	9	11	7	10	6	13	7	9	9	6	12	9	10	10	8	13	4	7
Safeguard Incident Report	2	4	8	3	4	2	2	6	6	7	7	8	4	4	10	4	5	5	6	9	6	7	4	7	10	3	6

Appendix 3: Review of Existing Health and Safety Priorities and New Objectives for 2023/24

2022/23 Objective	Progress at Year End	2023-24 Objectives
Deliver health and safety training for managers and mandated within the Managers Framework. External providers to deliver 3 x virtual IOSH for Directors and Executives with non-clinical designations being prioritised in the first cohorts.	15 sessions of the H&S for managers training were delivered during 2022/23. The training is now role-specific, meaning all staff with line-management responsibility will be required to attend (essentially locally mandated). IOSH for Executives was arranged to be delivered in autumn but due to winter pressures a decision was taken to deliver in the new financial year. 2 sessions were delivered to 20 candidates in June 2023	Monitor training attendance compliance through 'My Academy' and report through divisional and care group meetings highlighting areas of positive and negative compliance. Promote training through communication materials. Assess the viability of providing community-specific training sessions at locations outside of the acute hospital. Collate IOSH 'commitments' to develop and drive executive and directorship health and safety objectives organisationally and locally within specific divisions/ directorates.
Risk assessment/ management training to be delivered to staff through the Risk Management Policy Training Needs Analysis (TNA).	H&S Risk assessment training has been re-established and is being delivered face-to-face. Sessions are planned for the next financial year. Trust-wide risk management training has been delivered on an ad hoc basis over the last 12-months, whilst formal training has been developed.	Trust-wide risk management training has been developed and roll-out will commence with agreed priority services over the next 12-months.
Identify a suitable off-the-shelf digital system to monitor the Safety Management System or develop a local solution to enable front end input and rear-end extraction of data.	Datix developers are looking at a digital solution for a H&S compliance module which will replicate the managers H&S toolkit. Priority over the past 12 months has been given to the incident, risk management and legal modules which are due to go live within the 3rd quarter of the current financial year.	Appraise an alternative *interim* locally developed system to support in the collation of proactive and reactive information to support and strengthen the current manual Safety Management System. Work collaboratively with colleagues at RWT, digital services and performance to evaluate capabilities of readily available IT solutions.

Further mature relationships between divisional H&S representatives through development of clear KPI's for monitoring through performance review.	Work was undertaken in quarter 4 to develop H&S dashboards for each of the clinical divisions with KPI's detailed for each H&S topic. These went live as of April 2023. This is a new initiative and continues to develop to meet the needs of the divisions.	Continue to provide H&S dashboard data including KPI's to divisional governance meetings inclusive of metrics at care-group level. Attend care-groups to deliver key performance message and expectation.
Introduce director health and safety 'walkabouts' to highlight and address safety matters locally.	Divisional representative attendance at health and safety committee is positive. Further work is required to establish a robust H&S representative network across the trust and to develop training and role support for staff to undertake these responsibilities.	Review Health and Safety 'Co-ordinator' training against RWT Health and Safety Representative training with consideration to aligning where appropriate. Review role of the Health and Safety Co-ordinator against RWT Health and Safety Representative role with consideration to aligning where appropriate. Establish a quarterly network forum to bring health and safety co-ordinators together to provide two-way support and drive priorities.
Establish 'toolkit-talks' and Estates and Facilities and H&S 'walkabouts'.	Whilst we continue to work closely with our divisional directors, estates colleagues and beyond, more formal walkabouts have not yet been arranged. Now that Executive directors and estates directors have attended IOSH training, more formal commitments have been planned in terms of prioritising this objective for the forthcoming year.	Collate executive and directorship IOSH 'commitments' and align these to corporate objectives.
Review representation from corporate teams at H&S Committee to ensure there is adequate representation and consultation across the whole Trust.	Attendance at H&S committee is very good. The Terms of Reference has been reviewed and approved and there are members from clinical divisions and corporate colleagues present. The committee held all 4 scheduled meetings in the past 12 months.	Provide access to H&S Committee minutes via the Health and Safety resources page and share link via the health and safety newsletter.
All moderate and RIDDOR reportable incidents will be subject to an investigation utilising 'concise' documentation form the incident reporting policy.	All RIDDOR and moderate harm incidents are reviewed and investigated by the health and safety team and managers supported with these investigations. A RIDDOR investigation template has been developed to support comprehensive investigations. The sharps investigation tool has been implemented in the current financial year to aid gathering of factual and necessary information. Further work is required to	Embed a consistent approach to investigation of health and safety incidents through utilisation of adapted investigation tools. Establish a process for disseminating key learning outcomes within divisional and directorate teams; ***and*** health and safety committee

Utilise divisional safety huddles to escalate incidents requiring divisional review and investigation.	ensure all incidents are suitably investigated by managers, in proportion to harm caused, to elicit necessary learning to prevent reoccurrence.	
Develop and implement a face-to-face audit plan for 2022/23 and 2023/24. *****Capacity to deliver the full programme is co-dependent on H&S Team establishment and recruitment to 1 x WTE	A sharps audit was undertaken all hospital areas during quarter 3 (22/23). 38 wards/ departments were audited identifying: • Lack of awareness of relevant policies • Inconsistent advice from displayed posters • Poor medical compliance in terms of taking mobile sharps containers to the point of care. • No available/ lack of awareness of completed risk assessments. Following on from the audits the H&S Team developed new visual aids which were laminated and taken to every acute clinical area and disseminated to community colleagues. A sharps training slide-deck was reviewed and updated for use in practical training sessions such as phlebotomy. A communications plan was assembled and cascaded through the WHT staff intranet page advising staff of safety precautions and preventative measures in relation to safe sharps management. Sharps risk assessments were scrutinised and returned to assessors with comments and recommended actions including the need to share widely with the relevant team. The now superseded policy was also reviewed and updated to include post-injury advice from British Association for Sexual Health and HIV (BASHH)	Embed a programme of face-to-face health and safety audit aligned to the managers health and safety toolkit. Establish a process for disseminating key learning outcomes from audit, within divisional and directorate teams, ***and*** health and safety committee. Collaborate with key stakeholders to elicit thematic intelligence from audits undertaken outside of the health and safety team (i.e. IP&C, Occupational Health and Wellbeing, Tendable).
A strategy/policy document for management of perpetrated violence and aggression needs to be developed, agreed and implemented to ensure all staff understand their role in mitigating and managing the output of incidents to ensure all staff feel safe when working in both acute and community.	The security team have implemented a new security policy which contains arrangements for lone working & violence and aggression (including Zero Tolerance). This covers both the acute and community. Further work is required to implement this policy and gather assurance that key responsibilities are being met to safely manage and reduce these types of incidents.	Interrogate the suitability of violence and aggression safety management system specifically; • Policy (arrangements) • V&A/ Lone working/ Stress risk assessments and Safe Systems of Work • Support mechanisms • Training (competency, content and compliance) • Monitoring and audit.

<table>
<tr><td>Incident reporting has increased; we need to understand whether the Trust is an outlier in terms of its incident reporting, types of incidents per populous and also external reporting to the HSE.</td><td>We know there is a level of under reporting of incidents from sharps data that does not match that of Occupational health attendance and some RIDDORs relating to > 7-day absence where staff have been off sick as a result of an injury but have not reported this. Some crude benchmarking has been undertaken in relation to overall reporting and specifically relating to sharps, neither showed WHT as an outlier but more focused scientific benchmarking is required.</td><td>Collaborate with Black Country Colleagues to undertake targeted benchmarking on specific health and safety topics to determine performance.</td></tr>
<tr><th>Emerging Risks</th><th colspan="2">Objective 2023/24</th></tr>
<tr><td>Load/ manual handling incidents resulting in musculoskeletal injury and lost time from work continue to feature as themes from incident reporting, RIDDOR and claims data.

Following the Covid-19 pandemic, we have a large percentage of staff who continue to work from home or have adopted a blended hybrid approach to working. We continue to see an increase in requested DSE interventions.</td><td colspan="2">Interrogate the suitability of safety management system specifically in relation to prevention and management of MSK injuries, through;
• Policy (arrangements)
• Manual handling/ load handling risk assessments, DSE self-assessment and Safe Systems of Work
• Equipment provision and suitability
• Support mechanisms
• Training (competency, content and compliance)
• Monitoring and audit.</td></tr>
<tr><td>Fit Testing and First Aid Training Provision are limited to sole accredited trainers exposing the organisation to a single point of failure should these individuals leave the Trust or require leave for a specific reason.</td><td colspan="2">Establish competency requirement – i.e. who/ what roles require the competency.
Determine baseline numbers – how many staff require the competency and frequency of refresher-training.
Develop option-appraisal based on intelligence gathered.</td></tr>
<tr><td>Parts of the Trust estate and subsequent ventilation systems are old and operating sub-optimally. The Trust has a regulatory responsibility to minimise time weighted exposure to nitrous oxide (Entonox) in healthcare settings.
Work has already commenced with maternity, Estates & Facilities, pharmacy</td><td colspan="2">Interrogate the suitability of safety COSHH management system specifically, through;
• Policy (arrangements)
• COSHH risk assessments Safe Systems of Work
• Equipment
• Environment/ Ventilation
• Support mechanisms
• Training (competency, content and compliance)
• Monitoring and audit.</td></tr>
</table>

and occupational health colleagues to mitigate this risk.	

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Dee Johnson**	**Group Patient Safety Specialist**		
Reviewer				
Authoriser				

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Introduction

This patient safety incident response plan sets out how Walsall Healthcare NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

The Walsall Healthcare NHS Trust is registered with the Care Quality Commission to provide services in the following locations:

- Manor Hospital
- Homer Building
- Holly Bank House
- Goscote Hospice
- Community sites
- GP practices

The services provided include:

- Emergency and Urgent Care
- Surgery
- Maternity
- Diagnostic services
- End of Life care
- Services for children and young people
- Medical care including older people's care
- Critical Care
- Outpatients
- Community Services
- Day case services
- Therapy services
- GP services
- Rehabilitation services
- Pharmacy services

Further information can be found on the Trust's website.

Defining our patient safety incident profile

PSIRF sets the national requirements listed within the plan. The remainder of the plan is data driven, covering the last 3 years which has provided an insight into the key patient safety incident themes, patterns and trends, recurrence and the greatest opportunities for learning to improve patient safety outcomes.

The Trust engaged with key stakeholders using a dedicated profile and planning workstream, having reviewed Trustwide data from various sources to determine the Trust safety profile and identify the optimum methods of review to ensure maximum learning and effective plans to improve the quality and safety of services.

Our analysis included creating a list of the incident or issue types identified for each data source along with safety insights. The top 10 patient safety related themes were identified from each data source and then these were cross-referenced to find commonalities for inclusion as a feature in the plan. The list was agreed to take forward to the planning process.

The patient safety issues were identified through the following sources:

- Incident data 2020-21 to 2022-23
- Key themes from complaints, PALs, claims and inquests
- Key themes from specialist safety and quality groups (e.g., falls, pressure ulcers, Learning from Experience Group)
- Themes from learning from deaths reviews
- Trust and divisional risk registers
- Key themes from FTSU, safeguarding and staff survey
- Key themes from GIRFT
- Key themes from mortality reports
- ICS Quality surveillance reports
- Clinical audit data

Safety issues highlighted by the data

From the original data pull, we were able to identify 14 themes, although some themes were noteworthy in one data source, recurrence was a significant contributor in the consideration. These are shown in the table below:

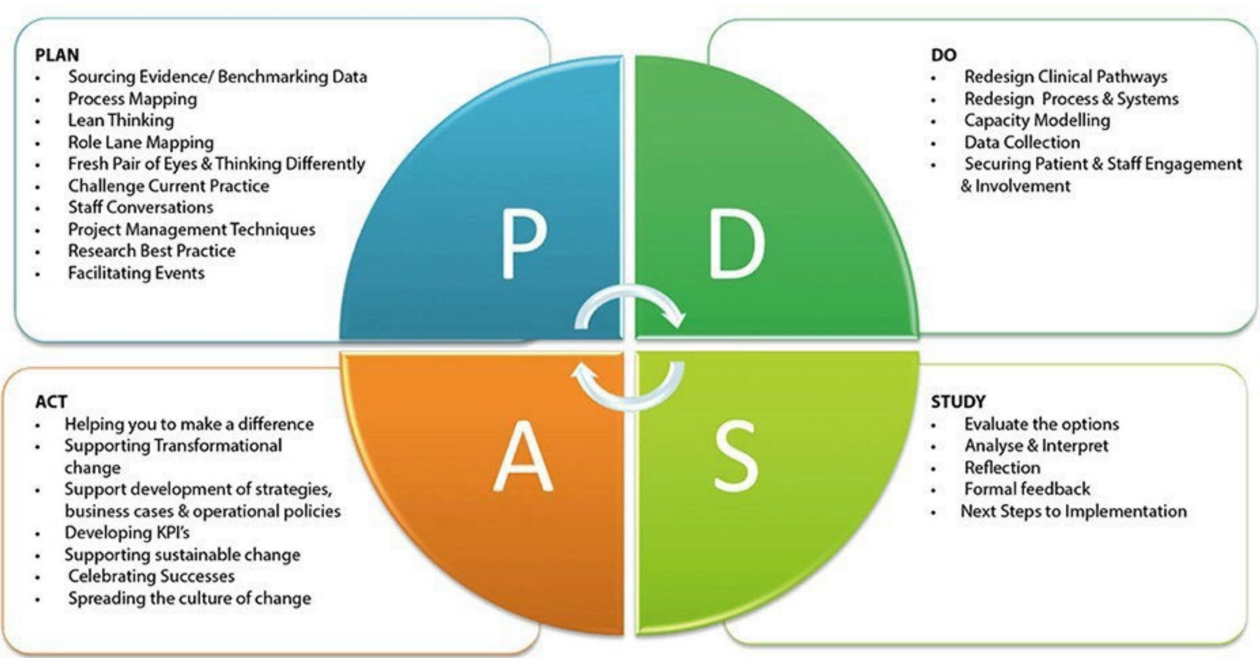
THEME	DELAYS	FALLS	PRESSURE ULCERS	FOLLOW UP OF PATIENTS	BEHAVIOURS
DATA SOURCE	Claims Quality Surveillance SIs Risks	Claims SIs Incidents	Claims Safeguarding SIs Incidents	Claims	Complaints Quality Surveillance Staff survey
THEME	COMMUNICATION - VERBAL/WRITTEN	MEDICATION	ADMISSION/TRANSFER /DISCHARGE	DIAGNOSIS	INFECTION PREVENTION & CONTROL
DATA SOURCE	Complaints Incidents Mortality	Complaints Safeguarding Quality Surveillance Incidents Risks Mortality	Complaints Safeguarding Incidents Mortality	Complaints SIs Risks Mortality	SIs Incidents
THEME	DETERIORATION	MATERNITY	STAFFING	INEQUALITIES	
DATA SOURCE	SIs Risks Mortality	SIs	Incidents Risks	LD (risks) MH crisis (risks) LD (mortality)	

Further details on the features within the themes are considered to identify and hone our overall profile. This leads to the priorities highlighted in local focus section below.

Whilst the list has been developed, we are conscious that it is not fixed. The Trust profile must retain flexibility in its approach to risk and learning, and therefore, where there is significant risk, opportunities for significant new learning and impacts on quality and safety of services, the Trust will retain capacity for additional PSII outside of the Trust profile where required.

Defining our patient safety improvement profile

The Trust has a comprehensive quality improvement programme across the organisation, using the Quality Service Improvement and Redesign (QSIR) methodology. The Plan, Do, Study, Act process forms the basis for our improvement work:



The quality improvement programme has patient safety as a theme of its work. The aim is that the use of QI methodology will help staff on the front line identify methods to deliver a safer service. The principles underlying this are to:

- Learn from accurate data from mortality, governance, benchmarking, complaintsetc.
- Reduce unwarranted variability
- Develop safe reliable systems that support and empower staff to do the right thing, first time and record it correctly

Our improvement priorities are directly informed by our patient safety priorities, identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation.

Future quality improvement priorities will be directly informed by implementation of the PSIRF, providing an opportunity to streamline and prioritise future improvement activity.

Our improvement priorities are supported by a specialist team of improvement practitioners, our Quality Improvement Team who provide support, facilitation and coaching for improvement activity across the Trust as well as providing a range of training/development opportunities to build capacity and capability at all levels of the Trust.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events 2018 criteria	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths thought more likely than not due to problems in care (meeting the learning from deaths criteria)	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths of patients detained under MHA or where MCA applies and are thought more likely than not due to problems in care	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths of a patient with learning disabilities (meeting the LeDeR criteria)	Referred to Learning Disabilities Mortality Review (LeDeR) PSII or other response may be required to support process	Respond to recommendations from referred agency/ organisation as required
Incidents meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required safety actions to feed into patient safety priorities and shared learning
Maternity incidents meeting HSIB criteria	Refer to HSIB for independent patient safety incident investigation	Respond to recommendations as required safety actions to feed into patient safety priorities and shared learning
Child deaths	Referred for Child Death Overview Panel PSII or other response may be required to support process	Respond to recommendations from referred agency/ organisation as required
Safeguarding incidents meeting criteria	Referred to Trust Safeguarding Lead	Respond to recommendations from referred agency/ organisation as required
NHS Screening incidents	Referred to PHE Imms and Screening Quality Assurance for consideration of response	Respond to recommendations from referred agency/ organisation as required

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Delays in patient care	PSII or MDT	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Patient deterioration	PSII or AAR	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Medication	AAR or SWARM	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Diagnostic incidents	PSII or AAR	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Falls	Rapid review Quarterly thematic review	Joint Falls Steering Group
Pressure ulcers	Rapid review Quarterly thematic review	Tissue Viability Steering Group
Infection Prevention and Control	Refer to IPC investigation matrix Quarterly thematic review	Infection Prevention Group

Part A - Document Control

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and Policy version: WHT-OP1008 V1	**Policy Title** Patient Safety Incident Response Policy	**Status:** Final	**Author** Dee Johnson, Group Patient Safety Specialist **Chief Officer Sponsor** Kevin Bostock, Group Director of Assurance
Version / Amendment History	Version	Date	Reason
	1	October 2023	New policy
Intended Recipients: All staff working within Walsall Healthcare NHS Trust			
Consultation Group / Role Titles and Date: n/a			
Name and date of Trust level group where reviewed	Trust Level Committee Reviewed: Keith Wilshere, Group Company Secretary 23/10/2023		
Name and date of final approval committee	Kevin Bostock, Group Director of Assurance 23/10/2024		
Date of Policy issue	25/10/2023		
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	25/10/2026 3 yearly If any legislation / changes in practice occur prior to this review, the policy will be subject to a		

	minor review to ensure compliance with the latest legislation/best practice.
Training and Dissemination: This policy and associated process will be shared via the Trust weekly dose including targeted emails to all staff groups and presentations to staff forums. The policy will also be linked to the Patient Voice dashboard available on the staff intranet. The policy will also be referenced in the Trust Formal Complaint Investigation E-Learning Module (currently being developed) requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with: • Duty of Candour	
Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator	
Monitoring arrangements and Committee	
Document summary/key issues covered. Aspects of patient safety reporting and investigation.	
Key words for intranet searching purposes	
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**No**

WHT-OP1008 V1

PATIENT SAFETY INCIDENT RESPONSE POLICY

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Appendices

Appendix 1: Patient Safety Incident Response Plan. Included as a separate file

TO BE READ BEFORE FOLLOWING THIS POLICY

WHT-OP1008 V1 PATIENT SAFETY INCIDENT RESPONSE POLICY

From 1 November 2023 this policy commences a phase out period, the guidance and principles of the NHS England Serious Incident Framework (2015) were used to write the WHT-OP1008 V1 Patient Safety Incident Response Policy

The National Patient Safety Strategy is introducing new ways of working in relation to patient safety incidents and investigations under the new Patient Safety Incident Response Framework (PSIRF).

The WHT-OP1008 V1 Patient Safety Incident Response Policy will be replaced once these changes are fully implemented by the Trust.

The change from the Serious Incident Framework 2015 to PSIRF *does not* apply to incidents outside the scope of PSIRF (i.e., incidents not involving a patient), including incidents that relate to:

- Professional standards
- Information governance;
- Health and Safety incidents (that do not highlight a significant patient safety concern);
- Digital and IT;
- Financial investigations;
- Estates and facilities;

These will continue to be managed the way they are now.

The transition from the WHT-OP1008 V1 Patient Safety Incident Response Policy will commence on 1 November 2023 and is expected to take 3 - 6 months.

Serious incidents occurring before 1 November 2023 will be investigated and closed under the Serious Incident framework (2015), this will then conclude the period of policy overlap.

In summary

Serious Incidents reported prior to 1 November 2023 will continue to be managed under the serious
incident framework (2015).

Patient safety incidents reported on or after 1 November 2023 will be managed using the PSIRF Policy.

Reference to both policies for processing should be made accordingly.

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Walsall Healthcare NHS Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy is to be read together with the current patient safety incident response plan, which sets out how this policy will be implemented, in conjunction with the Trust's Incident Reporting, Learning and Management Policy (OP917), which sets out how incidents outside of this policy are managed and the Duty of Candour Policy (OP929), which sets out the requirements where harm has been caused as a result of a patient safety incident.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Walsall Healthcare NHS Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

A patient safety response is conducted for the purpose of learning and improvement and there is no remit to apportion blame or determine liability, accountability, causality, preventability, or cause of death in a response under this policy. Where the principle aim of a response differs from this, they are beyond the scope of this policy. This includes, but is not limited to, the following processes:

- Claims handling;
- Human resources investigations into employment concerns;
- Professional standards investigations;
- Information governance concerns;
- Health and Safety incidents (that do not highlight a significant patient safety concern);
- Digital and IT concerns;
- Financial investigations and audits;
- Estates and facilities concerns;
- Safeguarding concerns;
- Coronial inquests and criminal investigations; and,
- Complaints (that do not highlight a significant patient safety concern)

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

Walsall Healthcare NHS Trust promotes a just culture approach (in line with the NHS Just Culture Guide) as part of its approach to learning from patient safety incidents.

There are clear mechanisms in place to enable reporting of patient safety related issues via multiple avenues, including a single incident reporting and management system, Freedom to Speak Up Guardians and processes for staff to raise concerns, and Complaint and PALs services for patients and the public.

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the Incident Reporting, Learning and Management Policy (OP917) for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

In support the development of a just culture, policies and procedures are being updated to ensure Just Culture principles and language are incorporated and to provide a clear distinction between patient safety incident responses and other processes that may involve investigation processes. Our policies do not promote multiple errors as a basis to trigger corrective or punitive processes following involvement in incidents and staff receive appropriate training regarding this.

We will use the findings from safety related staff survey results to evaluate progress with improving our safety culture. This will be supported by implementing new culture related measures to oversee the monitoring of outputs and processes.

Patient safety partners

The Patient Safety Partner (PSP) is an evolving role developed by NHS England and Improvement to help improve patient safety across the NHS in the UK and is involved in the designing of safer healthcare at all levels in the organisation.

PSPs enable the Trust to value, listen and provide meaningful involvement opportunities for patients, their carers and families in the ongoing patient safety work of the organisation, supporting a culture that is ‘patient centred’. They bring an independent non-Trust perspective and are involved, as an equal partner, in a wide range of activities and programmes such as the design of safer healthcare at all levels in the organisation. The Patient Safety Partner role ensures that the patient voice is heard within the Trust, with the core purpose of ensuring we prioritise the safety requirements of patients to improve care.

PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care. PSPs play a vital role by joining relevant safety groups and committees, where they will reflect the voice and needs of people who use hospital and community-based health services and will enhance the committee membership by providing appropriate challenge to ensure learning and change. Working alongside staff, volunteers and patients, PSPs will be involved in projects to co-design developments of patient safety initiatives including having a key role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuousimprovement.

PSPs will be supported in their role by the Patient Safety Specialist and the Patient Relations & Experience team for the Trust who provide expectations and guidance for the role, along with any support requirements they may need to maximise their opportunities for involvement and ensure they are fully supported and enabled. PSPs will have regular scheduled reviews and regular one-to-one sessions. PSP placements are on a voluntary basis and will be reviewed after one year to ensure the role stays aligned to the patient safety agenda as it evolves.

Addressing health inequalities

As a public authority, the Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. The Trust recognises there is a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to intelligently consider health inequalities to patients and advise our Trust Board and partner agencies on how to tackle these. We will directly address if there are any features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

We will ensure that we use all available tools to meet the needs of those concerned, for example, easy read, translation and interpretation services, to make involvement as accessible as possible following a patient safety incident response.

When constructing our safety actions in response to any incident and/or improvement work, we will consider inequalities, and this will be inbuilt into our documentation and governance processes. This holistic, integrated approach to patient safety under PSIRF will require increased collaboration with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident, maintaining effective communication with them, sharing the findings of any further review or investigation into the incident and signposting them to support as required.

Involving patients and families

Getting patients and families involved in how we respond to incidents is crucial, particularly to support improving the way we provide our services. Patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents and may have different questions or needs to that of theorganisation.

Our key principle is being open and honest whenever there is a concern about care not being as planned or expected, or when an error has been made, regardless of the level of harm caused. The Trust recognises the importance of involving patients and families following patient safety incidents and is committed to engaging them in the investigation process as well as fulfilling the duty of candour requirements.

This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

Involving staff, colleagues and partners

The involvement of staff and colleagues is vitally important when responding to a patient safety incident to ensure a holistic and inclusive approach from the start. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, concentrating on moving toward reviewing incidents, or groups of incidents that provide the greatest opportunities for learning and improvement.

This new way of working will be a culture shift for the organisation, providing support and guidance through the principles of good change management, so staff feel ‘a part of’ rather than ‘being done to’ during an investigation. This policy acknowledges the equal need for staff and colleagues to be involved in the same way as patients and families, as soon as possible, at all stages of an investigation or improvementplanning.

Staff and colleagues will need to feel consistently supported to speak up and openly report incidents and concerns without fear of recrimination or blame. The Trust also recognises the importance of ensuring the Just Culture principles are applied and is committed to treating staff equitably during an incident response.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

This approach allows the Trust to focus its resources on responding to patient safety incidents that offer the greatest opportunities for learning and improving the safety of the healthcare we deliver. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources, including direct feedback from staff and patients, to explore what we know about our safety position and culture. This will enable us to develop an evidence-based rationale for each identified patient safety incident type in our plan, which can also be updated in response to emerging intelligence and improvement efforts.

Our associated patient safety incident response plan (PSIRP) will reflect this approach, providing more detail on how the Trust will meet the national and local focus and will be published alongside this overarching policy.

Resources and training to support patient safety incident response

The Trust has committed to ensuring that we embed and meet the requirements of PSIRF and will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

The Trust will also have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The selection of appropriate learning response leads will be monitored to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will

work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety. There will be a pool engagement and involvement lead roles to independently support those affected by patient safety incidents.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan.

All systems-based Patient Safety Incident Investigations will initially be overseen by the Patient Safety Team; they will have undertaken specific training in systems-based investigation methodology. Currently the Patient Safety Team has the following working time equivalent posts to support and facilitate the PSIRF framework:

- 1 x Patient Safety Specialist
- 2 x Patient Safety Leaders

Other learning responses will be coordinated by the Divisional Teams or specialist subject teams (Quality), supported by the Assurance Team, and should be undertaken by staff who have received specific training in these techniques.

Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response.

There will be a pool of trained staff who can undertake learning responses, though the majority have a substantive clinical role, so therefore must be allocated time within job plans to complete investigations.

All staff in the trust are required to complete Level 1 National Patient Safety Syllabus training and for those staff who have a responsibility for managing and investigating

patient safety incidents at a local level, must complete Level 2 National Patient Safety Syllabus training.

All staff are also required to complete mandatory patient safety training which covers the basic requirements of reporting, investigating and learning from incidents as well as the PSIRF awareness training that will be developed.

Specific roles and competencies are required for PSIRF which are outlined below:

Learning response lead role

- Led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Competencies:
  - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
  - Summarise and present complex information in a clear and logical manner and in report form.
  - Manage conflicting information from different internal and external sources.
  - Communicate highly complex matters and in difficult situations.

Engagement and involvement lead role

- Led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Competencies:
  - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
  - Listen and hear the distress of others in a measured and supportive way.
  - Maintain clear records of information gathered and contact with those affected.
  - Identify key risks and issues that may affect the involvement of patients, families, and staff.
  - Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight lead role

- Led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.
- Have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
- Competencies:
    - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
    - Apply human factors and systems thinking principles.
    - Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
    - Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
    - Recognise when safety actions following a patient safety incident response do not take a system-based approach (eg inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
    - Summarise and present complex information in a clear and logical manner and in report form.

All specified roles in relation to PSIRF are required to undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Initial training support for learning responses will be as below:

- Patient safety team, assurance team leaders, governance managers and Corporate Nursing Quality team and quality leads from support services – 3 days training on systems investigations, compassionate engagement andoversight.
- Care Group leadership teams - 3 days training on systems investigations and compassionate engagement
- Divisional Leadership Teams – two half days training on compassionate engagement and oversight. level 1 for Senior Leadership and Boards National Patient Safety Syllabus training.
- Executive Director quality and safety leads (Group Chief Assurance Officer, Chief Nursing Officer, and Chief Medical Officer) - two half days training on

compassionate engagement and oversight and in line with PSIRF guidance level 1 for Boards National Patient Safety Syllabus training.

- Deputy executive leads (Deputy Chief Medical Officer, Deputy Directors of Nursing and Director of Midwifery) - two half days training on compassionate engagement and oversight and in line with PSIRF guidance level 1 for Senior Leadership and Boards National Patient Safety Syllabus training.
- Non-Executive Director members of Quality Committee – half day oversight training and in line with PSIRF guidance and Level 1 for Boards National Patient Safety Syllabus training.

Specific training in PSIRF tools will be made available and will be accessible via the Patient Safety Team. Training and coaching in other learning responses can be accessed via the Patient Safety Team or in the Patient Safety section of The Beat.

Our patient safety incident response plan

Our patient safety incident response plan sets out how Walsall Healthcare NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The plan is based on an analysis of themes and trends from all incidents from financial years 2020 to 2023 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from serious incident investigations, mortality reviews, legal claims and inquests, risk registers, complaints and feedback from staff and patients.

A copy of our current plan can be found in appendix 1.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response policy will be reviewed in line with Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01). As the Trust works toward meeting the patient safety incident response standards, any changes to the policy will be shared and discussed with stakeholders. Once agreed, these changes will be presented to Board for approval.

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

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Responding to patient safety incidents

Patient safety incident reporting arrangements

PSIRF does not change any arrangements to report patient safety incidents. Patient safety incident reporting will remain in line with the Trust's Incident Reporting, Learning and Management Policy (OP917). All patient safety incidents will continue to be recorded and monitored through the Trust's incident reporting system (Datix).

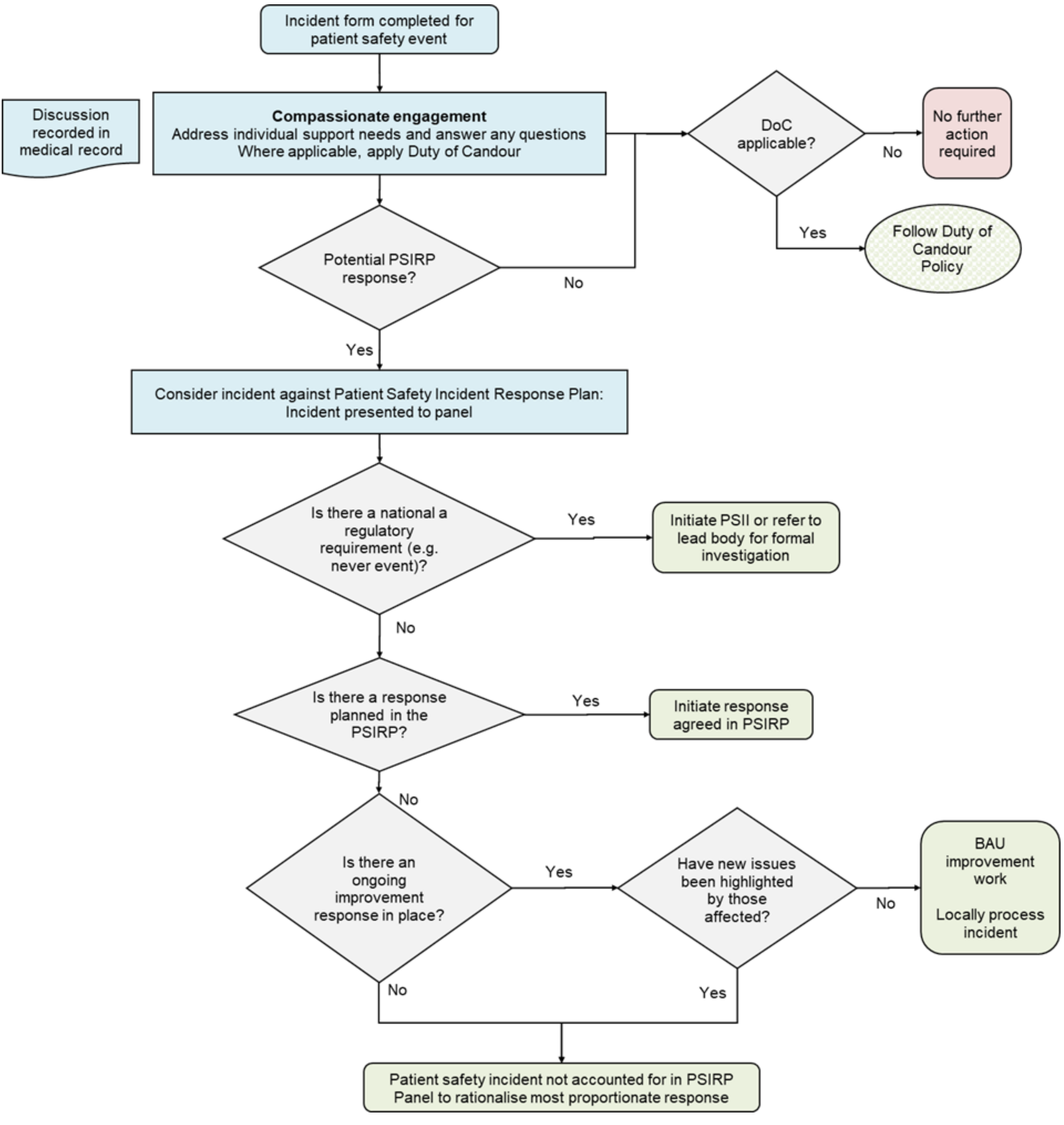
Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (see OP929)
Monitoring of patient safety incidents locally, through the Care Group's governance meetings will remain the same, supported by their respective Assurance team members.

Most incidents will only require local review to ensure an incident has been appropriately dealt with and any mitigating actions have been initiated and shared where needed to prevent recurrence. However, for some, where it is felt that the opportunity for learning and improvement is significant, or it appears to meet the criteria for a learning response, these should be escalated within the Division. Divisions and corporate service leads will highlight these to the Assurance team, initiating the decision-makingprocess.

Certain incidents require external reporting to national bodies such as HSIB, HSE and MHRA. The Patient Safety Team will work closely with relevant Trust departments to ensure we report incidents to external national bodies. Please refer to the Trust's Incident Reporting, Learning and Management Policy (OP917) for full details andguidance.

Patient safety incident response decision-making

The Trust PSII decision making panel will have delegated responsibility for the consideration of incidents for PSII and validation of response approach adopted on a weekly basis for incidents reported in-week. The meetings will be led by the executive lead for patient safety in the Trust. Figure 1 sets out the essential decision-making steps under PSIRF:



The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified.

Where it is clear a PSII is required (for example, for a Never Event) the Division should notify the Assurance team as soon as practicable so that the incident can be shared to the decision-making panel.

Decision making for escalation to the Trust decision-making panel can be aided by a rapid review. The purpose will be to recommend the most appropriate learning response

method based on the Trust PSIRF plan and the assessed learning potential of each incident being reviewed.

Incidents with positive or unclear potential for PSII will be escalated to the decision-making panel by the division. Cases will be presented by the senior leadership team for the area in which the incident occurred. The Trust PSII decision making panel will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), and any mitigation identified or that is still required to prevent recurrence.

The PSIRP supports proactive allocation of patient safety incident response resources, but it is recognised there will always need to be a reactive element in responding to incidents. To ensure that there are sufficient resources to allocate to support responses to emergent issues that are not included in the initial PSIRF plan, one Trust priority will be left unallocated. Collectively the attendees of the panel will agree a proportionate learning response agreed and allocate a learning response lead. This will allow the Trust greater flexibility to react more promptly to emerging system issues to ensure learning and improvement is completed more promptly.

It is also recognised that some incidents may still require a case based comprehensive investigation, like a Serious Incident investigation under the old framework during the transition from that framework to PSIRF. Where this is the case, reference must be made to available investigatory capacity and resources as detailed in the PSIRP.

The Patient Safety Group will have overall oversight of the operation and decision-making of the Patient Safety Incident Investigation Panel, providing challenge to the decision making and the incident responses the panel has delegated responsibility to commission. This will support the approval process for all PSIIs. Through this mechanism the Board will be assured that it meets expected oversight standards, the intent of PSIRF is being implemented within our organisation, we are meeting the national patient safety incident response standards and also understanding the ongoing and dynamic patient safety and improvement profile within the organisation.

Responding to cross-system incidents/issues

The Trust will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks. Where we identify the involvement of multiple agencies, we will invite our partner organisations to work with us

to understand the system issues, providing the opportunity for partnership colleagues to be fully engaged in investigations and learning as required.

Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

We will seek to involve our Integrated Care Board in the event that it is unclear which organisation should lead on a learning response or where commissioning is identified as an issue.

Where appropriate, we will review our patient safety intelligence alongside our system partners to collectively tackle common issues and promote the opportunity for consistent collaboration across specific themes (e.g., falls, health inequalities, mentalhealth).

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

A key factor in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

The purpose of learning responses is to understand the context of the incident and develop a thorough understanding of the work processes. PSIRF places resistance against the temptation to quickly identify what needs to change, instead, learning responses include the requirement to understand the work as done and what system factors affect this.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident.

PSII learning responses

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and timeframes for completion should be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. PSIIs should not take longer than six months.

A balance must be struck between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that actions to improve safety may be delayed until completion. This may impact on the need to make further checks to ensure the findings remain relevant.

In the extraordinary circumstance where there are issues with accessing information or where information cannot be provided, the Trust can opt to progress the PSII with the available information, with the caveat this can be revisited should the added information indicate the need for further investigative activity once this is received. This would require a decision by the Trust Patient Safety Incident Investigation Panel.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

Other forms of learning response

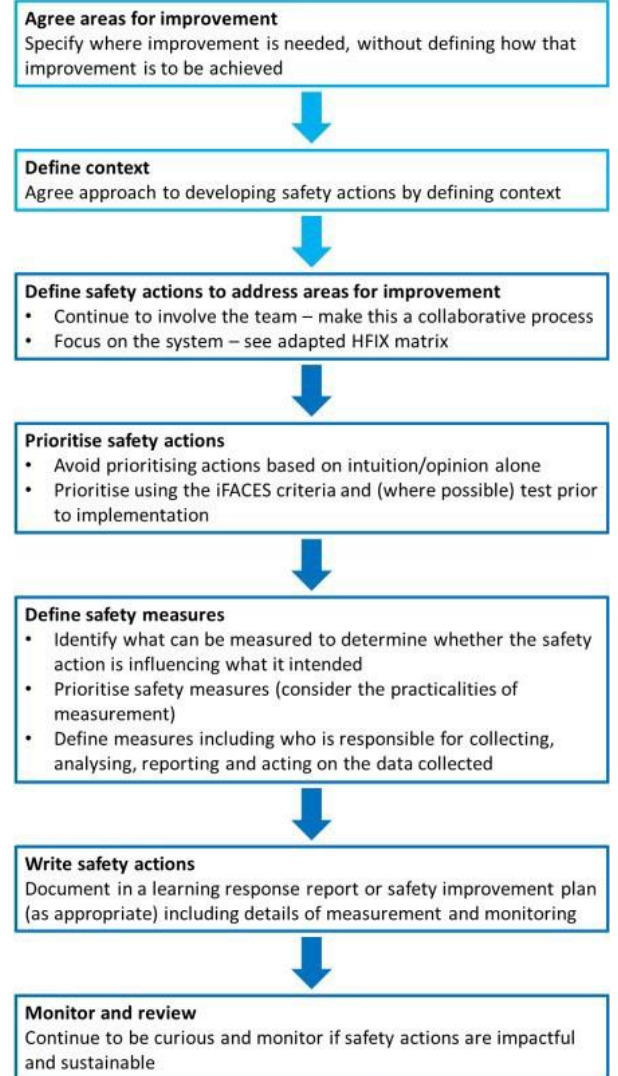
Other forms of learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

Safety action development

PSIRF promotes the term ‘areas for improvement’ instead of ‘recommendations’ with the aim of reducing the possibility of ‘solutionising’ at an early stage of the safety action development process. Following learning from incident responses, areas for improvement will be defined. Safety actions are created in response to each defined area for improvement and can depend on issues and boundaries that sit outside the scope of a learning response. PSIRF advocates a move toward implementing the lessons with an “integrated process for designing, implementing, and monitoring safety actions” to reduce risk and potential for harm.

Safety actions will be developed alongside the clinical and operational teams responsible for implementation to ensure ownership of the actions and outcomes. The Trust will use the process for developing safety actions outlined by NHS England in the Safety Action Development Guide (2022):



A quality improvement approach is essential to learning and improvement following a patient safety investigation. to ensure safety actions are: clearly defined, describe responsibilities and timescales, are aligned to reportable outcome measures and assurance processes. Close links with the Quality Improvement Team will be developed and maintained so their QI expertise and guidance can be utilised when developing safety actions. The quality improvement approach is recognised within the Trust and there is extensive, ongoing work to educate colleagues in the principles of QI methodology. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety teams to work more closely together.

Monitoring improvement

Monitoring of completion and efficacy of safety actions will be through the divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions, including the outcomes of any measurements will be made to the Patient Safety Group.

The Patient Safety Team will align its work with the Quality Improvement Team to maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction ofrisk.

For safety actions with a wider significance, this may require oversight by a Safety Improvement Panel, reporting to the Patient Safety Group.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvement plans in place which will be adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes.

The Patient Safety Incident Response Plan (PSIRP) clarifies what our improvement priorities are and takes into consideration the fundamental priority areas outlined in the Quality and Safety Enabling Strategy.

The themes detailed in the PSIRP that are selected for an improvement pathway will have an improvement plan utilising QI methodology, where appropriate, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness.

These improvement plans will be a key focus of the regular thematic reviews within the patient safety groups related to that theme and explore the impact of improvement plans on subsequent incidents. There will be a clear alignment between some safety actions arising from patient safety responses and the overarching safety improvementplans.

The Trust will use the outcomes from existing patient safety incident reviews where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed.

Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a care group or specialty level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach.

The Trust is reviewing governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through divisional and corporate governance structures and processes. Care group level improvements will be managed locally with assurance and reporting to Division, then, corporate oversight and assurance committees will provide 'ward to board' assurance.

Safety improvement plans will often lead to the outcome measurement and assurance processes that underpin safety actions and will be considered by the Safety Improvement Group both to receive progress and assurance regarding existing plans but also to recommend the need for future improvement plans following review of responses and individual safety actions.

Completed safety improvement plans should be examined to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared, adapted and adopted with other areas of the organisation and peer organisations via the Patient Safety Specialist to the ICB Patient Safety Incident Surveillance Group and/or Shared Learning Events.

Oversight roles and responsibilities

Responsibility for effective patient safety incident management sits with the Trust Board. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. The Executive Lead is the Group Chief Assurance Officer who holds responsibility for effective monitoring and oversight of PSIRF.

The Trust, through the Executive lead, has a responsibility to:

1. Ensure the Trust meets the national patient safety response standards
2. Ensure PSIRF is central to overarching safety governance arrangements
3. Quality assure learning response outputs

Working under PSIRF, the Trust aims to utilise oversight systems that allow improvements to be demonstrated rather than solely seeking compliance with centrally mandated measures. Oversight will focus on engagement and empowerment rather than the more traditional command and control.

The Trust acknowledges the 'oversight mindset' principles that will underpin the processes put in place to allow PSIRF to be implemented in line with the oversight roles and responsibilities specification supporting document (NHS England 2022, p 3).

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning.

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Patient Safety Group and Quality Committee. Safety reporting will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The Patient Safety Group will provide assurance to the Quality Committee that PSIRF and any related workstreams have been implemented to the appropriate standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement and monitoring of the balance of resources going into patient safety incident response versus improvement.

Divisions will be expected to report on their patient safety incident learning responses and outcomes. Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will implement a Patient Safety Incident Investigation Panel to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training available as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every four years alongside a review of all safety actions.

Complaints and appeals

Any complaints relating to this guidance, or its implementation can be raised informally with the Trust Patient Safety Specialist, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints process which is outlined here.

Part A - Document Control

To be completed when submitted to the appropriate committee for consideration/approval

<table>
<tr><td rowspan="1">Policy number and Policy version:

WHT-OP1008 V1</td><td>Policy Title

Patient Safety Incident Response Policy</td><td colspan="2">Status:

Final</td><td>Author

Dee Johnson, Group Patient Safety Specialist

Chief Officer Sponsor

Kevin Bostock, Group Director of Assurance</td></tr>
<tr><td rowspan="2">Version / Amendment History</td><td>Version</td><td>Date</td><td colspan="2">Reason</td></tr>
<tr><td>1</td><td>October 2023</td><td colspan="2">New policy</td></tr>
<tr><td colspan="5">Intended Recipients: All staff working within Walsall Healthcare NHS Trust</td></tr>
<tr><td colspan="5">Consultation Group / Role Titles and Date: n/a</td></tr>
<tr><td colspan="2">Name and date of Trust level group where reviewed</td><td colspan="3">Trust Level Committee Reviewed:
Keith Wilshere, Group Company Secretary
23/10/2023</td></tr>
<tr><td colspan="2">Name and date of final approval committee</td><td colspan="3">Kevin Bostock, Group Director of Assurance
23/10/2024</td></tr>
<tr><td colspan="2">Date of Policy issue</td><td colspan="3">25/10/2023</td></tr>
<tr><td colspan="2">Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)</td><td colspan="3">25/10/2026 3 yearly

If any legislation / changes in practice occur prior to this review, the policy will be subject to a</td></tr>
</table>

<table>
<tr><td></td><td>minor review to ensure compliance with the latest legislation/best practice.</td></tr>
<tr><td colspan="2">Training and Dissemination:

This policy and associated process will be shared via the Trust weekly dose including targeted emails to all staff groups and presentations to staff forums. The policy will also be linked to the Patient Voice dashboard available on the staff intranet.

The policy will also be referenced in the Trust Formal Complaint Investigation E-Learning Module (currently being developed) requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.</td></tr>
<tr><td colspan="2">To be read in conjunction with:

• Duty of Candour</td></tr>
<tr><td colspan="2">Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator</td></tr>
<tr><td>Monitoring arrangements and Committee</td><td></td></tr>
<tr><td colspan="2">Document summary/key issues covered. Aspects of patient safety reporting and investigation.</td></tr>
<tr><td>Key words for intranet searching purposes</td><td></td></tr>
<tr><td>High Risk Policy?
Definition:
• Contains information in the public domain that may present additional risk to the public
e.g. contains detailed images of means of strangulation.
• References to individually identifiable cases.
• References to commercially sensitive or confidential systems.
If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.</td><td>No</td></tr>
</table>

Report to the Trust Board Meeting - to be held in Public on Wednesday 13th December 2023		
Title of Report:	**Estates Strategy Update**	Enc No: 10.9.1
Author(s):	**Stew Watson, Group Director of Estates Development** Jane Longden, Divisional Director Estates and Facilities Paul Richardson, PFI Contract Manager Stuart Cornaby, Head of Estates	
Presenter/Exec Lead:	**Stew Watson, Group Director of Estates Development**	

Action Required of the Committee			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☒No☐	Yes☐No☒

Recommendations:

The Board is asked to note the contents of the report.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Capital (CRL) and associated external capital funding		
Report Data Caveats	The content of the report may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		
Equality and Diversity Impact	No impact.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • The Trust is complying with NHSE requirements in supporting the creation of a joined-up Black Country ICB Estates Strategy
Advise • To update the Board on the progress being made alongside NHSE and the Black Country ICB
Alert • The continued pressures of accessing capital funding remain (locally, regionally, and nationally) and that closer working as one-single ICS Group brings with it both opportunities and challenges

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 in the percentage of staff who feel positive action has been taken on their health and wellbeing • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Reduction in the carbon footprint of clinical services by 1 April 2025
Effective Collaboration	• Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Report to the Trust Board Meeting - held in Private on Wednesday 13 December 2023

Brief/Executive Report Details

1.0 **Introduction:**

This report is to note the current position of the Black Country ICB led requirement to have in place a “system based” Estates Strategy in line with meeting NHSE requirements. This is a significant shift away from individual Trusts preparing their own bespoke strategies and an attempt from NHSE to ensure greater alignment across both estates and clinical strategies across ICB areas and to look towards meeting the prioritised capital demands of respective ICB partners in line with an “umbrella” estates strategy.

In order towards looking to the future in meeting this requirement each Trust has to firstly ensure that it has in place appropriate procedures in place to assist in effective decision making when capital investment is needed to meet the delivery of existing and future services. In working alongside colleagues from the Royal Wolverhampton NHS Trust (RWT) we have been able to build on existing systems and also find new ways of working to seek additional capital funding as well as alternative ways to deliver changes to the estate that offer better value.

2.0 **Capital Programme Planning:**

The Trust’s Capital Review Group meets on a monthly basis to determine the needs of capital investment to meet both the clinical and strategic needs of the Trust. It is chaired by the Director of Finance and is the point at which Business Cases are examined in advance of being considered for funding from existing and planned capital resources. This paper is to provide an update to make the committee aware of some of the continuing funding challenges that will impact the delivery of any agreed Estates Strategy.

3.0 **Shaping the Estate:**

Demand for capital investment within the Trust and indeed across the Black County patch will continue to bring pressure to the limited resources to which the Trust have access to over existing and future years with demand likely to exceed supply once more.

With the delivery of the New ED facility the Trust capital programme has been able to deliver a replacement facility that became operational earlier in the year and work continues in the delivery of other Trust priorities across Ward refurbishments, the Maternity Unit revamp and additional activity-based works planned in the creation of an Intervention Suite and remodelled Theatres. Work also continues around improving vacated spaces and maximising opportunities to seek investment into decarbonisation measures to support the Trust in its journey towards Net Zero Carbon in line with NHSE targets.

If to maintain our focus in meeting the needs of the Estates Strategy and now the Trust Green Plan, we can see the areas where the Trust are needing to invest heading into the future. If to continue allow our pathway to maximising capital investment across the estate,

its infrastructure, and its equipment, be it Medical or ICT pressures, we must continue to pursue all avenues to continue to get the best from all capital resources and opportunities. More focus will be needed once again on looking to secure additional capital funding to support the areas the Trust wishes to target associated investment.

One of the continued challenges across the ICB are that each Trust/Service provider are all seeking access to more capital allocation year on year, and it is the role of the ICB to challenge each service provider on their respective capital needs across their estate, medical equipment, and proposed ICT investments. Whilst we understand that the ICB Capital allocation is in the order of c£90M each year, we continually compete with other Black Country NHS service providers to gain our share of access to this capital funding. We continue to seek backing from the ICB to maximise our share of the available capital but are now starting to see the ICB take a stronger stance in how capital is allocated across the Black Country service providers with the delivery of some of the larger projects across the Black Country requiring rescue funding for increased costs or delays in the delivery which is ultimately affecting the balance available for distribution across the service providers. This continues to be a contentious area and is continually debated across the respective ICB Directors of Finance and Directors of Estates Groups.

As in previous years we expect the submission of capital requests from other parties across the ICB to significantly exceed the capital allocation of the ICB. The movement is towards a focus on utilising the ICB Capital to focus on Backlog and Critical Infrastructure is evident and this will impact the Trust development and redevelopment plans in the future with a strong push towards all development projects being funded from capital streams opened up from NHSE across the year. Whilst we can point to recent success in scoping, bidding, and receiving additional grant funding, this is generally for targeted areas across the broader NHS and could potentially limit the priorities of the Trust set against the priorities of the broader NHS. Continued bidding and dialogue with NHSE will remain essential if we are able to merge both the Trust and ICB aspirations alongside NHSE and in turn have confidence in the preparation of an appropriate Estates Strategy

4.0 <u>The Black Country Estates Strategy</u>

Whilst the ICB are keen to establish a united Black Country Estates Strategy, we still await confirmation from NHSE on the mandatory requirements and indeed the guidance of the aspects that NHSE need to be included to meet such requirements. This information has been due for the last 12 months with little movement from NHSE on the exacting needs, thus the production of an umbrella strategy remains on hold. The latest NHSE update predicts that we will be presented with a National “Toolkit” before the end of 2023 in order to pull together a draft alongside our Black Country partners in the early part of 2024.

The ICB continue to pursue NHSE for such information in order to ensure compliance. A small group of ICB’s have prepared and published their respective Estates Strategies ahead of this guidance being made available. The steer the Black Country ICB have been given is to continue to wait for the guidance to be released before preparing the Estates Strategy to ensure we will be fully compliant. Whilst this has been debated across the ICB Estates Group, the respective Trust leads on Estates matters have agreed to this on the basis the Toolkit is published before the end of the financial year.

Much of the spade work has already been undertaken with providing information on the following factors that feed into other NHSE instruments and reporting requirements: Estate Condition and functional suitability; Backlog Maintenance and Asset Management; Estate Utilities and operating costs; Property make-up and tenure variation; Commercial challenges/opportunities; PFI Contract Monitoring; Investment Planning; RAAC etc.

5.0 National Policy

Whilst we fully recognise that the environment within which the NHS provides services is changing. The population is increasingly ageing, there are significant advances in medicine and surgery, patient expectations are changing and there is a need to harness research, innovation, and technology in delivery. There are a number of predominant national policies and local drivers that need to be captured in our Estates Strategy. These drivers will guide, set, and inform 'where we want to be' and 'how we get there'. Our System Estates Strategy will need to capture how our estate and infrastructure will utilise, enable, support, and empower collaborative delivery, ensuring we are improving lives together through the delivery of shared visions, objectives, and priorities. This approach remains forward facing, supporting place based clinical service strategies to achieve their objectives, working with other enabling workstreams toward transforming services. The future NHS estate remains a key driver to enable the development of strategies, and how the estate is one of the core resources that in turn enables the shaping of our clinical and service strategies.

We need to ensure that we consider the following, as a minimum:

- National Policies and priorities
- Health economy wider needs
- Local context needs
- System Strategy and priorities
- Localised "Place" and PCN needs

5.1 *The Carter Report (2015) Hospital Efficiency*

In June 2015, Lord Carter published his initial report into hospital efficiency. The scope focussed on the acute sector. He reviewed the efficiency of all 136 acute trusts in England to come to a target savings figure. He estimated, at the time, that if 'unwarranted variation' is removed from trust spend, that £5bn of savings could be saved by 2020. His final report gave a more detailed breakdown of how that figure could be achieved, as well as providing a range of recommendations in order to get there. These recommendations are mixed between what the national bodies – in the main NHS Improvement (now NHS England) – need to do and set out specific actions that providers were required to take and in some cases be held to account for delivering.

In his letter to the secretary of state prefacing the report, Lord Carter outlined five key points:

- The provision of high-quality clinical care and good resource management go hand-in-hand.
- A single reporting framework should be adopted across all trusts, which pulls together clinical quality and resource performance data and compares it to the 'best in class'.
- Delayed transfers of care have a significant impact on achieving efficiency savings.
- The need for genuine local and national collaboration and co-ordination.
- Rapid adoption of the review recommendations was paramount.

The introduction to the report outlined that of the £5bn savings potential, £3bn had been agreed in principle by the 136 acute trusts. The report went on to say that the NHS has to deliver the efficiencies of 2-3% per year, effectively placing a 10-15% real terms cost reduction target on trusts to achieve by April 2021. The £5bn of savings identified in the Carter report only go some way to achieving this.

In addressing the optimisation of clinical resources, the report outlines there is significant variation across Trusts regarding sickness, staff turnover and morale. To address this, it recommended the development of a 'national people strategy'. It also noted a wide variation in how Trusts manage annual leave, shift patterns and flexible working, with different approaches to the use of technology and e-rostering and suggested greater standardisation across shift rotors and planning. It also recommended the adoption of a metric for Care Hours Per Patient Day (CHPPD) metric - CHPPD can be used to describe both the staff required and staff available in relation to the number of patients - and improving supply chain management practices to reduce variation in total pharmacy and medicines costs across acute trusts.

In seeking to optimise non-clinical resources, the report outlined issues with procurement, estates and facilities management and back-office costs. Recommendations to address this included the implementation of a new purchasing price index with immediate effect for the 100 most commonly purchased items, providers creating estate management plans and limiting trust back office spend to 7% of income.

The report also noted the need for rationalising reporting on clinical quality and variation, the importance of having national IT funding for IT efficiency measures and ensuring alignment with other current national policy initiatives (such as the Five Year Forward View) and addressing system wide issues (such as delayed transfers of care).

One of the key recommendations of the report is to create a 'model hospital' (often now known as 'model healthcare facilities') dashboard, to set out a clear, consistent approach to setting expected standards that a good hospital should meet. The dashboard should hold a single view of all the items that providers are reporting on and are expected to be held to account against.

5.2 ***The Naylor Review (2017)***

In March 2017, Sir Robert Naylor produced his report for the Secretary of State titled 'NHS Property and Estates: Why the estate matters for Patients'. The review identified the opportunity to release £2bn of NHS assets for reinvestment and deliver land for 26,000 new homes. The report outlined 17 separate recommendations relevant to national or local structures, the four following recommendations are of note:

- Substantial capital investment is needed to deliver service transformation in well evidenced STP (now ICS) plans. This could be met by contributions from three sources: property disposals, private capital (for primary care) and from HM Treasury.
- Systems should develop affordable estates and infrastructure plans, with an associated capital strategy, to deliver the 5 Year Forward View (5YFV) and address backlog maintenance. These plans should be supported by robust business cases.
- System estates plans, and their delivery should be assessed against targets informed by the benchmarks developed for this review. Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need.
- In line with the Carter Report recommendations, NHS estate should aim to operate within a maximum of 35% non-clinical floor space and 2.5% unoccupied or under-used space

5.3 ***The NHS Long Term Plan (LTP) (2019)***

The NHS Long Term Plan sets out how the NHS will tackle the pressure its staff are facing while making extra funding go as far as possible. As it does so, it must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. It also sets out four major, practical changes to the NHS service model, to be delivered over the following five years:

- Boosting ‘out-of-hospital’ care, and joining up primary and community health services
- Reducing pressure on emergency hospital services
- Digitally enabled primary and outpatient care
- Increasing focus by local NHS organisations on population health and local partnerships

There are some key opportunities for Estates outlined in the LTP including “the NHS will improve the way it uses its land, buildings and equipment.” This includes the following key highlights:

- Improving quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment while supporting the Government’s target to build new homes for staff
- System providers working together to reduce the amount of non-clinical space, freeing up space for clinical or other activity
- In line with Lord Carter’s recommendations, the NHS needs to exploit opportunities for consolidation of the non-clinical estate to improve efficiency with a 30% cost reduction target, less than 2.5% unoccupied space and less than 35% non-clinical space
- Increase the provision of diagnostic equipment and services including digitisation of the service to meet the growing demand.

The LTP suggests that the NHS will continue to maximise the productivity benefits generated from estate, through improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency, and releasing properties that are no longer needed.

5.4 ***The Health Infrastructure Plan (2019)***

The Health Infrastructure Plan (HIP) will deliver a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, modernise our primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate. At the centre of this will be a new hospital building programme, to ensure the NHS' hospital estate supports the provision of world-class healthcare services. It is also about capital to modernise mental health facilities, improve primary care and build up infrastructure in interconnected areas such as public health and social care – all of which, together, ensure the best infrastructure needed by the NHS. Our infrastructure is maintained and improved through capital investment, which is a key part of meeting current and future patient demand through ensuring patient safety, better health outcomes, reducing key cost drivers in the system and supporting the NHS workforce to do their jobs effectively, in well-designed and safe settings. Investment in well-designed buildings can also help improve productivity and reduce costs across the NHS estate, for example reducing maintenance costs.

5.5 ***Delivering a Net Zero National Health Service (2020)***

In October 2020, the NHS published the 'Delivering a Net-Zero National Health Service' in response to the health emergency that climate change carries. Two clear and feasible targets emerged for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis. For the emissions we control directly (the NHS Carbon Footprint), net-zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 - For the emissions we can influence (our NHS Carbon Footprint Plus), net-zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

5.6 ***NHS Premises Assurance Model (PAM) (2020)***

The NHS PAM is a management tool, designed to provide a nationally consistent approach to evaluating NHS premises performance against a set of common indicators. It delivers a basis for assurance for Trust Boards, on regulatory and statutory requirements relating to their estate and related services.

- Assurance on the premises in which NHS healthcare is delivered
- Driving premises-related performance improvements throughout the system
- Providing greater understanding of the vital role that NHS premises play in the delivery of improved clinical and social outcomes

It is designed to be used locally by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners.

5.7	***Next steps for integrating primary care: Fuller Stocktake report (2022)*** The report discusses reimagining our approach to primary care estates and sets out a vision of integrated teams, providing joined up accessible care. But it also indicates that much of the general practice and wider primary care estate is not up to scratch. The focus of capital investment has been weighted towards secondary care – something that now needs to change. The ICS has the reach to take a 'one public estate' approach and to think creatively about primary care estates, considering: • Developing primary care estates plans from the perspective of access, population health and health inequalities • Making use of local authority, third sector and community assets, building on the approach to COVID-19 vaccination programmes, including places of worship, community centres etc. • Making creative use of void and vacant space in the NHS Property Services and Community Health Partnerships portfolio • Opportunities for co-locating primary care when bringing forward secondary care estates plans • Pragmatic, low-cost opportunities to repurpose existing space, within local funding streams, as well as making use of the potential ability of the local authority to raise capital beyond NHS limits to fund new estates • Opportunities for locating primary care onto the high street as part of local economic regeneration The re-focus towards primary care, emphasises the 'bottom up' development of service delivery and estate strategy. Ensuring each of our primary care networks has a secure estate plan that underpins and enables the clinical strategy and forms part of the system estate strategy. Defining the estate response begins within the 'Place', where integrating services locally can be supported with targeted management and investment in our estate.
6.0	**Capital Investment:** When the 22/23 Capital Programme was set in place by the ICB, we noted that the current ICB allocation was once again heavily oversubscribed and that we (and other Black Country partners) had no guarantees of receiving the amounts that were sought and as such compromise was set in place in the distribution of capital funding as had occurred in previous years. This remains the same across the West Midlands area, with the whole amount requested by the ICB members exceeding available resources. The funding gap, as in previous years, was in the order of £30M and each service provider was requested to review their respective Capital Plans to allow the ICB to operate within the controlled total. We provided additional supporting documentation to back up our proposals to ensure that we were able to fully justify our capital spending plans in the hope that we could maximise our share of the ICB funding.

Another factor that continues to emerge is the increased reliance upon additional capital funding and the need to seek out and bid for external funding across the wider NHS sector and indeed beyond (as we have seen in previous years).

Some of this funding can be obtained via grant funding and some can come with conditions that can, on occasion, have implications on our CRL (Capital Resource Limit). Some recent capital funding that we have been able to secure also can come with challenging spend deadlines or particular conditions attached which we have been successfully able to react and adapt to. It remains a tough environment with less and less flexibility year on year across the system and indeed the industry with significantly extended order periods for materials and components noted following BREXIT, the Pandemic and shortages of both resources and materials locally, nationally and across the globe. Conflict in the Ukraine, increased energy costs and transportation costs as well as uncertainty in the financial markets on recent Governmental leadership changes all contribute to essentially getting less value due to rising prices. Strikes from travel, transportation and supply chain providers are also contributing to inflationary increases in the delivery of programmes of work too.

Through discussions at the Capital Review Group this is monitored and managed accordingly with risks already recorded on volatility in tender prices as well as manufacturing entities now holding more of a dominant role in the marketplace where public sector clients are needing to think much further ahead than previously to secure key components to aid smoother programme delivery pathways.

6.1 ***Current "CRL" Programme:***

The below table shows the current Capital Resource Limit investment attributable to the Trust for 23/24.

AEC Refurbishment and Relocation	£	370,106
Hot Imaging and UTC works	£	3,849,357
Maternity works	£	600,000
Replacement Medical Equipment	£	1,073,000
Backlog maintenance	£	1,000,000
Health Records	£	1,000,000
IT (not frontline digitisation)	£	50,000
Intervention Room and Theatres project	£	1,057,537
TOTAL	**£**	**9,000,000**

Added to this the Trust secured additional capital funding to support the Sustainability agenda and Trust Green Plan.

	As reported under separate papers, we have been targeting the Public Sector Decarbonisation Scheme (PSDS). This is a funding stream that sits outside of the NHS but is available for all Public Sector bodies to apply for. Its primary target from the BEIS arm of the Government office is a stimulus towards investment in greener technologies to reduce carbon outage across the Public Sector and to move towards greener and more sustainable ways of using energy required to deliver services. Last year the Trust joined RWT in a joint system-bid which secured approximately £12M to make changes to the estate to support decarbonisation under the PSDS capital funding (Phase 3B). We have also lodged a further bid to look to secure funding in the next round – Phase 3C for delivery in 24/25 and 25/26.
7.0	**<u>Future Aspirations:</u>** Following the Trust Board's focus and desire to continue to invest in areas of Sustainability we are also investing, where possible, to meet the Greener NHS Plans and to provide complimentary investment where possible to support reducing the Trust's carbon footprint following the NHS signing up to become carbon neutral by 2040, with some challenging targets set to be achieved by 2028. As noted above, we await the outcome of another capital bid, this time on behalf of the ICS in partnership with RWT to lead on delivering changes across the ICS alongside Sandwell and West Birmingham and West Midlands Ambulance Service. This remains a rich source of targeted capital in support of the limited capital funding coming via the ICS. It also contributes towards reducing our backlog pressures with the replacement of aging plant room equipment such as boilers and various heating and cooling installations. Our partnership with RWT may support potential continued investment opportunities as we start to look at more collective working arrangements and how we can maximise shared delivery of services. The Black Country ICS have recently recruited an Estates specialist in Capital Development as a means to look to unite organisations across the patch and to focus on targeted capital investment to ensure funding is going to the areas that most require it. It will be important to forge positive relations with such parties if to look to maintain and indeed increase our share from the ICS Capital Funding allocation. The above points of note are not exhaustive and subject to additional funding that we hope to attract across future years. We will also continue to see further development proposals take shape with the Capital Review Group ensuring Trust priorities are embedded in future investment planning alongside appropriate business cases.
8.0	**<u>Recommendations:</u>** The Board please: -

	• Note that NHSE have determined that individual Trusts are no longer required to prepare nor hold an individual Estates Strategy and are required to work with their respective ICS partners to develop a joint strategy • Note the progression of the development of a Black Country ICS Estates Strategy will be developed alongside Black Country partners once NHSE release the Toolkit to which we must follow • Note the content of this report highlighting the local, national, and regional factors that we need to consider in preparing an ICB Estates Strategy • Recognise that in order to continue to deliver changes to our estate, in line with any future Estates Strategy, that appropriate capital funding remains a continued challenge to bid, secure and deliver timely changes to our estate • Agree to receive further reports on the progression and preparation of the Black Country Estates Strategy

Enc 10.10.1

EPRR Assurance 2023 Action Plan							
Standard Ref Number	**Domain**	**Standard**	**Criteria**	**Scoring**	**Action Plan**	**Led by Whom**	**Due Date**
8	Duty to risk assess	Risk Management	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Partially compliant	To work with Risk Management to establish review for the RM policy.	Head of EPRR	31/03/2024
10	Duty to Maintain Plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Partially compliant	The Major Incident Plan has not been reviewed since 2019. The MIP requires a complete re-write, due to building changes, changes in command and control, ICC locations, record keeping. In the event of an Incident, The Trust would still use the plan. The action to develop a new Incident Response Plan	Head of EPRR	31/03/2024
11	Duty to Maintain Plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Officer	31/12/2023
12	Duty to Maintain Plans	Infectious Disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Officer	31/12/2023
13	Duty to Maintain Plans	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/03/2024
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/03/2024
15	Duty to Maintain Plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	Head of EPRR	31/03/2024
16	Duty to Maintain Plans	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/03/2024
17	Duty to Maintain	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Officer	31/03/2024
21	Command and Control	Trained On Call Staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions		To establish training PDP for all on call staff.	Head of EPRR	31/03/2024
23	Training	EPRR Exercising and Testing Programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Partially compliant	A new T+E programme needs to be written, to outline the training needs and packages offered to meet needs of incident response	Head of EPRR	31/12/2023
28	Response	Management of Business Continuity Incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).		Management of BC incidents, needs to form into the Incident Response Plan	Head of EPRR	31/03/2024
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Partially compliant	Management of BC incidents, needs to form into the Incident Response Plan	Head of EPRR	31/03/2024
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker.	Partially compliant	Training Programme needs to be written, recruitment and training required	Head of EPRR	31/12/2024

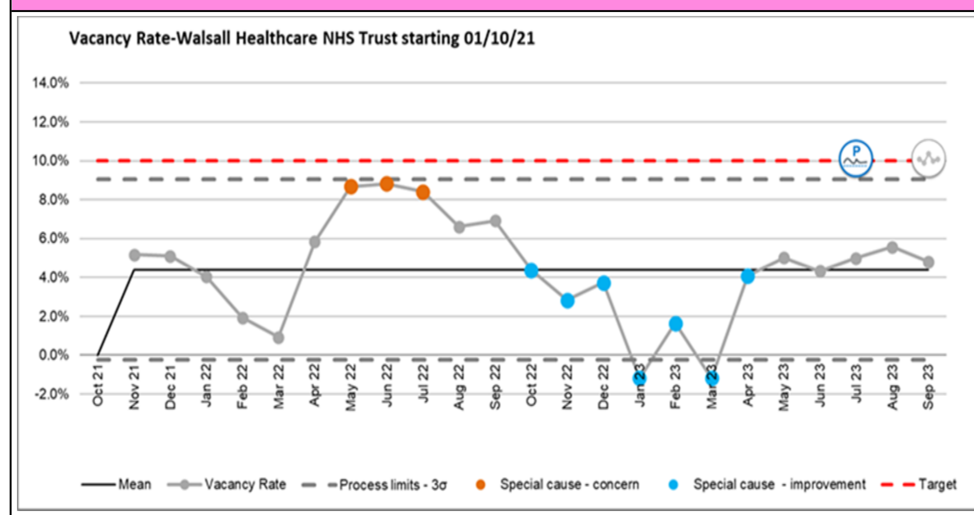
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.		Introducing of an Incident Activation SOP.	EPRR Officer	31/12/2023
31	Response	Access to Clinical Major Incident Guidelines	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.		To be included in the CBRN SOP and demonstrates sufficient evidence	EPRR Clinical Advisor	31/12/2023
32	Response	Access to CBRN Clinical Advice	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)		To be included in the CBRN SOP and demonstrates sufficient evidence	EPRR Clinical Advisor	31/12/2023
34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.		This plan needs to reflect comments from NHSE and have updated guidance in place.	Head of EPRR	31/03/2024
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Partially compliant	The Trust are Non-Compliant and have an separate action plan which can be provided.	Head of EPRR	31/12/2023
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially compliant	This plan needs to reflect comments from NHSE and have updated guidance in place.	Head of EPRR	31/03/2024
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially compliant	A new re-written BC Policy that reflects an audit section and monitoring.	Head of EPRR	31/01/2024
53	Business Continuity	Assurance of Commissioned Providers	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.		This plan needs to reflect comments from NHSE and have updated guidance in place.	Head of EPRR	31/03/2024
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented		This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/03/2024
58	Hazmat/CBRN	Planning Arrangements	The organisation has up to date specific Hazmat/CBRN plans, and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organization and in conjunction with external stakeholders		This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/03/2024
59	Hazmat/CBRN	BC audit	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Partially compliant	A new Trust wide recruitment package is ongoing to recruit CBRN volunteers to ensure 24/7 capability is in place.	EPRR Clinical Advisor	31/03/2024
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable:		This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/12/2023

			- PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks				
62	Hazmat/CBRN	Waste disposal arrangements	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments		This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/12/2023
63	Hazmat/CBRN	Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments		This plan needs to reflect comments from NHSE and have updated guidance in place.	EPRR Clinical Advisor	31/12/2023
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Partially compliant	Training Programme needs to be written, recruitment and training required	EPRR Clinical Advisor	31/12/2023
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Partially compliant	Training Programme needs to be written, recruitment and training required	EPRR Clinical Advisor	31/12/2023

Strategic Aim: COLLEAGUES

Strategic Objective: **Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff**

Board Level Metric(s): **Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff by March 2024**



Analyst Narrative:
Vacancy rates are reflective of budgeted versus actual workforce figures taken from the finance ledger, effective month-end. Due to this, reported vacancy rates indicate gaps within the financial establishment and may not wholly represent ongoing or historical recruitment campaigns.
The reported vacancy position reflects a month-on-month 88 FTE increase in the budgeted establishment, reconciled against a 22 FTE increase in the actual workforce; as per the month-end finance ledger. The September 2023 vacancy rate is stable above the 24-month average threshold.

SUPPORTING METRICS

Executive Narrative:
Issues:
Most of the budgeted establishment growth aligns with the Registered Nursing and Midwifery (RN&M) and Additional Clinical Services staff group, whereby funding for the N&M workforce increased by 31 FTE, while clinical support to N&M budgeted FTE rose by 20 FTE.
Actions:
The positive assurance regarding the 12 months Retention indicator reflects a year-on-year reduction in resignation due to organisational culture-related reasons.
Workforce and finance colleagues are working in partnership with divisional leads, ahead of the 24/25 budget setting process, with the aim of delivering enhanced establishment controls and sustainable workforce plans.

Strategic Aim: COLLEAGUES

Strategic Objective: **Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff**

Board Level Metric(s): **Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff by March 2024**

	ACTION	BY WHO	BY WHEN

Paper to the Trust Board – to be held in Public 13 December 2023		
Title of Report:	Group Chief People Officer Update	Enc No: 11.2.1
Author:	Clair Bond (Interim Director of Operational HR and Operational Development) clair.bond2@nhs.net	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The Board is asked to note the contents of the report.			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	The risk to the organisation is concerning: • Use of Resources. • Employment legislation. • Equality, Diversity & Inclusion. • Organisational Reputation. Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	Resource implications concerning staff health and wellbeing and attendance at work. Impact on financial resources concerning bank and agency cover.		
Report Data Caveats	Please see Appendix A		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well Led
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☒No☐	Details: The Board should have regard to the Core principles contained in the Constitution
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. All workforce policies and procedures are required to be compliant with all relevant employment legislation and the Equality Act 2010. NHS Employers guidance and terms and conditions.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date: 28 November 2023
	Board Committee	Yes☐No☐	Date: 27 November 2023
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

The report provides assurance regarding key workforce metrics;

- Vacancy rates
- Turnover and Retention rates
- Sickness Absence rates
- Mandatory Training Compliance rates
- Appraisal Compliance rates

- The Committee can be assured that two of the workforce metrics are within target. The vacancy rate of 6.1% and the12 month retention rate of 91.1%

Advise

- The 6.1% vacancy rate reflects a month-on-month 88 FTE increase in the budgeted establishment, reconciled against a 22 FTE increase in the actual workforce; as per the month-end finance ledger. Most of the budgeted establishment growth aligns with the Registered Nursing and Midwifery (RN&M) and Additional Clinical Services staff group, whereby funding for the N&M workforce increased by 31 FTE, while clinical support to N&M budgeted FTE rose by 20 FTE.

- Continued improvement regarding the 12-month Turnover performance and 12-month Retention, which remain above target levels, reflect colleague exit information, which suggests evidence of cultural improvement within the organisation.

- Whilst challenges remain regarding long-term assurance of target achievement, Mandatory Training compliance has continued the short-term improvement trajectory, rising 3% since July 2023. Progress continues against the mitigating actions set out within the deep dive compliance report received by the People Committee and Trust Management Committee in October 2023.

- In-month sickness absence, which was 5.6% during October 2023, is on a trajectory of continued special cause improvement. Rolling 12-month analysis, whereby absence during the 12 months to October 2023 was 5.74%, provides assurance of a strategic improvement regarding colleague attendance.

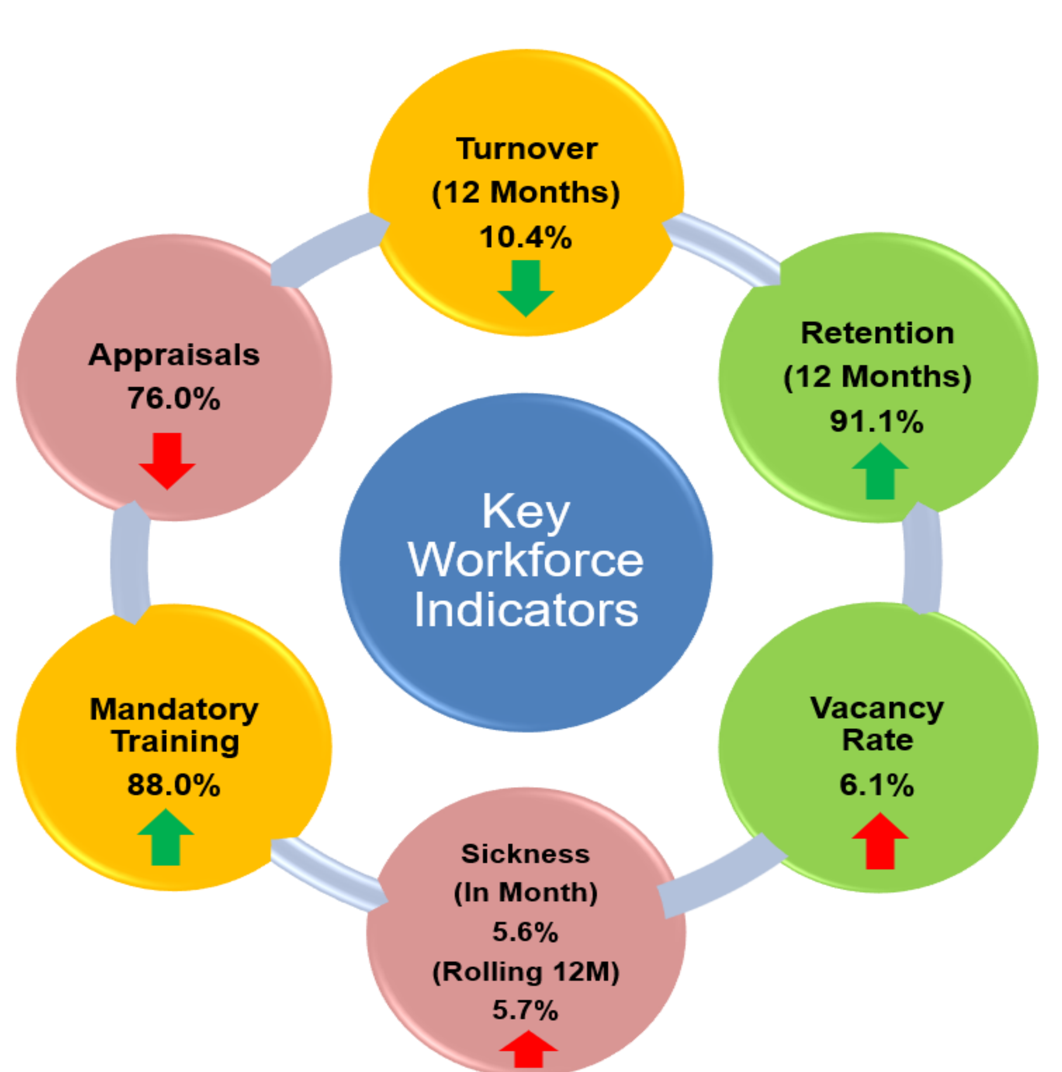
Alert

- A spike in winter illnesses, such as cold, cough and influenza-related absence, has driven an increase in short-term absence, which accounted for 42% of sickness episodes during October 2023, above the 35% 2023/24 average.
- The Trust continues to offer and encourage staff uptake of seasonal influenza and COVID-19 booster vaccination. As at 13 November, 26% of colleagues had taken an influenza vaccine which is an improvement on the position in November 2022 (18%). Currently 12.3% have accessed the COVID-19 Booster which is less than the 17.7% in November 2022.
- Compliance with appraisal, ensuring every member of staff has had an appraisal discussion within 12 months has fallen for the third consecutive month to 76%. The year to date average compliance level is 77.21% against a target of 90%. A deep dive assurance exercise has been undertaken with all divisions and is provided in a separate report.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Progress joint working across Wolverhampton and Walsall
Effective Collaboration	• Embed a culture of learning and continuous improvement

Walsall Healthcare NHS Trust

Key Workforce Metrics



Two of the six workforce indicators, vacancy rates and 12-month retention, meet the agreed targets/ thresholds. Mandatory training compliance and 12-month turnover are rated amber, whilst sickness absence and appraisal compliance are rated red.

Workforce performance trends are measured over a 24-month rolling period, with statistical process control methodology applied to provide assurance regarding consistent target achievement and performance stability.

There is limited assurance that the sickness absence rate, currently 5.6%, will consistently meet the 5% target, but performance in the context of a long-term trend is getting better.

The mandatory training compliance rate of 88% represents a short-term improvement, but with the context of a 24-month rolling period, there is no assurance that the 90% target will be consistently met.

There is no assurance that appraisal compliance, currently 76%, will consistently achieve the 90% target, with the performance trend getting worse. A deep dive exercise to provide assurance regarding an improvement trajectory is currently being undertaken and will be reported to Executive Committee, TMC and People Committee.

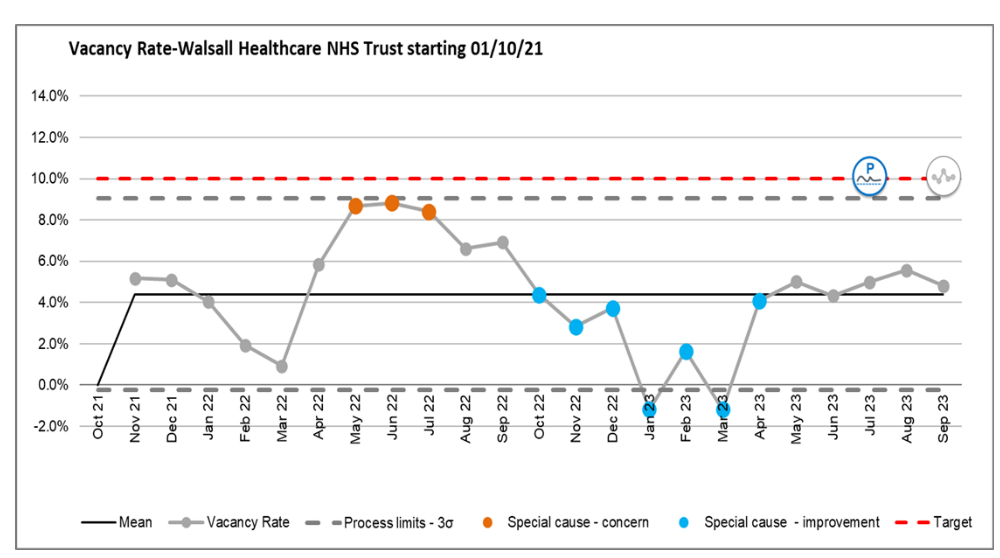
Whilst there is a need for more assurance regarding the consistent achievement of a 10% 12-month turnover target, the current 10.4% rate reflects improved performance.

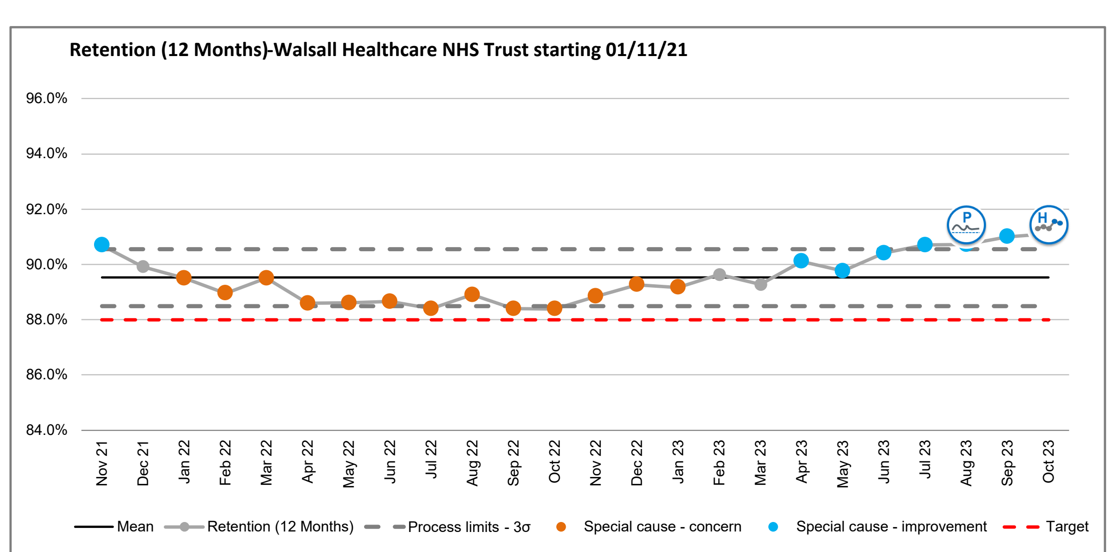
Assurance can be provided that the 12-month retention rate, currently 91.1%, will consistently meet the 90% target following continued performance improvement.

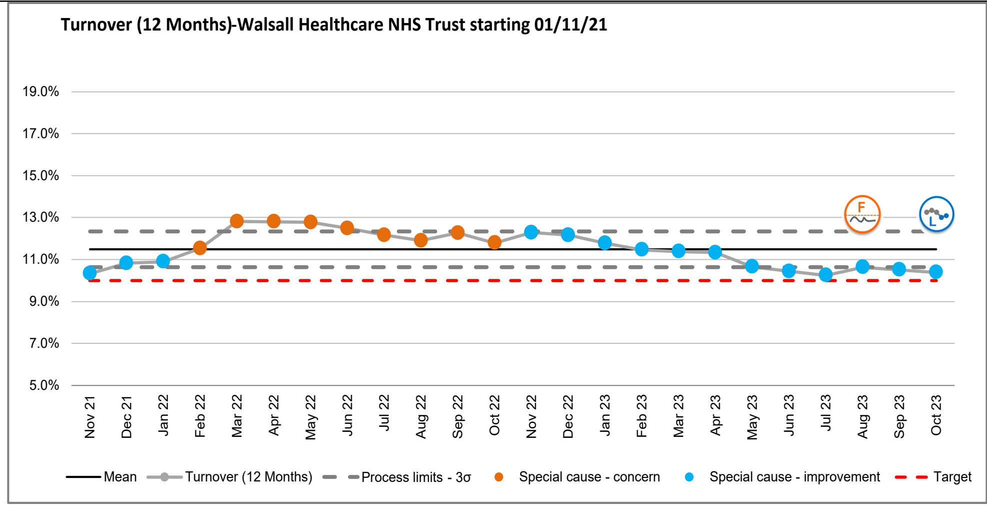
The 6.1% vacancy rate offers assurance that the 10% target will be met, with performance currently stable.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Attract, Recruit Retain





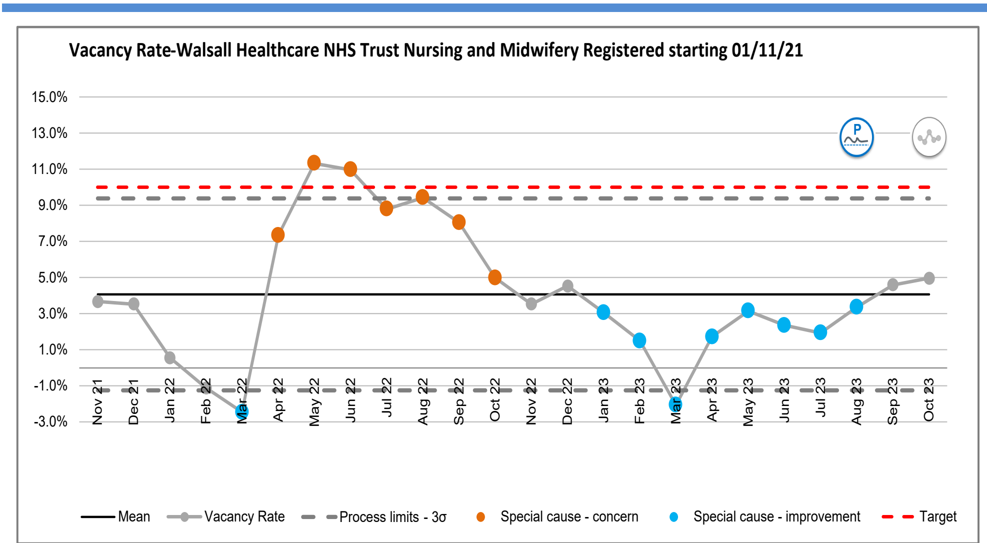


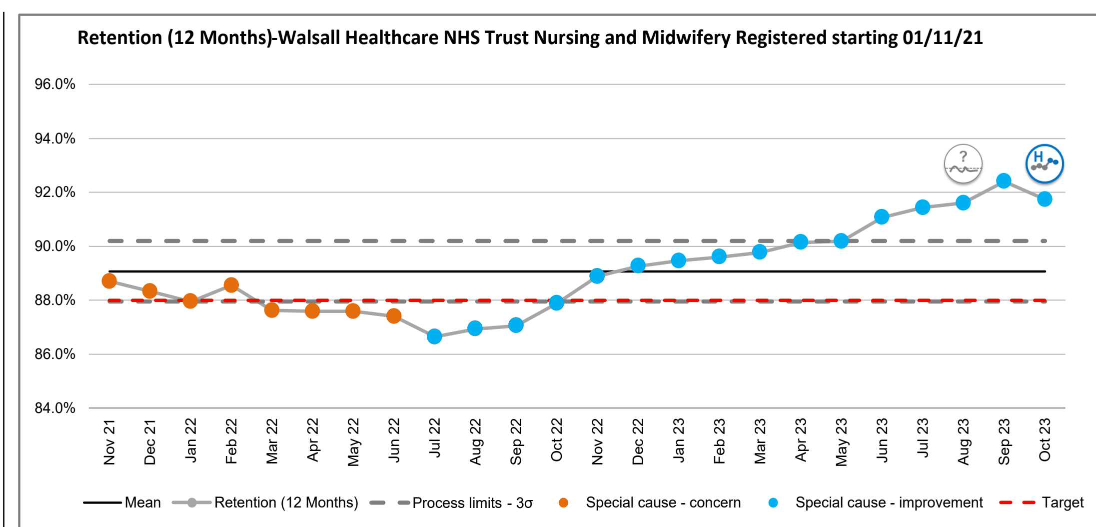
Key Issues & Challenges

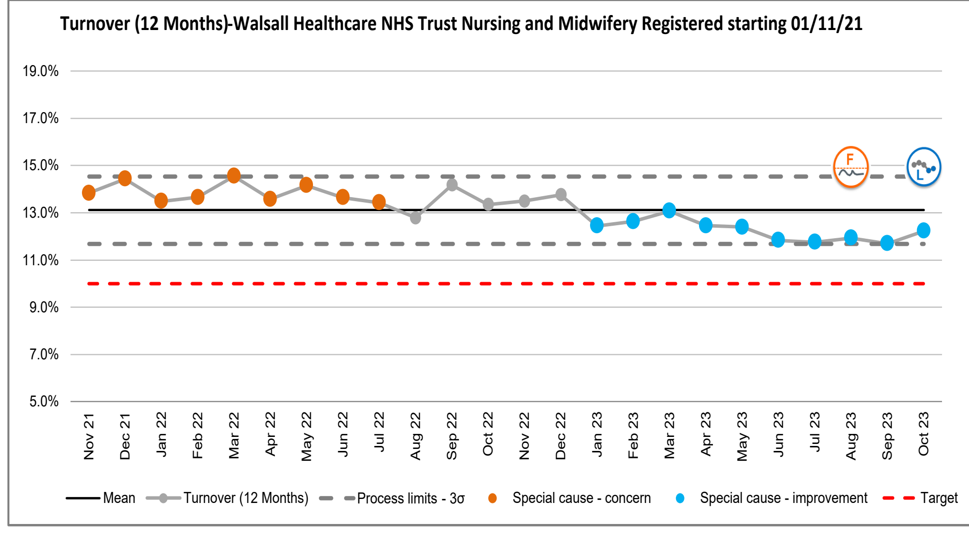
- The reported vacancy position reflects a month-on-month 88 FTE increase in the budgeted establishment, reconciled against a 22 FTE increase in the actual workforce; as per the month-end finance ledger.
- Most of the budgeted establishment growth aligns with the Registered Nursing and Midwifery (RN&M) and Additional Clinical Services staff group, whereby funding for the N&M workforce increased by 31 FTE, while clinical support to N&M budgeted FTE rose by 20 FTE.
- Recruitment work to mitigate the recent vacancy rise is supported by continued improvement regarding 12-month Retention and Turnover.
- This reflects a reduction year on year in colleagues declaring cultural reasons, such as work-life balance or incompatible working relationships, as their reason for leaving the Trust.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Attract, Recruit Retain





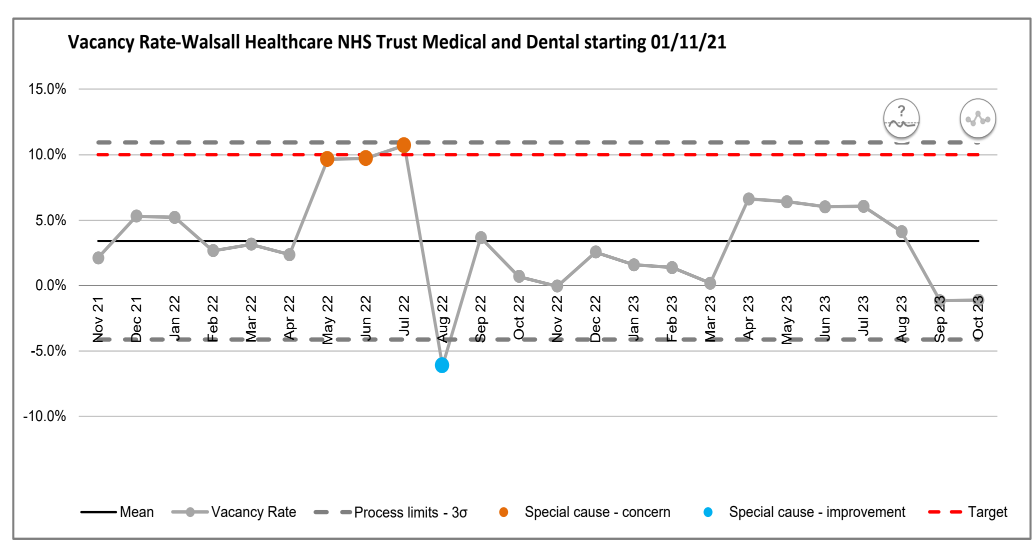


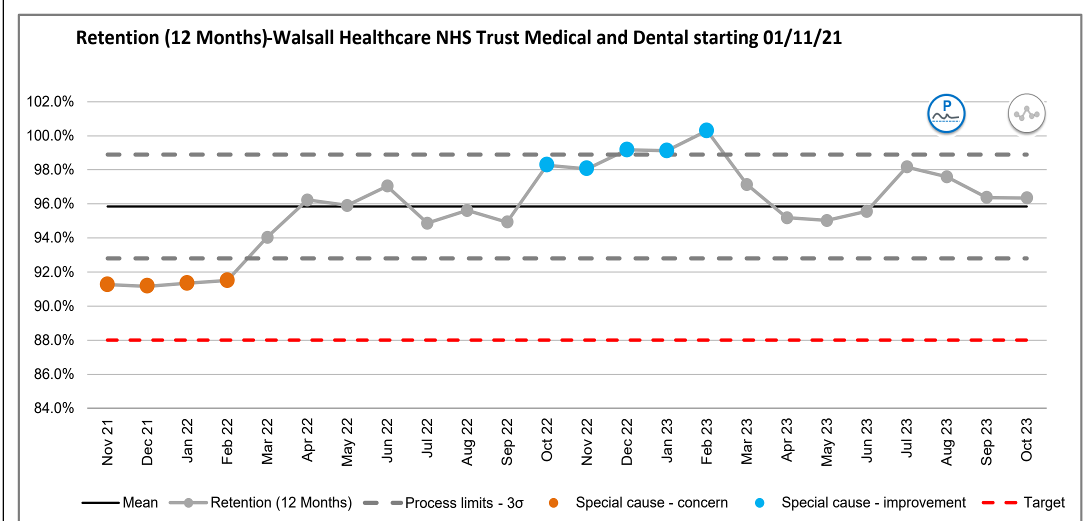
Key Issues & Challenges

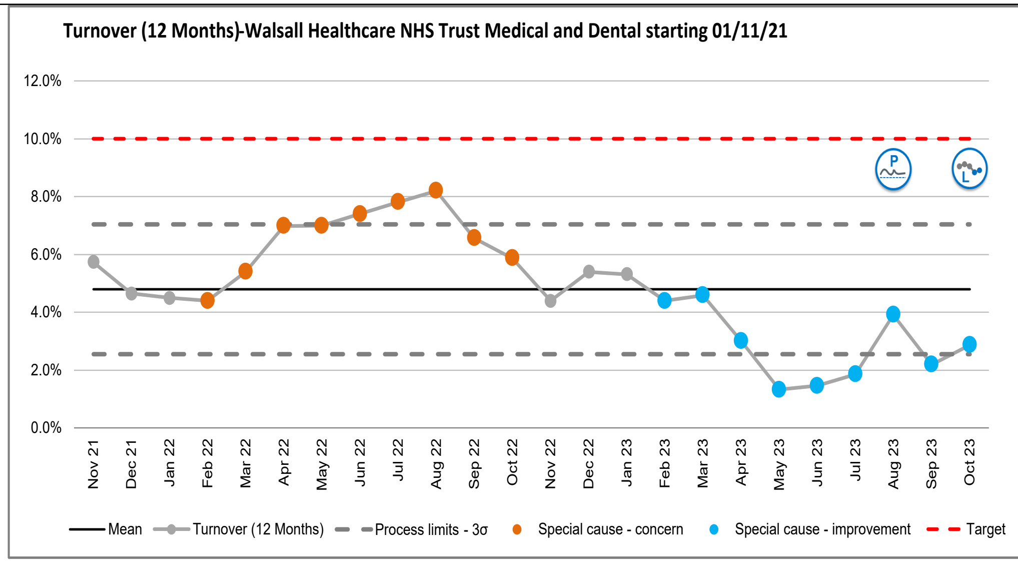
- The RN&M vacancy rate (4.96%) reflects a month-on-month 31 FTE increase in the budgeted establishment, reconciled against a 24 FTE increase in the actual workforce; as per the month-end finance ledger.
- Improved 12-month Turnover reflects a 59% reduction in RN&M colleagues leaving the Trust due to work-life balance versus 2022/23 turnover trends.
- The continued improvement trajectory for the 12-month Retention indicator has supported a 183 FTE growth in the RN&M workforce since October 2022.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Attract, Recruit Retain





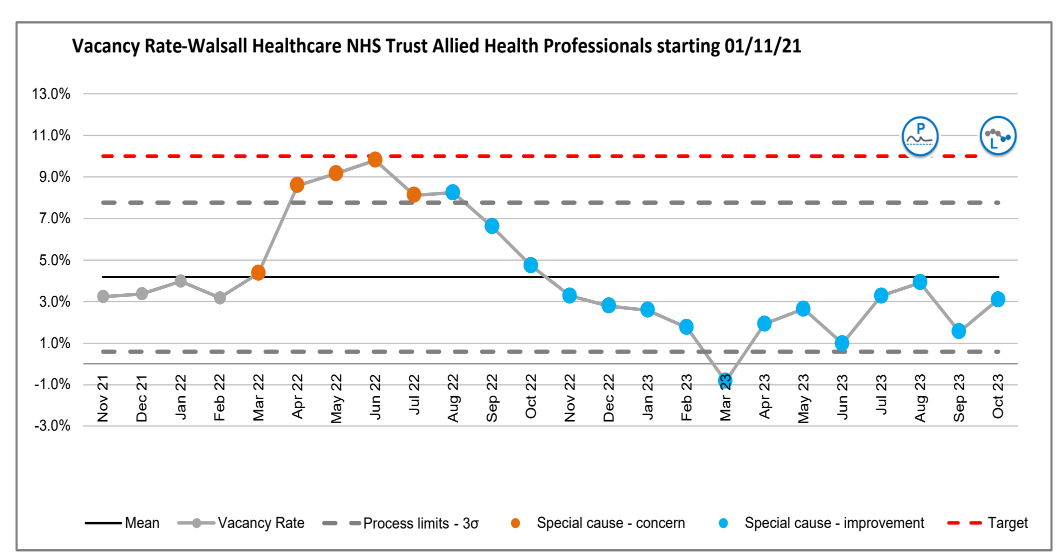


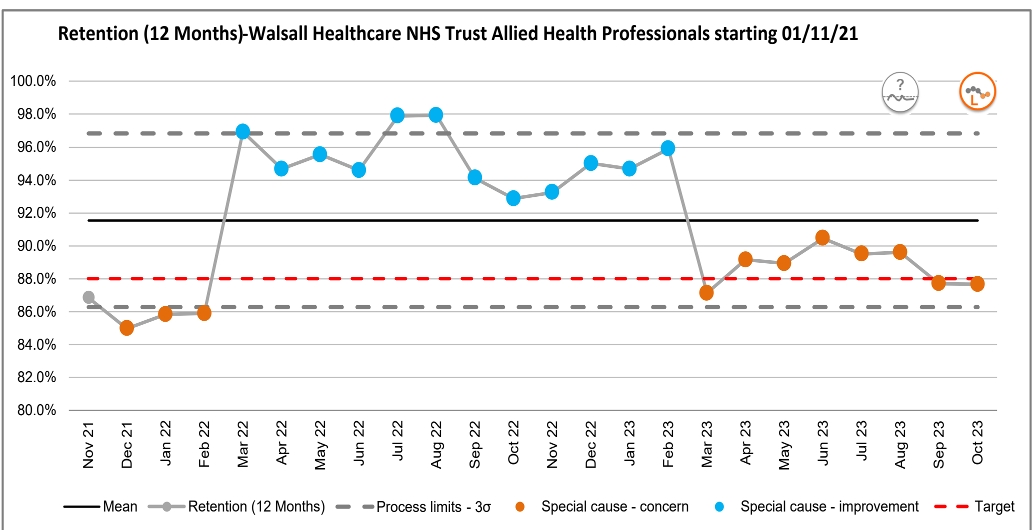
Key Issues & Challenges

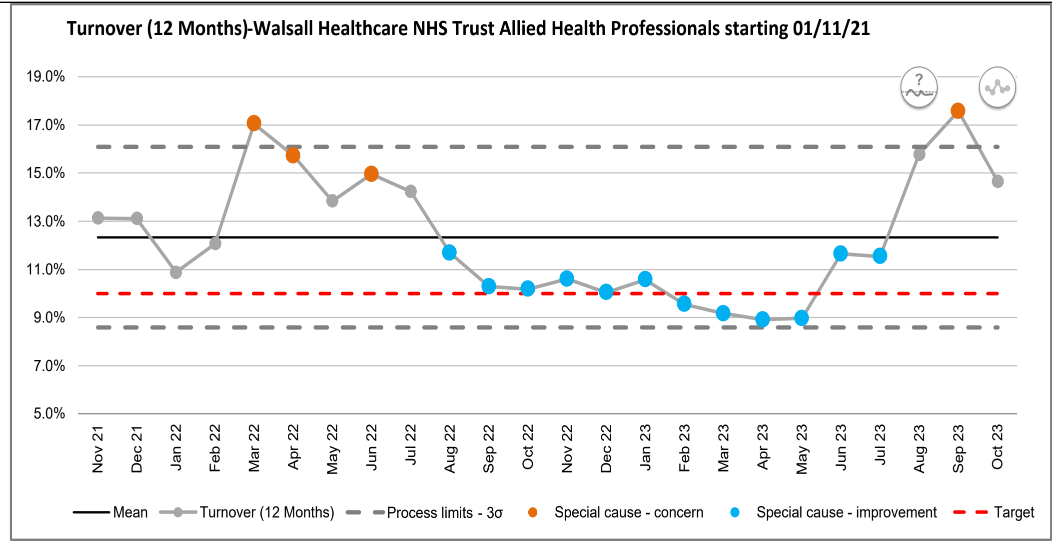
- There is continued Medical and Dental (M&D) over-establishment (1.1%) reflecting an 18 FTE increase in the budgeted establishment since April 2023, reconciled against a 58 FTE increase in the actual workforce; as per the month-end finance ledger.
- The 12-month Turnover metric remains positive, with most medics leaving the organisation for external promotion and a growing young demographic aged 35 and under strategically placed to support succession planning.
- 12-month Retention remains high, with the 2023/24 trend forecasting that 26% more M&D colleagues will have joined the organisation this year versus the year-end trajectory for M&D colleagues leaving.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Attract, Recruit Retain







Key Issues & Challenges

- The increased Allied Health Professionals (AHP) vacancy rate (3%) reflects a month-on-month 4.3 FTE increase in the budgeted establishment, reconciled against a 0.1 FTE decrease in the actual workforce; as per the month-end finance ledger.
- 12-month Turnover is back within the range following four months of negative trajectory, with AHP colleagues leaving the Trust during October 2023, declaring external promotion or a lack of internal opportunities as their exit reason.
- The 12-month retention indicator remains slightly below target. However, an 11% increase in the AHP workforce since October 2022 has been a catalyst for performance stabilising near the lows of a two-year range.

Walsall Healthcare NHS Trust

Mandatory Training and Appraisals

Medicine & Long-Term Conditions - Mandatory Training Compliance			
	Sep-23	Oct-23	Movement +/-
*Division Overall	88%	90%	1.83%
Acute Care Group	85%	88%	2.66%
Cardiology	88%	89%	1.47%
Elderly Care Group	92%	92%	0.85%
Emergency Care Group	87%	88%	1.40%
Gastroenterology	85%	92%	6.75%
Long-Term Conditions	87%	87%	0.31%
Medicine & Long-Term Conditions Management	87%	88%	0.34%

Surgery

Surgery - Mandatory Training Compliance			
	Sep-23	Oct-23	Movement +/-
*Division Overall	84%	86%	2.04%
Cancer Services	85%	87%	2.29%
General Surgery	84%	85%	0.99%
Head & Neck Care Group	82%	82%	0.23%
Outpatient & Support Services	76%	80%	3.75%
Surgery Management	88%	88%	-0.03%
Theatres, Critical Care & Anaesthetics	84%	88%	3.96%
Trauma Orthopaedics and MSK Services	84%	85%	0.34%

Women's, Children's & Clinical Support Services

Women's, Children's & Clinical Support Services - Mandatory Training Compliance			
	Sep-23	Oct-23	Movement +/-
*Division Overall	88%	88%	0.44%
Children's, Families and Neonates Care Group	90%	89%	-1.18%
Clinical Support Services	89%	90%	1.16%
Women's & Children's Management & Support	85%	89%	3.69%
Women's Services	87%	88%	0.99%

Estates and Facilities

Estates and Facilities - Mandatory Training Compliance			
	Sep-23	Oct-23	Movement +/-
*Division Overall	79%	79%	-0.05%
Facilities	78%	79%	0.26%
Estates Management	90%	85%	-4.32%
Facilities	78%	79%	0.26%

Community

Community - Mandatory Training Compliance			
	Sep-23	Oct-23	Movement +/-
*Division Overall	89%	90%	0.39%
Place Based Teams	82%	83%	0.74%
Adult Services Management	96%	96%	-0.62%
Intermediate & Urgent Care	90%	91%	0.92%
Palliative Care & End Of Life Care	94%	94%	-0.66%

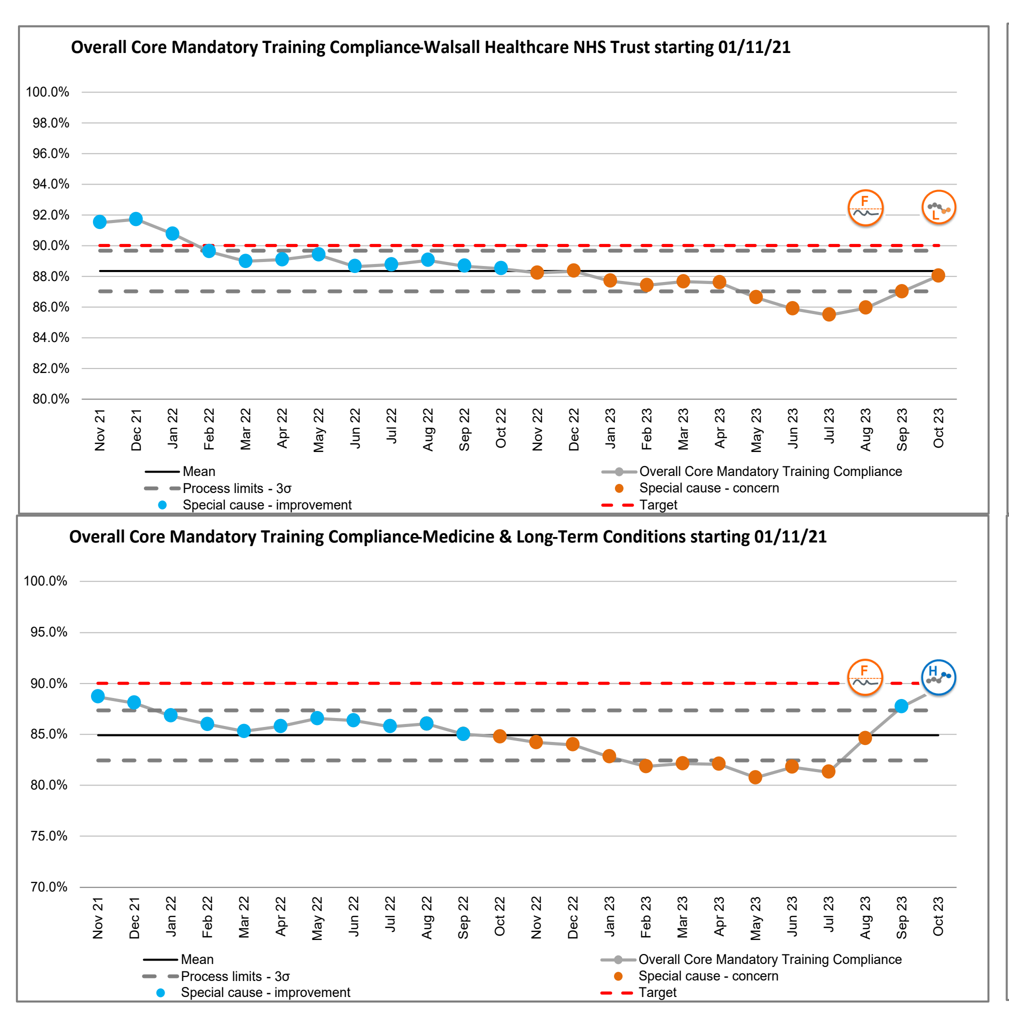
Staff Group	Appraisal Compliance Numerator	Appraisal Compliance Denominator	Appraisal Compliance Outturn
*All	2482	3264	76.04%
Add Prof Scientific and Technic	52	92	56.52%
Additional Clinical Services	545	676	80.62%
Administrative and Clerical	554	822	67.40%
Allied Health Professionals	203	251	80.88%
Estates and Ancillary	256	333	76.88%
Healthcare Scientists	30	44	68.18%
Medical and Dental	177	193	91.71%
Nursing and Midwifery Registered	665	853	77.96%
AfC Only	4787	6335	75.56%

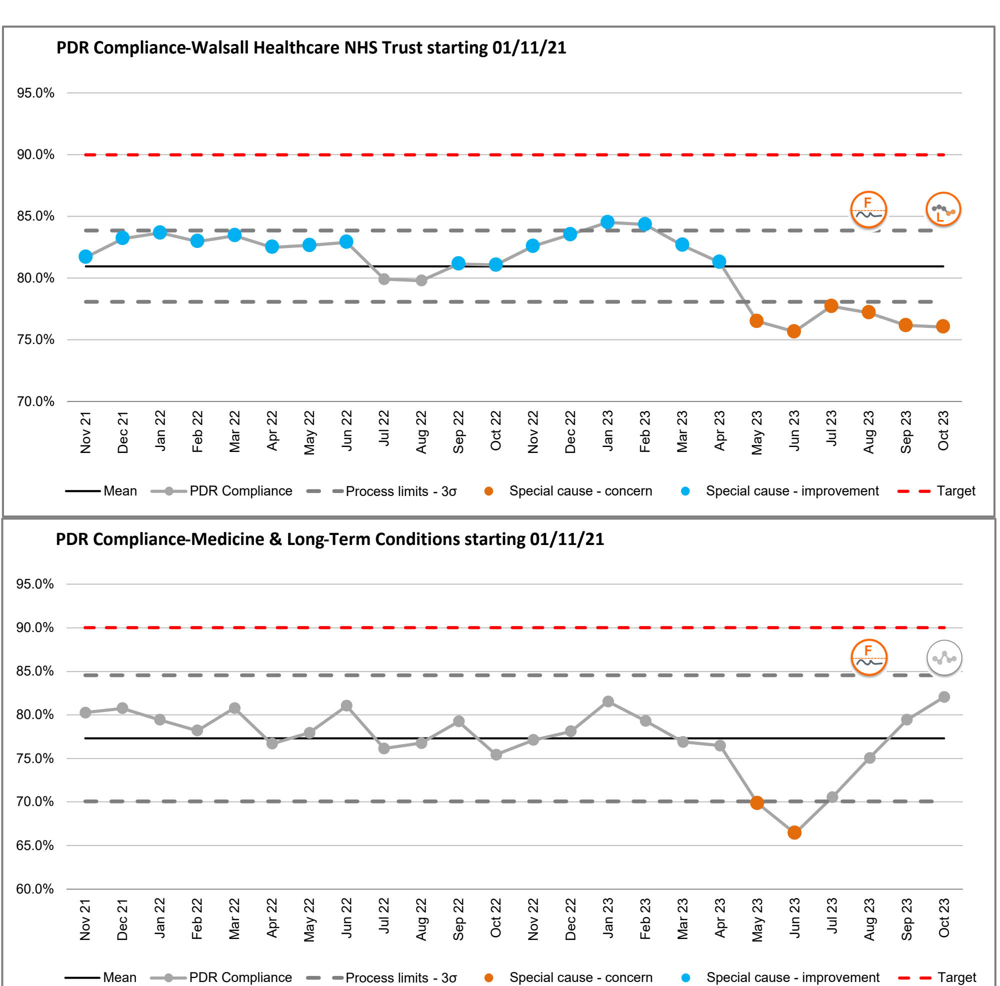
Key Issues & Challenges

- Whilst challenges remain regarding long-term assurance of target achievement, Mandatory Training compliance has continued the short-term improvement trajectory, rising 3% since July 2023.
- October 2023 performance reflects increased compliance amongst Safeguarding, Patient Handling and Adult Basic Life Support competencies.
- Appraisal compliance remains on a downward trajectory. A deep dive to provide assurance of an improvement trajectory is currently taking place.
- Whilst compliance amongst M&D colleagues remains above the 90% target, attainment rates amongst other staff groups have fallen.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

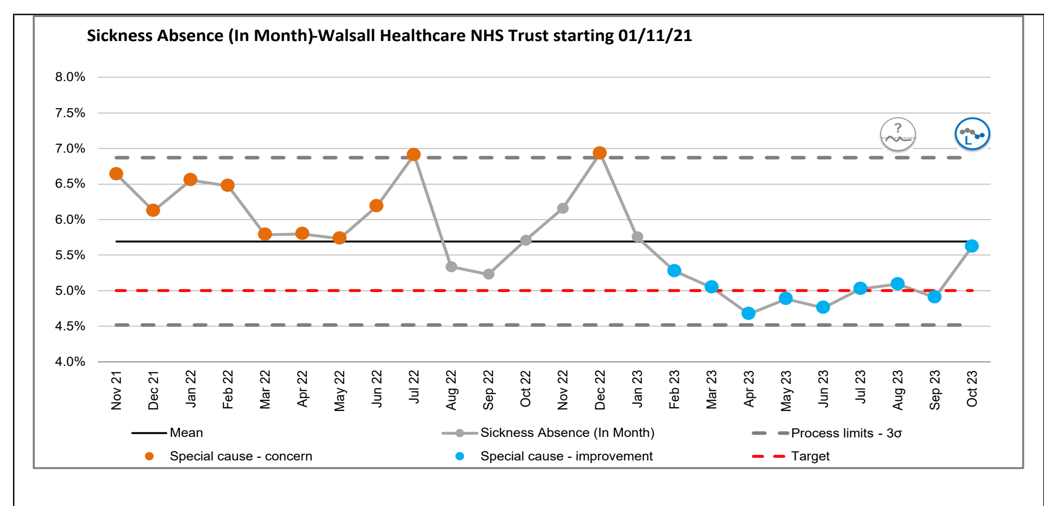
Mandatory Training and Appraisals

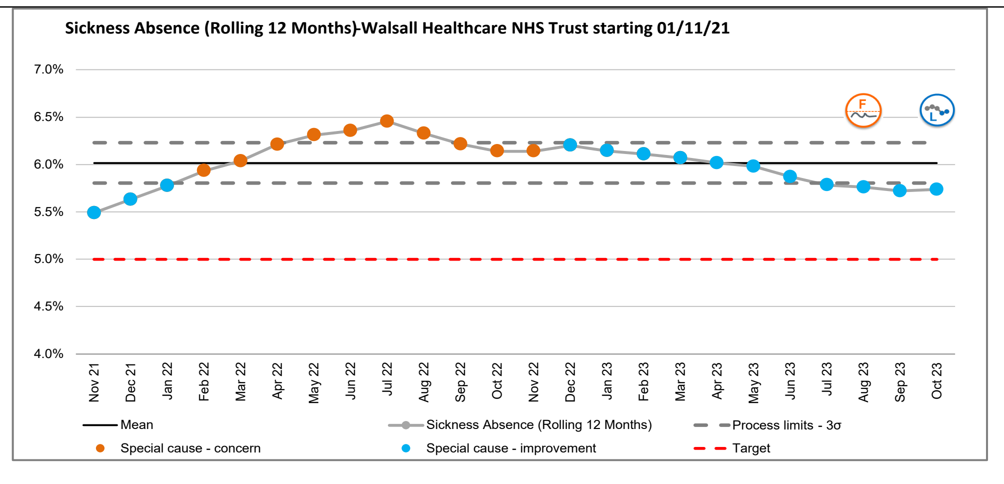




What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Health & Wellbeing



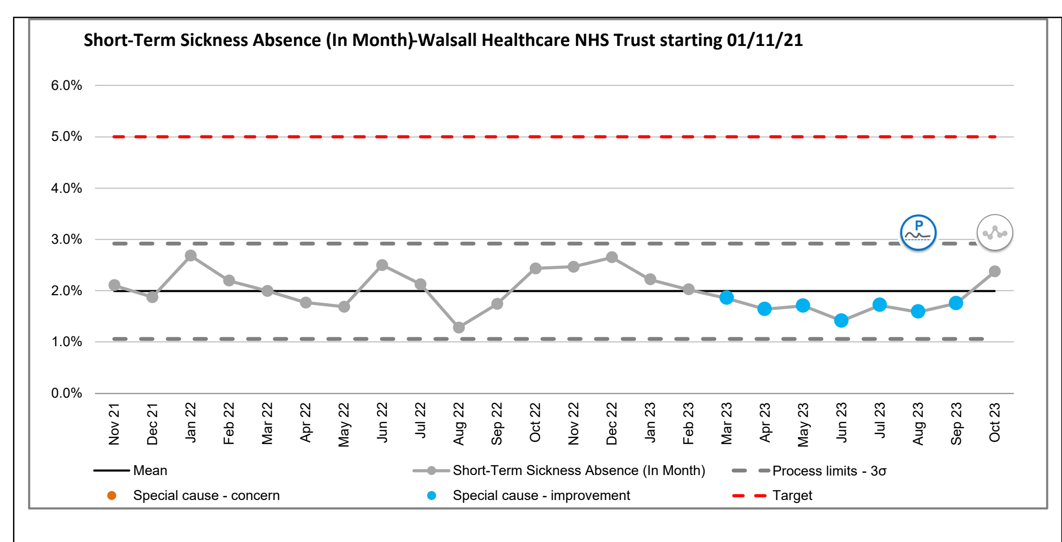


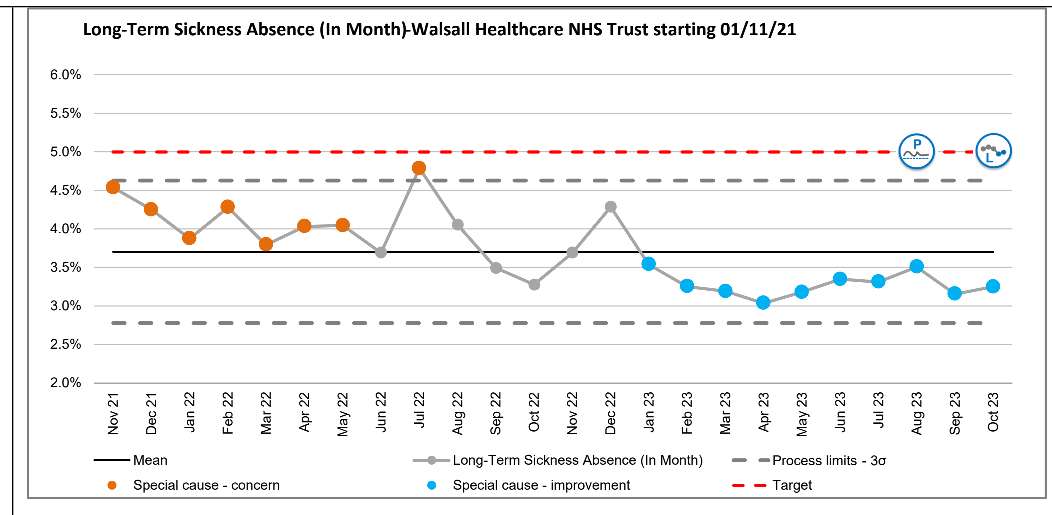
Key Issues & Challenges

- In-month sickness absence, which was 5.6% during October 2023, rose to equal the 24-month average but remains on an improved trajectory within the two-year trend context.
- This is reflected in the above chart analysis, which illustrates a continued special cause improvement and limited assurance regarding in-month sickness absence target achievement.
- Rolling 12-month analysis, whereby absence during the 12 months to October 2023 was 5.74%, remains below the two-year range, providing continued assurance of a strategic improvement regarding colleague attendance.
- The Estates & Facilities and Women's, Children's & Clinical Support Services divisions experienced high levels of sickness, with October 2023 in-month sickness rates of 9.6% and 6.6% respectively. Within both divisions, high absence levels are influenced by a spike in winter illnesses.
- Influenza and Covid-19 Booster vaccinations continue to remain available to staff.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Health & Wellbeing





Key Issues & Challenges

- A spike in winter illnesses, such as cold, cough and influenza-related absence, has driven an increase in short-term absence, which accounted for 42% of sickness episodes during October 2023, above the 35% 2023/24 average.
- The most prominent driver for sickness absence remains stress/anxiety (long-term), but a reduction of 16% in days lost to this absence reason (during 2023/24 year-to-date) suggests broad improvements regarding colleague mental health.
- There has been a notable increase in colleagues absent due to pregnancy-related or gynaecological reasons during 2023/24, with related sickness absence up by 58% and 22%, respectively, since 2022/23. Combining to account for 1 in 10 days lost during October 2023, tailored support for colleagues reporting related illnesses could improve staff well-being and overall absence rates.

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	4461.89	4481.04	4488.98	4535.01	4580.51	4588.40	-	-	-	-	-	152.68
Substantive Staff FTE (Ex. Rotational Drs)	4341.71	4342.69	4369.89	4389.04	4396.98	4423.58	4471.08	4479.97	-	-	-	-	-	138.25
Substantive Staff Headcount	5112	5119	5141	5167	5170	5217	5269	5277	-	-	-	-	-	165
Bank Staff Only Headcount	1181	1198	1230	1219	1050	1074	1083	1072	-	-	-	-	-	-109
% Staff from a BME Background	37.30%	37.60%	39.03%	39.23%	39.42%	39.57%	39.92%	39.85%	-	-	-	-	-	2.55%

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	101.10	101.77	102.77	102.63	101.90	102.26	-	-	-	-	-	-1.03
Additional Clinical Services	845.07	835.77	839.50	837.37	838.35	833.73	839.09	831.07	-	-	-	-	-	-14.00
Administrative and Clerical	921.93	920.29	916.72	914.25	920.35	923.17	924.15	926.87	-	-	-	-	-	4.93
Allied Health Professionals	294.29	291.18	293.43	293.28	295.15	299.65	305.02	305.44	-	-	-	-	-	11.15
Estates and Ancillary	256.83	255.87	253.30	253.18	251.93	255.75	256.75	255.57	-	-	-	-	-	-1.27
Healthcare Scientists	44.02	45.61	44.61	44.61	44.61	44.51	44.51	45.51	-	-	-	-	-	1.49
Medical and Dental	498.05	494.53	511.78	512.93	514.12	532.18	538.59	543.65	-	-	-	-	-	45.60
Nursing and Midwifery Registered	1454.23	1470.44	1482.46	1504.66	1502.71	1524.38	1550.50	1558.04	-	-	-	-	-	103.81
Students	18.00	20.00	19.00	19.00	19.00	19.00	20.00	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	37.46	44.86	21.05	159.27	71.94	54.79	-	-	-	-	-	442.94
Add Prof Scientific and Technic	13.17	2.40	2.30	0.20	0.00	2.07	0.91	0.00	-	-	-	-	-	7.87
Additional Clinical Services	176.28	15.48	4.61	15.17	7.84	6.53	18.31	6.53	-	-	-	-	-	74.47
Administrative and Clerical	124.51	14.36	7.41	9.80	5.60	8.99	7.80	10.88	-	-	-	-	-	64.84
Allied Health Professionals	47.80	1.00	3.92	4.00	3.00	5.80	10.03	4.60	-	-	-	-	-	32.35
Estates and Ancillary	29.57	0.00	0.45	0.00	0.00	4.00	0.00	1.00	-	-	-	-	-	5.45
Healthcare Scientists	5.20	1.60	0.00	0.00	0.00	0.00	0.00	1.00	-	-	-	-	-	2.60
Medical and Dental	219.34	6.00	10.00	8.00	4.00	113.95	18.54	13.60	-	-	-	-	-	174.09
Nursing and Midwifery Registered	134.22	12.73	8.76	7.69	0.61	17.93	14.36	17.17	-	-	-	-	-	79.27
Students	15.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	-	-	-	-	-	2.00

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	6	0	0	1	9	0						16
Number of Staff Converted to Apprentices in month	68	1	6	0	0	2	11	11						31

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	38.97	38.87	45.15	131.41	49.42	59.91	-	-	-	-	-	**411.64**
Add Prof Scientific and Technic	13.24	0.00	2.00	0.00	0.00	0.80	1.64	0.64	-	-	-	-	-	5.08
Additional Clinical Services	112.73	11.06	6.43	5.01	5.95	13.92	12.79	11.35	-	-	-	-	-	66.51
Administrative and Clerical	119.94	11.65	7.88	13.48	8.35	8.59	10.04	9.72	-	-	-	-	-	69.71
Allied Health Professionals	36.30	1.00	0.60	3.80	2.12	7.80	4.60	2.40	-	-	-	-	-	22.32
Estates and Ancillary	20.20	0.47	3.48	0.00	0.89	0.40	0.00	1.27	-	-	-	-	-	6.51
Healthcare Scientists	6.57	0.00	1.00	0.00	0.00	0.00	0.00	1.10	-	-	-	-	-	2.10
Medical and Dental	152.30	10.00	4.00	5.80	10.10	87.46	9.17	11.88	-	-	-	-	-	138.40
Nursing and Midwifery Registered	161.63	13.72	13.59	10.77	17.75	12.44	11.18	19.56	-	-	-	-	-	99.01
Students	1.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	-	-	-	-	-	2.00

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%**	**89.76%**	**90.41%**	**90.71%**	**90.72%**	**91.00%**	**91.11%**	-	-	-	-	-	**90.55%**
Retention Rate (24 Months)	**79.39%**	**79.39%**	**79.18%**	**79.64%**	**79.81%**	**80.26%**	**80.16%**	**80.79%**	-	-	-	-	-	**79.89%**
Retention Rate (5 Years)	58.62%	58.09%	57.75%	57.94%	58.56%	58.45%	58.34%	58.36%	-	-	-	-	-	58.21%

Retention Rate (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	
Add Prof Scientific and Technic	**69.23%**	**86.25%**	**80.06%**	**85.44%**	**51.43%**	**56.86%**	**55.61%**	**54.49%**	-	-	-	-	-	**67.16%**
Additional Clinical Services	**86.84%**	**87.02%**	**86.69%**	**87.08%**	**76.88%**	**77.48%**	**78.11%**	**78.55%**	-	-	-	-	-	**81.69%**
Administrative and Clerical	**92.36%**	**92.23%**	**91.47%**	**91.03%**	**82.20%**	**82.61%**	**82.62%**	**82.30%**	-	-	-	-	-	**86.35%**
Allied Health Professionals	**87.13%**	**89.16%**	**88.93%**	**90.47%**	**85.40%**	**84.10%**	**79.57%**	**79.53%**	-	-	-	-	-	**85.31%**
Estates and Ancillary	**89.79%**	**90.60%**	**91.29%**	**92.35%**	**80.40%**	**81.60%**	**81.17%**	**82.12%**	-	-	-	-	-	**85.65%**
Healthcare Scientists	**86.28%**	**87.26%**	**89.32%**	**91.48%**	**85.72%**	**85.58%**	**85.58%**	**83.61%**	-	-	-	-	-	**86.94%**
Medical and Dental	**97.13%**	**95.19%**	**95.02%**	**95.56%**	**91.96%**	**92.67%**	**92.35%**	**95.57%**	-	-	-	-	-	**94.04%**
Nursing and Midwifery Registered	**89.78%**	**90.15%**	**90.19%**	**91.07%**	**79.28%**	**79.52%**	**79.96%**	**81.41%**	-	-	-	-	-	**84.51%**

Employee Relation Activity – Number of Open & Closed Cases	2022/23 Monthly Avg.	2023/24												YTD Monthly
		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	15	13	11	9	6	6	5	5						8
Open Bullying & Harassment Cases	5	4	4	4	1	2	2	2						3
Open Capability Cases	3	2	2	5	4	2	2	3						3
Open Disciplinary Cases	18	24	28	27	29	28	25	22						26
Cases Closed	10	3	10	7	3	10	4	7						6

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%	10.65%	10.44%	10.24%	10.63%	10.51%	10.38%	-	-	-	-	-	10.60%
Add Prof Scientific and Technic	12.45%	12.45%	14.99%	14.53%	13.31%	12.83%	13.81%	12.61%	-	-	-	-	-	13.50%
Additional Clinical Services	14.35%	15.09%	13.58%	13.04%	13.52%	13.86%	13.43%	13.52%	-	-	-	-	-	13.72%
Administrative and Clerical	9.14%	9.61%	8.38%	8.80%	8.18%	7.97%	7.43%	7.14%	-	-	-	-	-	8.22%
Allied Health Professionals	9.17%	8.91%	8.97%	11.65%	11.54%	15.78%	17.58%	14.66%	-	-	-	-	-	12.73%
Estates and Ancillary	8.04%	6.87%	7.67%	6.33%	5.20%	2.86%	3.98%	4.77%	-	-	-	-	-	5.38%
Healthcare Scientists	9.96%	9.45%	8.63%	3.55%	2.43%	2.53%	2.60%	4.05%	-	-	-	-	-	4.75%
Medical and Dental	4.59%	3.01%	1.33%	1.46%	1.86%	3.92%	2.19%	2.87%	-	-	-	-	-	2.38%
Nursing and Midwifery Registered	13.08%	12.45%	12.40%	11.84%	11.76%	11.93%	11.70%	12.23%	-	-	-	-	-	12.04%

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%	4.89%	4.76%	5.03%	5.09%	4.91%	5.62%	-	-	-	-	-	5.00%
% Sickness Absence (Rolling 12 Months)	6.07%	6.02%	5.98%	5.87%	5.78%	5.76%	5.72%	5.74%	-	-	-	-	-	5.84%
FTE Days Lost	6917	6200	6749	6384	6994	7144	6713	7986	-	-	-	-	-	6881
% Short Term Sickness	34.68%	35.06%	34.91%	29.67%	34.13%	31.12%	35.72%	42.20%	-	-	-	-	-	34.69%
% Long Term Sickness	65.32%	64.94%	65.09%	70.33%	65.87%	68.88%	64.28%	57.80%	-	-	-	-	-	65.31%
Estimated Cost of Sickness £	£8,662,364	£586,363	£667,728	£603,515	£645,432	£687,953	£650,689	£796,753	-	-	-	-	-	£662,633

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	1880.3	1802.1	1810.4	1740.1	1597.4	1736.9	-	-	-	-	-	-15.78%
Cold, Cough, Flu - Influenza	740.3	386.9	339.3	205.4	281.4	377.4	391.8	962.6	-	-	-	-	-	-43.17%
Gastrointestinal problems	726.2	670.8	659.5	727.1	808.3	619.2	579.1	669.9	-	-	-	-	-	-6.87%

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%	86.61%	85.88%	85.47%	85.94%	87.01%	88.03%	-	-	-	-	-	86.65%
Appraisal	82.66%	81.27%	76.48%	75.65%	77.70%	77.18%	76.16%	76.04%	-	-	-	-	-	77.21%

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	161	127	153	105	88	77						852

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	8	10	20	21	13	12	55						139

Establishment Gap By Staff Group (FTE)	2022/23	2023/24												YTD Change
	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	
Total Establishment Gap	**-72.75**	**168.82**	**205.03**	**223.05**	**208.68**	**264.37**	**231.61**	**297.44**	**-**	**-**	**-**	**-**	**-**	**370.19**
Additional Clinical Services	-68.44	-48.41	-43.38	-27.77	-29.87	-18.94	-26.00	14.46	-	-	-	-	-	82.90
Administrative and Clerical	-16.41	63.31	73.22	74.08	83.36	84.78	88.96	97.42	-	-	-	-	-	113.83
Allied Health Professionals	-2.15	5.05	7.00	6.18	8.96	8.97	4.31	8.71	-	-	-	-	-	10.86
Estates and Ancillary	53.71	84.82	87.62	87.93	88.16	89.09	84.53	87.30	-	-	-	-	-	33.59
Healthcare Scientists	-1.05	0.92	-1.88	-0.44	0.56	0.28	7.09	8.14	-	-	-	-	-	9.19
Medical and Dental	0.92	34.18	33.40	32.80	23.20	21.65	-6.19	-5.99	-	-	-	-	-	-6.91
Nursing and Midwifery Registered	-47.50	26.82	48.42	46.64	30.97	47.22	75.27	82.78	-	-	-	-	-	130.28
Professional and Scientific	8.17	2.13	0.63	3.63	3.34	5.87	3.64	4.62	-	-	-	-	-	-3.55
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	0.00

Agency Spend (£000's)	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 Agency Spend	**£15,777**	**£867**	**£1,186**	**£826**	**£886**	**£504**	**£466**	**£445**	**-**	**-**	**-**	**-**	**-**	**£5,180**
Nursing and Midwifery Registered	£6,815	£135	£244	£349	£328	£17	£172	£98	-	-	-	-	-	£1,344
Qualified Scientific, Therapeutic and Technical	£1,334	£145	£160	£101	£96	£36	£90	£95	-	-	-	-	-	£723
Support to Clinical Staff	£900	£77	£92	£187	£134	£177	£137	£184	-	-	-	-	-	£988
of which support to nursing staff	£292	£4	-£18	£39	£29	£83	-£21	£43	-	-	-	-	-	£159
NHS Infrastructure Support	£2,029	£156	£162	£2	£114	£127	£17	£57	-	-	-	-	-	£635
Medical and Dental	£4,699	£353	£527	£188	£215	£147	£50	£10	-	-	-	-	-	£1,490
of which Consultants	£1,609	£100	£213	£64	£123	£89	£35	£16	-	-	-	-	-	£641
of which Career/Staff Grade	£1,345	£136	£153	£52	£47	£56	£20	-£5	-	-	-	-	-	£458
of which Trainee Grades/Trust Grade	£1,746	£118	£161	£71	£46	£1	-£4	-£2	-	-	-	-	-	£391

Bank Spend (£000's)	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 Bank Spend	**£30,435**	**£2,581**	**£2,702**	**£2,625**	**£2,556**	**£2,898**	**£2,940**	**£2,575**	**-**	**-**	**-**	**-**	**-**	**£18,879**
Nursing and Midwifery Registered	£9,301	£949	£900	£726	£794	£854	£789	£730	-	-	-	-	-	£5,742
Qualified Scientific, Therapeutic and Technical	£26	£4	£3	-£2	£3	£8	£1	£1	-	-	-	-	-	£18
Support to Clinical Staff	£6,765	£556	£573	£663	£608	£657	£622	£553	-	-	-	-	-	£4,231
of which support to nursing staff	£5,801	£459	£489	£568	£515	£558	£517	£469	-	-	-	-	-	£3,574
NHS Infrastructure Support	£2,541	£236	£214	£230	£285	£205	£247	£224	-	-	-	-	-	£1,642
Medical and Dental	£11,802	£837	£1,012	£1,008	£866	£1,174	£1,281	£1,067	-	-	-	-	-	£7,246
of which Consultants	£6,273	£522	£646	£619	£440	£763	£866	£639	-	-	-	-	-	£4,496
of which Career/Staff Grade	£2,765	£47	£247	£197	£224	£227	£244	£287	-	-	-	-	-	£1,473
of which Trainee Grades/Trust Grade	£2,763	£268	£119	£192	£203	£184	£171	£141	-	-	-	-	-	£1,277

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

Appendix B - HR KPI RAG Rating Scales

Appraisal rate	<81%	81% - 90%	>=90%
Mandatory Training Attendance	<81%	81% - 90%	>=90%
Retention (24 Months)	<75%	75% - 85%	>=85%
Retention (12 Months)	<78%	78% - 88%	>=88%
Sickness Absence %	>6%	5% - 6%	<=5%
Turnover	>11%	10% - 11%	<=10%
Vacancy Rate	>11%	10% - 11%	<=10%

Appendix C - 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

Walsall Healthcare NHS
NHS Trust

MEETING OF THE EXTRAORDINARY FINANCE AND PRODUCTIVITY COMMITTEE HELD ON WEDNESDAY 20 SEPTEMBER 2023 AT 14:15 ON MICROSOFT TEAMS

PRESENT

Members

Mr Paul Assinder	Non-Executive Director (Chair)
Ms Rachel Barber	Associate Non-Executive Director
Mrs Mary Martin	Non-Executive Director
Mrs Lisa Carroll	Chief Nursing Officer (Part)
Dr Manjeet Shemar	Chief Medical Officer
Ms Steph Cartwright	Group Director of Place
Mr Ned Hobbs	Chief Operating Officer
Mr Dan Mortiboys	Operational Director of Finance
Mr Kevin Bostock	Group Chief Assurance Officer
Mr Keith Wilshere	Group Company Secretary
Mr Simon Evans	Group Chief Strategy Officer (Part)

In Attendance

Ms Katherine Geal	Executive Assistant (Minutes)

Apologies

Ms Dawn Brathwaite	Non-Executive Director
Mr Kevin Stringer	Group Chief Finance Officer

APPROVED

91/2023	Chair's Welcome, Apologies, and Confirmation of Quoracy
	Mr Assinder welcomed everybody to the meeting and declared the meeting to be quorate. Mr Assinder informed the committee that the extraordinary committee has been convened in preparation for a potential change to the Trust financial plan to be submitted to the ICB, which would require full Board review. Formal apologies were received and noted as above.
92/2023	**Trust Financial Outturn**
	Mr Mortiboys introduced the committee to the financial outturn slides, and advised the committee of the following, below. Based on the Month 5 financial position, the most likely year end forecast shows a deficit of £31,092M. This is c£17M adverse to the original plan. £9,332M of this is due to issues outside of the Trust control. The remaining c£7.710m comes from under achievement of CIP (£3.4m), risks around paediatric staffing (c£2.1m) and the requested stretch to reduce workforce. A best case would be **£19.713m deficit** and a worse case **£46.203m deficit.** The Trust continues to work to reduce the deficit across all areas within the forecast. The Trust is challenging all bank usage to ensure RN and CSW usage are in line with agreed plans.

	All staffing overspends are being reviewed at Exec Director level and action plans developed. Vacancy Panels are in place across the Trust. The Trust is generating ERF based on current plans, noting the variance between ICB and NHSE plans. The Trust is seeing increases in drugs costs and will be taking further action to reduce these costs. Divisions have been placed in financial recovery; Surgery, Medicine and Long Term Conditions, and Women's, Children's, and Clinical Support Services. Mrs Martin raised concern that work had not been done in these divisions in the first 5 months of the year. Mr Mortiboys assured the committee that work had been ongoing, and that a granular review has now commenced, with focus on WTE, for example. Mr Assinder asked for assurance that all ICB expectations regarding the vacancy approvals is in place. Mr Mortiboys assured that the return has been sent, and that Mr Stringer has provided a response from the Chair. Mr Mortiboys furthered that the 4 provider trusts have met to discuss the return, ensuring consistency in response. Mr Mortiboys gave an example of ongoing work, a Staffing Bridge from 2018/19-2022/23, and that the 67 business cases from that timeframe is still under review to ensure that benefits are understood. Mr Assinder stated that a key function of the committee is to ensure that the Trust delivers the benefits of what the Trust are signing up to when approving business cases and business plans, so the post implementation benefit investigation is important and rather than wait for completion, it would be beneficial to see the results of what has been done so far. **ACTION** Mr Mortiboys to feed back to Mr Evans who leads the process for confirmation of what cases have gone through Investment Group. Mr Mortiboys advised the committee that there is some debate at ICB level regarding the deficit pan, asking the Trust and provider colleagues to provide £1.7M to the STF fund. Mr Mortiboys advised that this will be feedback to the committee if a formal request is made. Mr Mortiboys outlined the Cost Growth challenge, as WHT's growth has been slower over the last 5 years, in comparison to other Black Country Trusts. Mr Mortiboys stated that WHT's comparative workforce growth is the lowest across the Black Country; with NHSE challenge that WHT cost per head count has significantly grown since COVID, asking for confirmation of what is being delivered.

APPROVED

Mr Mortiboys advised that WHT was asked for the largest balance sheet adjustment across the Black Country, despite being the smallest provider by turnover; and that the distribution of ICS funding was not favoured towards WHT.

Mr Assinder asked if the Balance Sheet contributions are validated by PWC and requested an update. Mr Mortiboys advised that the final report has not yet been received, but that discussions have been had between Mr Jackson, ICB CFO and Nicola Hollins, NHSE Regional CFO who are aware of PWC work. Mr Mortiboys advised that PWC have provided some simple opportunities such as holding fewer accruals for goods received un-invoiced and to hold fewer accruals for invoices that have been recorded on the Trust ledger. Some of this wont be possible as they are capital accruals that cannot be released into revenue, and that some go through the Agreements and Balance exercise with NHSE.

Mrs Martin requested clarification regarding the accruals. Mr Mortiboys advised of the process for raising orders and advised that at the point goods are booked in and received, accruals are generated.

Mr Assinder asked that if there is an expectation from the ICB for the Trust to make a contribution to the overall ICB deficit, and the ICB receive external validation and it transpires that the Trust are not to provide a contribution, should there be a compensation. Mr Mortiboys stated that he has raised this concern to Mr Stringer, and that he will raise this point with ICB colleagues.

ACTION
Following the outcome of the PWC, Mr Mortiboys to have dialogue with ICB regarding expectations.

Mr Mortiboys informed the committee that WHT is the 3rd best value across the model hospital population, for cost per weighted activity unit, for 2021/22.

Mr Mortiboys advised that WHT is seeing larger growth for emergency activity, in comparison to other Black Country trusts.

Mr Mortiboys informed of various inflationary impacts, such as the Pay Award and Industrial Action at £3.98M.

Mr Mortiboys advised that the Trust are £300k behind the CIP plan, but the plan will become more challenging throughout the year. There is considerable non-pay cost with some outsourcing due to issues such as UHB non-support in Neurology due to their ongoing sickness issues. Mr Mortiboys advised that vacancies are offsetting individual pay overspend. Divisions are being challenged to ensure that there is correct staffing.

APPROVED

Mr Assinder asked for assurance on finance for the Winter Plan and the opportunities for additional capacity. Mr Hobbs advised that the full Winter Plan is to be presented at the upcoming Finance and Productivity Committee for scrutiny. There is an internally allocated £1.5M envelope for Winter, though this is less than in previous years. Mr Hobbs advised that the challenge for this year is that there is no additional national or regional allocations confirmed, though the Secretary of State for Health has announced a £200M fund for winter, though it is unclear how real the money is and how it will be allocated. There is a modest underspend at regional level to be allocated non-recurrently, though this has not yet been confirmed.

Mrs Martin requested clarity on income allocation for community projects, with known reduction in income allocation for a number of community projects and the plan to scale back certain activity in [redacted] Ms Cartwright stated that Community Services is predicting an overspend, and there is an agreement with ICB colleagues regarding some funding disputes. [redacted] Mr Mortiboys furthered that Community Services holds a number of vacancies and has lower variances.

Mr Mortiboys outlined the I&E Forecast slide to the committee and the assumptions made at Month 5.

Mr Mortiboys advised normal efficiencies, the technical adjustment and the stretch, and that the Trust are not achieving 80% or normal efficiencies achieved; this is reflected across Black Country Trusts. The Trust are currently achieving 65% of CIP.

Mr Mortiboys informed that a letter has been received from the ICB who have agreed to give a cash advance in November and December 2023, up to £10M.

Ms Barber asked for assurance around Procurement, as advised at the last Finance and Performance Committee that there will not be a loss of staff, and asked if all opportunities have been reviewed, and asked as the ICB are reviewing as a collaborative, how much of this is an issue for WHT as a Trust. Mr Assinder stated that Sir David Nicholson has talked about the overall position of the acute provider collaborative. Mr Hobbs agreed to discuss the collaborative offline with Ms Barber.

ACTION
Mr Evans to provide an update at Finance and Productivity Committee on collaborative working.

APPROVED

Signed:

Committee Chair: Paul Assinder

Date: 25 October 2023

APPROVED

MEETING OF THE FINANCE AND PRODUCTIVITY COMMITTEE HELD ON WEDNESDAY 25 OCTOBER 2023 AT 15:00 BOARD ROOM, TRUST HEADQUARTERS, AND MICROSOFT TEAMS

PRESENT

Members

Mr Paul Assinder	Non-Executive Director (Chair)
Ms Rachel Barber	Associate Non-Executive Director
Mrs Mary Martin	Non-Executive Director
Mr Kevin Stringer	Group Chief Finance Officer
Ms Steph Cartwright	Group Director of Place
Mrs Lisa Carroll	Chief Nursing Officer
Dr Manjeet Shemar	Chief Medical Officer
Mr Ned Hobbs	Chief Operating Officer
Mr Dan Mortiboys	Operational Director of Finance
Ms Kate Salmon	Deputy Chief Strategy Officer- Improvement and Collaboration

In Attendance

Mr Stephen Jackson	Director of Operations, Community Services
Mr Stew Watson	Group Director of Estates Development
Ms Katherine Geal	Executive Assistant (Minutes)

Apologies

Mr Simon Evans	Group Chief Strategy Officer
Mr Keith Wilshere	Group Company Secretary
Mr Kevin Bostock	Group Chief Assurance Officer
Ms Dawn Brathwaite	Non-Executive Director

113/2023	Chair's Welcome, Apologies, and Confirmation of Quoracy
	Mr Assinder welcomed everybody to the meeting and declared the meeting to be quorate. Formal apologies were received and noted as above.
114/2023	**Declarations of Interest**
	There were no declarations of interest made.
115/2023	**Minutes of Previous Meeting 20 September 2023**
	Mr Hobbs advised that on page one the second paragraph should be amended to read '*This is c£17M adverse to the original plan. £9,332M of this is due to issues outside of the Trust control*'. Mr Hobbs stated that the last paragraph on page 3 should read *'There is considerable non-pay cost with some outsourcing due to issues such as UHB non-support in Neurology…'* Mrs Carroll requested that her job title be amended to correctly state 'Chief Nursing Officer'.

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	RESOLVED That, having incorporated the changes above, the minutes from the 20 September 2023 be approved as a true and accurate record of discussions and decisions that took place.
116/2023	**Minutes of Previous Meeting 27 September 2023**
	Mrs Carroll requested that her job title be amended to correctly state 'Chief Nursing Officer'. **RESOLVED** That, having incorporated the changes above, the minutes from the 27 September 2023 be approved as a true and accurate record of discussions and decisions that took place.
117/2023	**Matters Arising**
	Mr Assinder requested an update on the Winter Plan from Mr Hobbs. Mr Hobbs advised that there is support for the WHT interventions, though there is not yet formal funding allocation. Dr Shehmar stated that pressures are already being seen in services, and advised the committee that there is focus at the Quality Committee to ensure that clinical services and staffing are safe according to the Winter Plan; Dr Shehmar stated that she expects issues will be escalated to the Board. Mr Assinder asked if pressures in October will be alleviated by funding. Mr Hobbs advised that the predicted worst months are December and January, and that other acute Trusts nationally have already declared critical incidents and there is national concern. Mr Stringer advised that he is to meet with Mr Tom Jackson, Chief Finance Officer, NHS Black Country ICB and will advise that there is significant risk; this will also be escalated to Mr Loughton for Chief Executive discussion.
118/2023	**Action Log**
	Community Services Modelling and Financial Risks This was raised with the Group CEO within the agreed deadline. Tactical decision was taken to not raise the issue with ICB CEO at the time. Action to be kept open and would be raised - expect by late September. **RESOLVED** That the action be closed. *Estates Strategy* Mr Watson to provide Estates Strategy update paper October 2023 to committee. **RESOLVED** That the Estates Strategy Paper has been tabled at this meeting, 25 October 2023.

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Trust Financial Outturn
Mr Mortiboys to discuss with Mr Evans the Business Cases from 2018/19-2022/23 to confirm what has gone through Investment Group.

Ms Salmon advised that the review is in progress, from April 2020-June 2022, and that at the recent Investment Group meeting there were 7 post implementation reviews, with a paper prepared for TMC outlined those approved and returned.

Ms Salmon advised that there are 56 business cases awaiting review, and infirmed that the post implementation reviews were paused during the height of the COVID pandemic but confirmed that the review process was now well underway.

Mr Assinder requested assurance on the realisation from the implementation reviews. Ms Salmon advised that there are business cases with evidenced clear benefits, but some are more complicated.

Mr Stringer informed the committee that the ICB are to request information from Trusts on the top 10 Business Cases for each trust. Mr Stringer stated that he also expects there to be a similar request from PA Consulting.

Dr Shehmar asked if Quality Impact Assessments (QIA) were being completed. Ms Salmon stated that, as part of the efficiency scheme there were Equality Impact Assessments (EQIAs), but not QIAs, and agreed that QIAs should have been completed. Ms Salmon confirmed that the QIA review will be added to the Business Case template.

ACTION
That a Business Case summary be prepared for Finance and Productivity Committee going forward.

RESOLVED
That the action be closed.

Trust Financial Outturn
Following the outcome of PWC, Mr Mortiboys to have dialogue with ICB regarding expectations.

Mr Mortiboys confirmed that information has been shared with the ICB and NHSE for assurance, and that a discussion was to be had between Mr Stringer and Mr Tom Jackson, BC ICB.

RESOLVED
That the action be closed.

	Trust Financial Outturn Mr Evans to provide an update at Finance and Productivity Committee on collaborative working. **RESOLVED** That the action be closed. *Monthly Finance Update* Mr Mortiboys to commence review of external contracts. Mr Mortiboys advised the committee of the Sexual Health contract with Walsall Council, and informed that other local councils have their own local policy. Mr Mortiboys stated that negotiations continue with local councils, and advised the committee that block arrangements are most appropriate. **RESOLVED** That the action be closed.
GOVERNANCE	
119/2023	**Board Assurance Framework**
	Report received for information and noted. Cyber Risk still at 15. Note that. NSR101 Cyber Security Controls and Actions The committee agreed that the risk remain at 15. **RESOLVED** That the risk remains scored at 15. NSR105 Insufficient capital funding resulting in breakdowns and risks Mr Assinder raised that there was discussion at the last Finance and Productivity Committee that the risk be increased to 25. The group agreed with the consensus at the last committee that the risk should remain at 20. Mrs Martin requested assurance that managerial staff receive appropriate finance training. Mr Mortiboys stated that regular face to face training sessions are being arranged for staff with budget holders. **ACTION** That a paper be prepared for March 2023 with a position statement of financial training completed by staff with budgetary responsibility. **RESOLVED** That the risk remains scored at 20.

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FINANCE	
120/2023	Monthly Finance Update- Month 6
	Report taken as read. Mr Mortiboys introduced the Committee to the Financial Performance slide pack and outlined the following, below. For months 1-5, the Trusts adverse variances to plan were primarily from national pressures of industrial action, unfunded inflationary pressures and to a lesser extent pay award. The Trust has performed a deep dive on headcount during October 2023, and divisions have attended financial recovery meetings with challenges raised. A review meeting is to be arranged. Ms Martin asked if struggling care groups had been identified within divisions. Mr Mortiboys assured the committee that the most struggling four care groups have been identified and actions have been agreed. Mr Hobbs stated that there are common themes in the four care groups, including workforce and medical staff, and stated that, at a divisional level, the biggest variance is in MLTC. Mr Mortiboys advised that the ICS is posting a £79M deficit and £135M forecast deficit for the year. Mr Mortiboys informed that year to date agency spend is 3.48% of total pay spend, with the in-month position dropping below the target for the last two months. Mr Mortiboys advised that nursing bank usage is decreasing, compared to the last two years. Discussion was had regarding nursing over-establishment. Ms Carroll advised the committee that there were a number of newly qualified nurses awaiting PINs and work was being done with divisional managers to understand the position. Mr Assinder queried the non-pay spending. Mr Mortiboys stated that there was significant work regarding clinical consumables, and that a deep dive is being done. Mr Assinder requested assurance regarding locum doctor spend. Dr Shehmar advised that the additional spend is due to emergency activity, in paediatrics, and other care groups where the Trust were unable to recruit. **RESOLVED** That the Finance Month 6 report be received and noted.

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121/2023	Efficiency Programme Update
	Report taken as read. Mr Hobbs introduced the report to the committee and outlined the following, below. Progress has been made on the current 2023/24 CIP plan with £12.2m (£12.2m in the previous period) identified equating to 70.8% of the £17.2m target. Forecast outturn has identified a further £1.8m of pipeline schemes in development totalling £14m in year. ERF income is £729k ahead of plan at Month 6 despite industrial action and before the full impact of various schemes. Discussion was had regarding the expected CIP target proposed by the Chief Executive at 120% and what actions could be put in place to increase delivery from 104%. **RESOLVED** That the Efficiency Programme Update report be received and noted.
PRODUCTIVITY	
122/2023	Constitutional Standards- Community
	Report to note. Mr Jackson introduced the report to the committee and outlined the following, below. Community Services saw a sustained high level of referrals for services such as Care Navigation Centre, Rapid Response team and Integrated Front Door service. The increase in calls received was from traditional sources of primary care, particularly WMAS, Care Homes, and patients and families. The Integrated Front Door Service saw 213 patients in the Emergency Department, supporting the streaming of patients to community pathways to avoid admission. The Intermediate Care Team saw an increase in the average number of patients who were medically fit as a result of demand to 32; the average length of stay was 2.5 days, in month. Mr Assinder requested assurance regarding the 32 patients on the medically safe for discharge list. Mr Jackson stated that, looking at the average, the number has been higher. The service has benefited from the staff increase from last winter. Mr Stringer stated that admission avoidance details are documented as a percentage on the performance slides, and requested if there could be a numerical value added to slides, going forward. **ACTION** Mr Jackson to review dataset for performance metrics in slide pack Mrs Martin requested assurance on the number of virtual beds kept open when there has been no funding. Mr Jackson informed the committee that a Virtual Ward Summit has been arranged for November 2023 to which acute colleagues have been invited in

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	an effort to increase awareness and confidence in the ability to step patients down from hospital safely. **RESOLVED** That the Constitutional Standards- Community report be received and noted.
123/2023	**Constitutional Standards- Acute, Including Restoration and Recovery**
	Report to note. Mr Hobbs introduced the report to the committee and outlined the following, below. The Trust continues to deliver some of the best Ambulance Handover times in the West Midlands, with 89.26% of patients handed over within 30 minutes of arrival by ambulance in September 2023. In September 2023, 74.2% of patients were managed within 4 hours of arrival, against the revised national expectations of at least 76%. In August 2023, the Trust met the constitutional standard for 62-day GP Urgent Referral to Treatment Cancer performance for the second consecutive month, with 86.0% of patients treated within 62-days. This places the Trust in the upper decile of performance nationally, at 5th best Trust out of 119 reporting general acute Trusts. The Trust delivered the national standard to have no patients waiting in excess of 78 weeks as of the end of September 2023 (excluding patient choice), for the 7 th consecutive month. The Trust's total RTT incomplete waiting list has stabilised, and is showing some gradual reductions, against a national context of continuing further increases in the total national RTT incomplete waiting list. The Trust continues to experience significant elective procedure and outpatient appointment postponements as a result of the medical staff industrial action. The Trust has so far postponed 2,610 outpatient appointments and 202 elective surgical procedures in year. **RESOLVED** That the Constitutional Standards- Acute, Including Restoration and Recovery report be received and noted.
GOVERNANCE	
124/2023	**Trust Risk Register**
	Report to note. Mr Assinder outlined the following relevant risks for assurance and noting. <u>Risk 208 Emergency Waiting List</u> Mr Hobbs advised that this risk score may be increased in October 2023. For discussion at next Finance and Productivity Committee.

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	<u>Risk 2081 Financial Performance</u> For discussion at next Finance and Productivity Committee **RESOLVED** That the Trust Risk Register be received and noted.
ESTATES	
125/2023	**Estates Strategy**
	Report to note. A further report will be provided to committee once the NHSE toolkit has been provided.
126/2023	**PFI Update**
	Report to note.
127/2023	**Any Other Business**
	Nil raised
MEETING GOVERNANCE	
128/2023	**Matters for Escalation to Trust Board**

	• Financial Performance 2023/24 YTD
	    o Deficit Plan 2023/24 £14.7m
	    o M6 deficit position £20.8m, £8.2m worse than period plan
	    o Drivers: excess inflation, cost of industrial action, additional staffing in ED and Paediatrics
	• Cash- projected need for external loan funding likely required in Q4
	• Concern regarding robustness of Trust's Annual Financial Plan
	• Re-casting of 2023/24 Financial Plan to be completed for Board consideration for re-submission to ICB
	• Black Country ICS off plan by £27m
	• Endoscopy Services challenge with 1,700 patients waiting over 2 weeks for scans
	• Cancer Services- 86% met the 62 day wait targets in September 2023
	• Industrial Action- Cancellations to date 2,610 outpatients and 202 surgical procedures

129/2023	**Cycle of Business**
	Document to note.
130/2023	**Reflection of the Meeting**
	Discussion was had regarding the detailed agenda and the need to amend the start time by 30 minutes to allow for more detailed discussion.
131/2023	**Date and Time of Next Meeting**
	Date: 29 November 2023 **Time:** 14:30-17:00 **Venue:** Board Room, Trust Headquarters

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Signed:

Committee Chair: Paul Assinder

Date:

MEETING OF THE FINANCE AND PRODUCTIVITY COMMITTEE
HELD ON WEDNESDAY 27 SEPTEMBER 2023 AT 15:00
BOARD ROOM, TRUST HEADQUARTERS, AND MICROSOFT TEAMS

PRESENT

Members

Mr Paul Assinder	Non-Executive Director (Chair)
Ms Dawn Brathwaite	Non-Executive Director
Ms Rachel Barber	Associate Non-Executive Director
Mrs Mary Martin	Non-Executive Director
Mr Kevin Stringer	Group Chief Finance Officer
Mr Kevin Bostock	Group Chief Assurance Officer
Mrs Lisa Carroll	Chief Nursing Officer (Part)
Dr Manjeet Shemar	Chief Medical Officer
Mr Ned Hobbs	Chief Operating Officer
Mr Dan Mortiboys	Operational Director of Finance

In Attendance

Mr Stephen Jackson	Director of Operations, Community Services
Mr Nick Bruce	Group Director of Digital Technology
Mr Liam Ferris	Head of EPRR
Ms Katherine Geal	Executive Assistant (Minutes)

Apologies

Mr Simon Evans	Group Chief Strategy Officer
Ms Steph Cartwright	Group Director of Place
Mr Keith Wilshere	Group Company Secretary

93/2023	Chair's Welcome, Apologies, and Confirmation of Quoracy
	Mr Assinder welcomed everybody to the meeting and declared the meeting to be quorate. Formal apologies were received and noted as above.
94/2023	**Declarations of Interest**
	There were no declarations of interest made.
95/2023	**Minutes of Previous Meeting 30 August 2023**
	The minutes were taken as a true reflection of the meeting held. **RESOLVED** That the minutes from 26 July 2023 be approved as a true and accurate record of discussions and decisions that took place.
96/2023	**Matters Arising and Action Log**
	Community Services Modelling and Financial Risk *August 2023- Mr Stringer advised that the dispute will be formally raised with Mr Axcell* [redacted]

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	Mr Stringer advised the committee that conversations have continued, and that around 70% of the income dispute has been agreed to be paid, the original ICB offer was a 50/50 funding split. **RESOLVED** That an update be provided at the November Finance and Productivity Committee
GOVERNANCE	
97/2023	**Board Assurance Framework**
	Report received for information and noted. <u>NSR101 Cyber Security Controls and Actions</u> Mr Assinder informed the committee that the cyber security risk is currently scored at 15. Mr Bruce advised that the risk score is currently under review, with the aim to reduce to 12. Mr Bruce stated that additional controls have been put in place, which will reduce the likelihood of a future cyber attack being successful. Mrs Martin requested clarity on the implications of the lack of an IT solution to enable effective backups stored offsite and compliance with SPT standards. Mr Bruce stated that currently data is backed up locally onto the on-site infrastructure, and there is a risk associated to that as it is not fully compliant to recommendations that copies be backed up offsite. Mr Bruce stated that an investment case would be required to provide offsite backup, and that discussions had commenced regarding this. **RESOLVED** That the risk remains scored at 15 <u>NSR105 Insufficient capital funding resulting in breakdowns and risks</u> Mr Assinder raised the previous request that this risk be raised to 25. Mr Stringer stated that, upon further reading of the national definitions of risk, that rating at 25, with the consequence weighted at 5 (catastrophic), is too high. Mr Hobbs agreed, and stated that a risk score of 25 would be at a point where the Trust is forecasting to a much more material deficit. Mr Bostock added that there are clear definitions across both Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust of the risk, and that the risk is currently under review so that they can be aligned. **RESOLVED** That the risk remains scored at 20

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FINANCE	
98/2023	Monthly Finance Update- Month 5
	Report taken as read. Mr Mortiboys introduced the Committee to the Financial Performance slide pack and outlined the following, below. The Black Country ICS as a whole remains overspent. The Trust has delivered a deficit of £16.860M at month 5, this is £4.575M above the re-profiled planned deficit of £12.284M. Key drivers of the deficit are impact of industrial action (c£1.9m) and excess inflationary pressures (c£1.9m). Non-Pay overspends are (c£0.7m), driven by pressures on clinical consumables and outsourcing. Mr Mortiboys informed the committee that challenges have been put out to divisions regarding their variances, with work taking place to control, particularly from a nursing point of view. Mr Mortiboys informed that the ward nursing establishment is higher than expected, as last month; a large amount of this will be driven by Clinical Support Workers working in Mental Health. The cash balance as at 31 August 2023 is £16.79m, a £2m decrease on the previous month and a decrease of £9.6m on financial plan. The cash balance has moved by £21.6m (decrease) on the closing balance at March 2023 of £38.4m. Mr Mortiboys informed that there is now a full list of medical equipment that the Trust are to commit to this year Mrs Martin raised payments owed by councils, and the need for the Trust to review and negotiate contracts. **ACTION** Mr Mortiboys to commence review of external contracts.

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	Ms Brathwaite requested clarity regarding the possibility of requiring additional cash. Mr Mortiboys advised that the Trust can access cash in different ways; working with other Trusts to move money based on agreements, but more commonly cash will be requested from the ICS. Mr Mortiboys informed that the Trust have written to the ICS to request an advance against all of the quarter 4 money to receive in quarter 3, which will therefore bring forward payments and ensure that the Trust is supported through quarter 3. Mr Mortiboys furthered that in the short term some money can be moved from The Royal Wolverhampton NHS Trust to support. Mr Mortiboys stated that, historically, the Trust has approached the DoH for a loan. Ms Barber asked if NHSE are aware of the Trust's financial position. Mr Mortiboys informed that the Trust have not moved off the notified plan at this stage but that NHSE are provided a copy of the Committee slide pack and the report provided to committee, and that there are monthly meetings with NHSE leads to review the Trust financial position. Ms Barber requested confirmation that the remaining £10M capital funding would be spent by the end of the year. Mr Mortiboys advised the committee of the capital programme governance; that all capital projects require a business case and are approved or rejected at the Capital Review Group, and all schemes are queued until capital becomes available. Mr Mortiboys assured the committee that all capital money would be spent. Mrs Martin referred to the report stating that the Trust has the third lowest cost per weighted activity unit, and asked if there was a specialty breakdown. Mr Hobbs stated that the cost per weighted unit is on aggregate, driven heavily by the efficiency of non-elective inpatient pathways because they are the highest weighted type of activity, and detailed the importance of outpatient productivity work, as reported previously in the Constitutional Standards report boosting activity through selective specialties. Mr Hobbs reminded the committee that cost per weighted activity is a year in arrears. Discussion was had regarding the need to understand certain key drivers, and that Sir David Nicholson is keen to understand the deficit plan, where the Trust is against the plan, and the pay bill. **RESOLVED** That the Finance Month 5 report be received and noted.
99/2023	**Efficiency Programme Update**
	Report taken as read. Mr Hobbs outlined the report to the committee, and outlined the following, below. Progress has been made on the current 2023/24 CIP plan with £12.2m (£9.2m in the previous period) identified equating to 70.6% of the £17.2m target. Forecast outturn has identified a further £1.6m of schemes in development totalling £13.8m in year.

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	Year to date delivery of £4.1m against plans of £4.5m (profiled target of £4.4m cumulative to Month 5 included in the phasing of the Trust's 23/24 Financial Plan submission). Annual delivery of £4.7m against the targeted £17.2m. Ms Barber asked if the schemes marked red because they have not completed gateway assurance. Mr Hobbs stated that red rated schemes will not turn amber, then green, until patient data has been captured and ERF income is registered, and assured the committee that there will not be any issues with the delivery of the scheme. Ms Barber requested assurance that the remaining savings not yet identified are on task to be identified and asked how the Trust can assure itself about the opportunities and efficiencies in non-clinical space. Mr Hobbs assured the committee that the Trust continues to increase the CIP plan, as reflected in the Month 4 £9.2M increase to Month 5 £12.2M identified. Mr Hobbs stated that there is opportunity for non-clinical functions to be more resilient and more cost effective. Ms Barber asked if there was opportunity to influence other organisations across the ICB. Mr Hobbs stated that the constructs of a joint provider committee across the four Black Country Trusts and through the work of the provider collaborative, is to try to unblock some of the things that benefit the collaborative as a whole, though there may be of detriment to an individual Trust. **RESOLVED** That the Efficiency Programme Update report be received and noted.
100/2023	**Reduction in Temporary Medical Staffing Spend**
	Report taken as read.

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	Dr Shehmar introduced the report to the committee and advised that workshops have commenced with each division to interrogate establishment and rotas. Dr Shehmar informed the committee that Paediatrics are building a business case around the new ED and paediatric assessment unit. Dr Shehmar stated that there is still some use of Locums, and that work is ongoing to review the recruitment strategy and plans. Dr Shehmar stated that the winter funding roles have now finished, these positions included the EDS & FES Medics, as well as the Winter Sunday Ward Rounds. A recruitment pipeline has been set with clinical directors against vacancies within the division, with a budget re-alignment regarding HEE Trainee Posts, ESR discrepancies and job plans also being commenced. Discussion was had regarding the total vacancies and £6.7M overspend; with Mrs Martin questioning if the spend was on top consultants and locums. Dr Shehmar assured that some of the pay for consultants and overspend was due to the industrial action and consultants acting down. Mrs Martin raised concern that consultant and locum cover was also being provided around Bank Holidays, and asked if there was a review to ensure that leave was being staggered. Dr Shehmar stated that this was something that could be reviewed. Discussion was had regarding the approval process for agency spend, and Dr Shehmar assured the committee that approval was at executive level.
PRODUCTIVITY	
101/2023	**Constitutional Standards- Community**
	Report to note. **RESOLVED** That the Constitutional Standards- Community report be received and noted.
102/2023	**Constitutional Standards- Acute, Including Restoration and Recovery**
	Report to note. **RESOLVED** That the Constitutional Standards- Acute, Including Restoration and Recovery report be received and noted
103/2023	**NHSE- Protecting and Expanding Elective Capacity**
	Report to note. Mr Hobbs informed the committee that a letter was received from NHSE setting out standards and expectations associated with elective care, with the commitment to eradicate patients waiting over 65 weeks by the end of March 2024, and that each Trust is required to report to board the contents of the letter and of the need to submit response by 30 September 2023. Mr Hobbs advised of requirements that the Trust are at risk of not delivering, detailed below. At present, the Trust is at risk of not achieving the clearance of all first outpatients in the cohort of patients who will be over 65 weeks by 31March 2024, by the end

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	of October 2023. The Trust expects up to 555 first outpatients to not be seen by 31 October in Oral Surgery, Dermatology, and Rheumatology. Plans are in place to mitigate the risk for each service, which will incur additional costs covered by ERF income, however it is unlikely that the 31October 2023 target will be met. It is anticipated that clearance will be achieved by the end of January 2024. The Trust does not have a plan in place to reduce follow up appointments by 25%, in line with the NHS England Elective Care priorities 2023/24. However, the Trust annual plan committed to the aim of a 6% reduction in outpatient follow ups by the end of March 2024, which we are ahead of plan to deliver. Actions are in place to support reduction in outpatient follow ups, including a focus on increasing Patient Initiated Follow up (PIFU) at specialty level, supported by clinically agreed discharge pathways, virtual review of diagnostics and dedicated administrative navigator posts (Patient Centred Follow ups for Cancer patients). In addition to the Trust identified actions, the Trust are also participating in the GIRFT Further Faster Programme, which aims to maximise outpatient capacity by transforming traditional outpatient pathways. **RESOLVED** That the Protecting and Expanding Elective Capacity report be received and reviewed for approval at Trust Board.
102/2023	**Winter Plan**
	Report to note. Mr Hobbs outlined the Winter Plan report to the committee and informed that provision was made for £1.5M of resource to help manage through winter. Mr Hobbs advised that there is challenge this year as no external funding has been received. Mr Hobbs stated that the preferred option set out in the report is option 2. Mr Hobbs stated that option 1 provides insufficient resilience to adequately manage Winter. In particular it includes a forecast bed deficit of between 11 and 48 beds that is not mitigated. This contains increased risks of delayed admission from ED to acute hospital beds, delayed ambulance handover, potential requirement for ED corridor nursing, and risk of increased harm as a result. This would be more likely to be experienced if prevalence of norovirus or influenza or Covid is high, or if Winter has sustained adverse weather. Option 2 would provide reasonable resilience for the Winter ahead but relies on £646,774 external funding to support. Discussion was had regarding the concern that additional funding would not be sourced by the time the paper is presented to Trust Board. Mr Hobbs requested his thanks to Mr Roberts who wrote the Winter Plan paper be noted. **RESOLVED** That the Winter Plan Report be received and noted.

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DIGITAL	
104/2023	**Digital Strategy Update**
	Report to note. Mr Bruce outlined the report to the committee, and highlighted the convergence pathway between Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. Mr Bruce assured that the aim with regional partners, would be to move towards the 'Cloud First' principle, providing scalability and accessibility at a system level. Mrs Martin asked where Health Records would sit within the roadmap. Mr Bruce informed that medical records and the implementation of electronic records is noted in the 'Digital Clinician' section of the plan and is discussed as part of the Frontline Digitisation Business Case. It was noted that the scanning of paper records wasn't detailed in the Digital Strategy update. Ms Barber asked what the governance process was for approval. Mr Bruce informed the committee that the digital strategy is reported to the Transformation Board, chaired by Dr Shehmar. Mr Bruce assured the committee that this paper has been presented to this committee and to TMC for additional visibility.
105/2023	**Frontline Digitisation Programme Delivery Business Case**
	Mr Bruce informed the committee that the Frontline Digitisation Programme Delivery Business Case is critical in terms of meeting all of the objectives and enablement of frontline digitisation. Mr Bruce stated that the business case is supported by NHSEI funding; £2.7M capital in year 1, and £4.2M in capital in year 2. The programme is planned to be delivered by March 2025. Mr Bruce highlighted the financial proforma, and noted that significant paybacks are projected, with cash savings from 2025/26. Discussion was had regarding the certainty of receiving external funds and the capitalising of revenue costs that can be incurred. It was agreed that this business case supports strategic development and would support clinical services such as electronic prescribing. Mr Bruce stated that lessons have been learnt from previous IT implementation, and there has been focus on how to achieve the pace the Trust would like. The business case is to be presented to the upcoming Trust Board meeting for formal approval. **RESOLVED** That the business case be received and noted.

APPROVED

ESTATES	
106/2023	**Emergency Preparedness Resilience and Response Annual Report and NHS Assurance**
	Report to note. Mr Assinder welcomed Mr Ferris to the committee. Mr Hobbs outlined the report to the committee and stated that there is need to increase the rigour of the assessment process, and highlighted the EPRR Assurance 2023 Action Plan which details the improvement actions. Mr Hobbs advised that there is a risk, post moderation, that the ICB and NHSE could moderate the Trust down on its self-assessment compliance score. Mr Ferris stated that the ICB check and challenge will take place at the end of October 2023, when the Trust will have 5 days to turn around any additional evidence. The report will be presented to Trust Board December 2023. **RESOLVED** That the committee endorses the self-assessment.
107/2023	**Sustainability Update**
	Report to note. **RESOLVED** That the report be received and noted.
108/2023	**Any Other Business**
	Procurement of Car Parking and Security Services Mr Mortiboys informed the group that there was some ongoing work required regarding the allocation of the contract, and requested that the paper be removed from the agenda. Mr Stringer advised that the updated paper will require virtual sign off to ensure it can be presented to the October Trust Board.
MEETING GOVERNANCE	
109/2023	**Matters for Escalation to Trust Board**
	• Continuing challenge of financial position • Elective plan • Approved Frontline Digitisation Business Case • Endorsement of Winter Plan • Minutes of Extraordinary Finance and Productivity Committee
110/2023	**Cycle of Business**
	Document to note.
111/2023	**Reflection of the Meeting**
	• Commence meeting 30 minutes earlier due to complex agenda • Update of agenda and cycle of business for some papers to be received for information only

APPROVED

112/2023	Date and Time of Next Meeting
	Date: 25 October 2023 **Time:** 14:30-17:00 **Venue:** Board Room, Trust Headquarters

Signed:

Committee Chair: Paul Assinder

Date: 25 October 2023

APPROVED

MEETING OF PATIENT EXPERIENCE & SAFETY COMMITTEE

HELD ON FRIDAY 22 SEPTEMBER 2023
HELD VIRTUALLY VIA MICROSOFT TEAMS

Members

Dr J Parkes	Non-Executive Director (Chair)
Dr M Shehmar	Chief Medical Officer
Mrs M Metcalfe	Deputy Group Director of Assurance
Mr K Bostock	Group Director of Assurance
Professor L Toner	Non-Executive Director
Mr N Hobbs	Chief Operating Officer
Mrs O Muflahi	Associate Non-Executive Director
Mrs L Carroll	Chief Nursing Officer
Ms F Allinson	Associate Non-Executive Director

In Attendance

Mrs J Wright	Director of Midwifery, Gynaecology and Sexual Health
Ms Sally Giddings	Head of Midwifery, Gynaecology and Sexual Health
Ms S Noon	Executive Assistant (Minutes)
Mrs A Boden	Head of Infection Control
Mr Keith Wilshere	Group Company Secretary
Mr S Jackson	Divisional Director of Operations, Community

Apologies

Mr M Dodd	Interim Director of Integration

524/23	**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. Committee noted that Mr Jackson is attending on behalf of Mr Dodd. The meeting was recorded.
525/23	**Declarations of Interest**
	Nil.
526/23	**Minutes of Previous Meeting – Friday 21st July 2023**
	Mrs Muflahi requested an amendment to page 2. Minutes approved.
527/23	**Items for Redaction**
	There were no items for redaction and minutes were approved for publication.
528/23	**Matters Arising and Action Log**
	There were no matters arising.

	<u>Action 882 and 823</u> *See item 529/23.* **Actions closed.** <u>Action 799</u> Mrs Carroll confirmed that there are no outstanding nursing campaigns to be launched. **Action closed.**
	Items for Discussion, Approval and Assurance
529/23	**Theatre Utilisation and Performance – Action 822 & 823**
	Report taken as read. Mr Hobbs noted that the objective is that operating theatre metrics that are a cause for concern will be taken through Patient Safety Group as part of the surgical division's escalations and feature in the safe high quality care report.
530/23	**Trust Winter Plan**
	Report taken as read. Mr Hobbs confirmed that the plan has been developed having reviewed evidence from previous winters and learning from previous interventions. Mr Hobbs noted that option one, which is solely Trust allocation, would not give sufficient resilience for the most likely scenario through this Winter. If external funding can be secured to strengthen interventions in option one, a further 21 adult acute medical beds could be opened, and it would provide some extension to the weeks or months that the core interventions can cover. Dr Parkes queried the likelihood of obtaining the funding. Mr Hobbs discussed the three potential routes to funding via NHS England, ICB and government funding. Ms Allinson asked if there is clarity in the NHS Midlands around repatriating out of area patients. Mr Hobbs noted that if patients are brought to Trust there is duty to provide care. Repatriating patients is difficult but invoices to the appropriate systems should be considered for 2024/25 financial planning. Mrs Muflahi asked if the Trust are seeing an increase in Covid-19 positive patients requiring hospitalisation. Mr Hobbs confirmed there has been a steady increase over the previous two months and patients are presenting with a variety of symptoms. Mrs Carroll confirmed that there will be no update to the national Covid-19 guidance however local guidance and risk assessments are being reviewed. Dr Parkes asked how bed occupancy and the winter effects can be monitored. Mr Hobbs confirmed the Safe High Quality Care Report, and the Constitutional Report should cover the aspects to be discussed.
531/23	**Unfunded Business Cases**
	Report taken as read. Dr Shehmar and Mrs Carroll discussed the listed cases that require funding and the clinical risks associated with them. The paediatric nursing establishment review is the priority from the list.

	Mrs Muflahi expressed concern over the national shortage of paediatric trained staff. Mrs Carroll confirmed that current vacancies that go out to advert are easily recruited to with interest from external candidates. The is a route of recruiting adult nurses and offering RN Child courses and the Trust are also working with universities as to what a post-graduate option could look like. Dr Parkes asked for confirmation that the digitalisation programme is for electronic patient records and an electronic prescribing module. Dr Shehmar confirmed that the case is for the full suite including prescribing, results reporting, single sign-on for accessing patient's records.
532/23	**Maternity Services Update**
	Report taken as read. Mrs Wright noted 5.3 whole time equivalent Maternity Support Worker (MSW) vacancies relate to the closed midwifery led unit so there is not a deficit in staffing as significant as it appears. 1:1 care has been maintained during periods of staffing shortages. Mrs Wright confirmed that following internal CNST audits, education around deteriorating women and patients is being focussed on owing to issues with identifying worsening pre-eclampsia. Ms Allinson noted that Dudley has a good result in smoking cessation during pregnancy. Mrs Wright confirmed that they are in communication with the Dudley team to identify what can be utilised in Walsall. Mrs Allinson asked if there is a correlation between perinatal mortality and smoking. Mrs Wright confirmed this aspect is considered when using the Saving Babies Lives care bundle and there was no correlation identified. Dr Shehmar noted concerns about the perinatal mortality rate and asked what actions are being taken surrounding early booking and pre-conception. Mrs Wright confirmed pre-conception formed part of the Ockenden paper and an area of diabetes is being worked on as part of a phased approached. Dr Shehmar noted there is an opportunity for joint learning and training with RWT. Mrs Muflahi queried how many fellowship midwives are transitioning into roles. Mrs Wright confirmed twelve. Mrs Muflahi had feedback from staff on maternity safety walkarounds of the maternity department that works are incomplete. It would be helpful to have reassurance around this in the maternity report to the committee. Mrs Muflahi has concerns around the 10-week booking and would like additional assurance. Mrs Wright confirmed that some mitigations are being put into place including working with community teams to alter the timing of early bird booking appointments. A self-booking addition to badger net is also an option that works well at RWT.

	Mrs Muflahi noted there was also a maternity culture review however there is no set of recommendations or actions. Mrs Wright confirmed that the recommendations are not published as of yet however each staff group within maternity have been met with. The full report will be shared when it is complete. Dr Shehmar suggested a meeting outside of the committee with Mrs Carroll and the Maternity team and any actions can be brought back to the committee **(action).**
533/23	**CQC Action Plan Update and Section 29A Notice Response**
	Report taken as read. Mr Bostock confirmed the most recent CQC inspection report has been published following a review of the section 29A warning notice from Autumn 2022. It is concluded with three actions which will be built into the current action plan and presented through this committee and Trust Board.
534/23	**Constitutional Standards and Restoration and Recovery Report**
	Report taken as read. Mr Hobbs noted that the 62-day cancer GP referral to treatment standard has been delivered for the first time in the last three and a half years. The Trust has also seen four consecutive months of incremental 18-week RTT ranking improvement. Mr Hobbs confirmed that 638 outpatient appointments across the four industrial action days have been postponed and a further nineteen surgical procedures have been postponed. This poses a risk in the coming months on elective care. Dr Parkes noted that upper GI cancer two-week wait has slipped to 26%. Mr Hobbs noted that the main pressure is colonoscopy and there was a slight pressure within GI where booking was just over fourteen days however this is now within fourteen days so there are no concerns with this as a tumour site. Mrs Muflahi asked if Walsall are finding it difficult to recruit to tumour specific clinical nurse specialists. Mr Hobbs confirmed that this is the case for urology however not for other tumour sites and the roles are usually attractive for internal promotions. Ms Allinson noted the funding is reducing for virtual wards, but the utilisation was at 50% of capacity and asked if the effectiveness of the virtual wards had been assessed. Mr Jackson confirmed that the team strive to improve utilisation of virtual wards which has progressed since it's implementation. NHSE have accepted the Trust to participate in national research, particularly around the palliative care and end of life virtual wards.
535/23	**Performance Constitutional Standard Report - Community**
	Mr Jackson presented the report as per the paper, the committee did not ask Mr Jackson any questions.
536/23	**Safe High Quality Care Oversight Report (to include the Board Assurance Framework, Corporate Risk Register and Performance Dashboard)**
	Report taken as read.

	Mrs Carroll highlighted that on wards where the 'eat, drink, dress, move to improve' programme is being piloted, there have been no falls for the last month. Mrs Carroll raised that there is a discrepancy in data shown on My Academy compared to that held locally in departments. Clair Bond is ensuring that the discrepancies are being worked through. Mrs Carroll signed off a letter template this week that will be sent to staff who are non-compliant with level 3 safeguarding training once data accuracy is confirmed. Mrs Boden discussed the C.difficile fishbone analysis with the committee, confirming that she has liaised with IPC Leads across the Black Country with NHSE and an IPC independent consultation to discuss interventions, policies and procedures. Mrs Boden noted that a significant number of the Trust's cases have been deemed avoidable and were due to inappropriate antibiotic prescribing. Dr Shehmar advised it would be useful for Mrs Boden to attend Joint Clinical Forum to present as there are GPs present. Cases can then be discussed that have been identified as having an issue with prescribing in the community. Dr Shehmar would also like this to go through Medicines Management Group. Dr Shehmar asked how the Trust can obtain fecal microbiota transplantation (FMT). Mrs Boden confirmed it is not yet available in the UK, but it is being manufactured in Scotland and the Trust have approached and offered to be a trial site.
537/23	**Serious Incident Update**
	The report was delivered as per the paper and highlights were discussed. Nine serious incidents were reported and 12 were closed by the ICB. 17 remain under investigation with 32 reports still with the ICB for closure. Mr Bostock added that action needs to be taken regarding enacting duty of candour. Mr Bostock also added that over 1000 incidents have been identified that have not been managed since the transfer or urology transferred. Dr Parkes asked how the duty of candour work can be moved forward. Mr Bostock advised that clinicians need to enact this. Dr Shehmar assured the committee that cases are tracked on a case-by-case basis through the Serious Incident Group weekly, although Dr Shehmar acknowledges that there are concerns within urology. Dr Shehmar also noted that duty of candour is included in all doctor inductions.
538/23	**Infection Control Update**
	Report taken as read. IPC discussion held as per item 536/23.
539/23	**Medicines Safety Officer Report**
	Report taken as read, highlights were discussed. Dr Shehmar confirmed that mandatory training is now part of the new doctor induction programme. Dr Shehmar confirmed that although incidents have increased, the number of moderate and severe incidents have decreased, this is partly due to a better surveillance and audit programme. There has been a spike in prescription errors and further detail has been requested. Dr Shehmar noted that a piece of work is needed to ensure when national

	audits take place how they are then reviewed and how the recommendations are taken forward at care group level.
540/23	**Validation Report**
	Report taken as read, highlights were discussed. Dr Shehmar noted the Trust are not where they need to be in terms of NICE guidance compliance. In terms of national clinical audits and clinical outcomes of audits there is a gap, and a more robust system is needed. Dr Shehmar is discussing this at the next Medical Advisory Committee. Mrs Muflahi asked if prescription errors are due to a system or human error. Dr Shehmar confirmed that it is a combination. The new drug chart is a contributory factor but it is also around individual knowledge and complacency.
541/23	**CQUIN Quarter 4 – 2022/23 and Quarter 1 – 2023/24**
	Dr Shehmar confirmed the report is for information. Dr Shehmar confirmed that the CQUINs allocated for quarter one are non-negotiable and set externally.
542/23	**WM Senate Review: Urology Integration**
	Mr Hobbs confirmed that West Midlands Senate have endorsed in principle the reconfiguration of the urology service and eight recommendations have been made that would strengthen this. The response will be led by RWT however patients treated on site are Walsall's registered clinical activity. Mr Hobbs recommended to the committee that assurance is brought back to the meeting against the eight recommendations along with the initial action plan. Mr Hobbs suggested this would be ready for November's meeting **(action).**
543/23	**Board Assurance Framework**
	Papers taken as read. Mr Wilshere noted that there are no emerging risks on the watch list however this may need to be reviewed considering discussions held at committee today. Dr Shehmar noted that urology may need to be considered.
	ITEMS FOR INFORMATION
	Reports will be taken as read and questions only will be addressed
544/23	**104 Day Harm Update**
	Report to note.
545/23	**Recall Project Update (Complex Case)**
	Report to note.
546/23	**Quarter 1 Safeguarding Report**
	Report to note.
547/23	**Committee Effectiveness Survey**
	Report to note.
	Closing Items
548/23	**Exception Reports from any Subgroup Reporting to Committee**
	No exception reports were received for discussion.
549/23	**Matters for Escalation to the Trust Board**
	Not discussed.

550/23	**Any Other Business**
	Nil discussion.
551/23	**Reflections on meeting**
	The meeting finished at 13:34 Dr Parkes noted that the meeting feels rushed towards the end. Mr Wilshere suggested a reduction in agenda items moving forward. Mr Hobbs noted that there have been items at committee today that are not recurring and have added to the pressure. As reporters, presentations should be kept to the most important points allowing time for questions and assurance. Dr Shehmar suggested utilising iBabs to ask questions in advance. The committee agreed that by having papers in advance of the meeting with a fully completed and comprehensive front sheet, questions can be prepared by committee members in advance. Mr Hobbs noted that questions for member's clarification are welcomed outside of the meeting but questions for member's assurance should be asked in the meeting.
552/23	**Date of next meeting**
	Date: Friday 27th October 2023, 11:30-13:30

Signed:

Committee Chair:

Date:

MEETING OF THE

PEOPLE COMMITTEE

MINUTES OF THE MEETING HELD ON MONDAY 25TH DAY OF SEPTEMBER 2023 AT 13:30
VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mr Junior Hemans **(Chair)**	Non-Executive Director
Mrs Dawn Brathwaite	Non-Executive Director
Ms Catherine Griffiths	Chief People Officer
Ms Clair Bond	Deputy Chief People Officer
Miss Rachel Barber	Non-Executive Director
Mrs Lisa Carroll	Chief Nursing Officer
Mr Kevin Bostock	Group Director of Assurance

In Attendance

Mrs Jane Wilson	Joint Staff Side Representative – Unison
Mrs Marsha Belle	Associate Director of People and Organisational Development
Mrs Pat Usher	Joint Staff Side Representative – Unison
Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead
Dr Tamsin Radford	Occupational Health Consultant
Mr Brad Allen **(Minutes)**	Executive Assistant to Group Director of Place and Chief People Officer

Apologies

Mr Alan Duffell	Group Chief People Officer
Mr Paul Assinder	Trust Deputy Chair and Non-Executive Director

054/23	**Chair's Welcome, Apologies and Confirmation of Quorum**
	Mr Hemans 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.
055/23	**Declarations of Interest**
	There were no declarations of interest raised by members.
056/23	**Minutes of Previous Meeting – July 2023**

	Having been circulated to members prior to the meeting, there were no comments or amendments from committee, therefore committee **resolved** to **approve** the minutes of the meeting that took place on 24th July 2023 as a true and accurate record of decisions and discussions that took place.
057/23	**Matters Arising and Action Log**
	Committee noted that there were no outstanding actions requiring discussion.
058/23	**Integrated Care Board Update**
	Ms Griffiths advised there had been no further updates since the previous committee in July 2023 and suggested a written update be presented to either October of November 2023 committee. There were no comments from members.
059/23	**Trust Workforce Metrics**
	Ms Bond introduced the report as read and highlighted the following points to committee for their reference: • Overall sickness figures were above target due to an increase in Musculoskeletal-related illness. To target this, the organisation's Healthy Attendance programme has been introduced to support colleagues both returning to work and in work following their return. • Mandatory and Statutory training figures were reported to remain static, with the Trust's new E-Learning programme, MyAcademy, being rolled out to support colleagues in completing their modules where necessary, with some modules such as the Corporate Update, now requiring just 2 hours to complete. • Overall appraisal rates were reported to be stood at 77%. • Retention figures had increased due to the recent rotation of Junior Doctor colleagues, of which had seen an increase in allocation slots for 23/24. Mr Hemans advised that discussions had taken place with Ms Bond regarding turnover, where he had suggested that conversations be held with departmental Managers who may be aware of colleagues intending to retire or apply for other positions to ensure positions are filled and or reviewed as necessary. Miss Barber queried why figures within areas such as Estates and Facilities and Corporate services were low and requested assurance that the end-of-year target would be met. Ms Bond responded to assure Miss Barber that this

	issue had been picked up and that discussions with departmental leaders were taking place to introduce supportive measures, such as training for appraisees. Committee noted that staff within the Estates and Facilities division were having difficulty in finding time to complete their appraisal due to the nature of their work and staff sickness figures. Miss Barber then referred to the open and closed cases within the report and queried whether any learning points or trends had been identified to support future development. Ms Bond responded to advise that reviews are undertaken on a quarterly basis and included within the Employer Relations report. There were no questions from members. **RESOLVED** That committee note the contents of the report for their assurance.
060/23	**Corporate Risk Register Update**
	Ms Bond introduced the report as read and highlighted the following corporate risk updates to members for their reference: • Risk 2072: Trust-wide Shortage of workforce capacity and capability. Risk has remained unchanged as a 12 Moderate (Severity 4 x Likelihood 3). • Risk 2489 - Trust-wide: Staff bullying, discrimination and harassment. Risk has remained unchanged as a 12 Moderate (Severity 4 x Likelihood 3). • Risk 3036 – Reduction in workforce due to industrial action that will impact safe patient care. Risk has remained the same in April as a 16 High (Severity 4 x Likelihood 4)

	Mr Hemans referred members risk 3036 and queried whether workforce capacity was something being monitored by the People and Culture Team. Ms Bond responded to advise that there were concerns to Clinical Support Worker capacity within Radiology, but the Trust was not too dissimilar to other organisations within the region. Miss Barber referred members to risk 2489 and sought assurance as to how the organisation communicates with staff discrimination would not be tolerated, and that collectively we do not condone poor behaviour and nor are we afraid of calling it out. Miss Barber queried whether Freedom to Speak Up links were stronger in some areas than others and that weaker areas receive additional attention. Mr Hemans raised concern that with the number of colleagues transferring to other organisations, issues of discrimination could simply travel to other areas, stressing the need for any reports of discrimination to be dealt with as soon as possible. Mrs Wilson agreed with points raised but cautioned colleagues from creating elements of blame culture, sighting that some colleagues had not been spoken to in order to advise them of organisational policy and had immediately been dealt with via disciplinary routes. Both Mr Hemans and Bostock agreed and advised it was essential for the organisation to strike an appropriate balance between both elements. There were no further comments from members. **RESOLVED** That committee note the contents of the report for assurance.
061/23	**Anchor Employer Update**
	Ms Belle gave a presentation to committee highlighting updates to partnership working with external organisations to support their tenants and service users into employment at the Trust. Within the report, Ms belle also highlighted data around colleagues leaving the Trust and gave a breakdown of categories. Members were then given the opportunity to ask any questions. Mr Bostock highlighted concerns to incompatible relationships at work being a point raised during disciplinary hearing discussions and suggested that concerns with staff professional relationships be dealt with at the earliest opportunity. Ms Bond responded to Mr Bostock and advised that the Trust's new Behavioural Framework developed in collaboration with the Royal Wolverhampton NHS Trust, would support as it details what the organisation expects as an employer. Mr Hemans sighted that as the organisation employs local people, it was essential for the organisation to treat staff well and fairly, as this could impact

	on the reputation of the Trust and influence service users. Mr Hemans then referenced the recently recruited Radiology team member as highlighted in the presentation and suggested this be profiled across the organisation as a success story. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
062/23	**Nursing and Midwifery Career Framework**
	Mrs Walford introduced the report, sighting the report had been collated in collaboration with The Royal Wolverhampton NHS Trust to support staff careers being included within the appraisal process. In addition to this, conversations with the Clinical Illustration team were also being held to digitalise the document itself to allow colleagues to complete electronically. Members were then given the opportunity to ask any questions. Mr Hemans queried whether there was sight of staff already using the revised format. Mrs Walford advised that a project launch had been planned in partnership with the Communications team. Mrs Carroll stated that this project was the framework would also play part of the Higher Education Institute. Mrs Richards queried how levels of fairness would be monitored following the project implementation. Mrs Walford responded to assure Mrs Richards that the document would include fundamentals where staff can highlight why they wish to be put forward for particular developmental opportunities. The framework had also been collated in partnership with PNA colleagues. Ms Belle offered her support in building this into the new MyAcademy service for audit purposes and advertisement. *Mrs Walford left the meeting at 14:24.* There were no further comments from members. **RESOLVED** That committee note the content of the reports for their assurance.
063/23	**Safe Staffing Update**
	Mrs Carroll introduced the report as read and highlighted the following points to committee for their assurance:

	• Overall vacancy rates were stood at 1%, with the overseas Nursing recruitment drive being terminated until the next financial year. • Agency usage across the Trust was reported to be reducing, with the Paediatric department being the largest user in the Trust due to reduced staffing numbers. A business case has been submitted to the Quality Committee for review and approval to increase staffing numbers. • An increase, but warranted, usage of agency staffing has been reported within the Mental Health team due to increase demand for Clinical Support Workers due to higher rates of patients presenting at the UECC. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
064/23	**Bi-Annual Skills Mix Review**
	Committee noted that this item had been tabled for information only. There were no queries or comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
065/23	**Health and Wellbeing Assurance Report**
	RESOLVED Committee noted that this item had been deferred to November 2023 for discussion.
066/23	**Items for Information Only**
	There were no comments or queries from members. **RESOLVED** That committee note the contents of the report for their information.
066/23	**Escalations to the Trust Board**
	Committee resolved to escalate the following points to the Trust Board: • Mandatory and Statutory training figures. • Career Framework Positives.

067/23	**Any other Business**
	Item 1 – Mr Hemans – Non-Executive Lead for EDI and Health and Wellbeing Mr Hemans said he would hold conversations with the Group Company Secretary to appoint a Non-Executive Lead for Health and Wellbeing and EDI. **Item 2 – Committee – Recognition of Ms Griffiths' contributions and leadership to the People Committee and People and Culture Department** Members paid tribute to Ms Griffiths for her support and dedication to the committee, the Department and themselves individually during her tenure as Chief People Officer and wished her every success for her secondment at Sandwell and West Birmingham NHS Trust. There were no further items of business raised by members for discussion.
068/23	**Date and Time of the Next Meeting**
	Committee noted that the next meeting would take place on Monday 27th November 2023 at 13:30 via Microsoft Teams

Signed:

Committee Chair: Mr Junior Hemans

Date: Monday 30th September 2023

MEETING OF THE

PEOPLE COMMITTEE

MINUTES OF THE MEETING HELD ON MONDAY 30TH DAY OF OCTOBER 2023 AT 13:30 VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mr Junior Hemans **(Chair)**	Non-Executive Director
Mr Alan Duffell	Group Chief People Officer
Mr Paul Assinder	Deputy Trust Chair and Non-Executive Director
Mrs Dawn Brathwaite	Non-Executive Director
Ms Clair Bond	Interim Director of Operational Human Resources and Organisational Development
Miss Rachel Barber	Non-Executive Director
Mrs Lisa Carroll	Chief Nursing Officer
Mr Kevin Bostock	Group Director of Assurance

In Attendance

Mrs Jane Wilson	Joint Staff Side Representative – Unison
Mr Suleman Jeewa	Lead Freedom to Speak Up Guardian
Mr Brodie White	Deputy Care Group Manager – Head and Neck Services and Vice-Chair of the LBGTQ+ Network
Dr Tamsin Radford	Occupational Health Consultant
Mrs Aradhika Heer	Black Country Provider Collaborative Human Resources and Organisational Development Project Manager
Mr Brad Allen **(Minutes)**	Executive Assistant

Apologies

Mrs Catherine Wilson	Deputy Chief Nursing Officer
Dr Liam Manley	Junior Doctor and Chair of the LGBTQ+ Network

070/23	**Chair's Welcome, Apologies and Confirmation of Quorum**
	Mr Hemans 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 and recorded above.
071/23	**Declarations of Interest**
	There were no declarations of interest raised by members.

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072/23	Minutes of Previous Meeting – September 2023
	Having been circulated to members prior to the meeting, there were no comments or amendments from committee. It was **resolved** that the minutes of the meeting that took place on 25th September be **approved** as a true and accurate record of decisions and discussions that took place.
073/23	**Matters Arising and Action Log**
	Committee noted that there were no outstanding actions requiring discussion.
074/23	**Safe Staffing**
	Mrs Carroll introduced the report as read and highlighted the following points to members: • Overall staffing numbers for registered nurses and midwives had increased slightly to 4%. • Establishment figures across ward areas were reported to be positive. • A total of 300 additional overseas Nurses are due to commence employment within the Trust during October 2023, but no further colleagues would be recruited until the next financial year. • A recent business case to secure external funding to increase staffing levels in Paediatrics has been approved at Board Level for submission to the ICB for further discussion. Mr Assinder suggested that Prof. Louise Toner be briefed on the business case submission considering her position on the ICB Committee. Mrs Carroll responded to advise that the report would initially need to be sent to the programme board. Mr Assinder referred to national Health Visiting Team vacancy rates and requested that Walsall-specific figures and progress updates be included in future Safe Staffing reports. Mr Duffell referred members to Healthcare Assistant figures and advised that issues being experienced were not Walsall-specific. He advised that conversations were being held with neighbouring Human Resources Directors to host a system-level recruitment drive to resolve this. Miss Barber praised improvements to Bank staff mandatory and statutory training levels within the last two months and requested a trajectory as to where colleagues foresaw the organisation would be by year end. Mrs Carroll responded to suggest that training levels would not achieve full 100% compliance due to the nature of Bank work itself, but did assure that all staff receive a letter to complete their training and removed from the Bank should they not complete. Ms Bond added that should colleagues join the Bank from

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	other Trusts, the new My Academy service could assist with providing a training overview. Mr Hemans requested clarity as to why agency usage had increased between August and October 2023. Mrs Carroll clarified that due to demand and staffing levels in Paediatrics, Neonates and the Mental Health services additional support was required to ensure safe staffing levels. There were no comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
075/23	**Corporate Risk Register**
	Ms Bond introduced the report as read and highlighted the following points to committee for their reference: **RESOLVED** That committee note the contents of the report for their assurance.
076/23	**Corporate Risk Register Update**
	Ms Bond introduced the report as read and highlighted the following corporate risk updates to members for their reference: • Risk ID 2072: Trust-wide Shortage of workforce capacity and capability. Risk has reduced from a 12 Moderate . • Risk ID 2489 - Trust-wide: Staff bullying, discrimination and harassment. Risk has remained unchanged as a 12 Moderate. • Risk ID 3036 – Reduction in workforce due to industrial action that will impact safe patient care. Risk has remained the same in April as a 16 High. • Risk ID 2394 – Reduced capacity in the Health Visiting service due to recruitment and retention challenges. – Reduced from Moderate 12. • Risk ID 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level. Remains a 16 High. • Risk ID 3043 – Risk of suboptimal care and potential harm to patients due to minimal compliance to national standards for paediatrics nursing ratios. Remains at 16 High.

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Mr Hemans sighted the committee on a further phase of clinician industrial action due to go to ballot on 18th December 2023.

There were no further comments from members.

RESOLVED
That committee note the contents of the report for assurance.

077/23 Freedom to Speak Up Quarterly Report

Mr Jeewa introduced the report and highlighted the following points for committee reference:

- The FTSU service supports colleagues to escalate patient and staff safety concerns which when appropriately addressed contribute to establishing a culture of openness and safety.

- The report provides analysis assurance of the number of concerns generated through Freedom to Speak Up from 1st April 2023 – 30th September 2023, where within Quarter 1 (April, May, and June 2023) 38 concerns were raised and with Quarter 2 (July, August, and September 2023) 46 concerns were raised.

- Freedom to Speak Up data identified that concerns raised by colleagues from a BAME (Black, Asian and Minority Ethnic) background represent 42% of colleagues from quarter 1 and 52% in quarter 2 of the total concerns. This was deemed a slight over representation of colleagues from a non-BAME background raising concerns though the Freedom to speak up route against the 38% of BAME colleagues working at the Trust.

- It was reported that there had been a continual increase in the number of concerns raised to the Freedom to Speak Up Team in 2021/22, with a total of 110 concerns being raised compared to 144 concerns in 2022/23. In total and year-to-date for 2023/24, 84 concerns had been raised.

- Committee noted that an increase in the number of cases reported related to negative behaviours, bullying and harassment from 35% in 2021/22 to 48% in 2022/23. Of the 84 cases raised in quarter 1 and quarter 2 of 2023/23, 47 were related to negative behaviours, bullying and harassment.

Mr Assinder stated that it was disappointing to review the number of cases being reported and queried whether any particular characteristics had been identified when reviewing data, and requested a highlight map to determine where numbers of concerns were being raised to identify hot spots. Mr Jeewa responded to advise that meetings have been held with several area managers

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	to discuss concerns as they arise, but no particular areas were identified as hot spots. Members then held a wider conversation around the increase in figures compared to data released this time in 2022 and noted that additional efforts had been made to promote the service and provide assurance to colleagues that conversations and escalations were treated in the strictest confidence. Committee noted the efforts made by the Executive Team to promote the freedom to speak initiative, but raised concern with the number of escalations being submitted from International Nursing colleagues. Mrs Carroll advised that to tackle this, a task and finish group had been established by the Nursing Directorate to troubleshoot concerns as they arise and provide action plans for areas where frequent concerns are raised. Dr Radford highlighted that data from this initiative would be reviewed in line with occupational health referral data to collate a heat map for overview and to benchmark against the NHS Employer Framework. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
078/23	**Nursing and Midwifery Career Framework**
	There were no further comments from members. **RESOLVED** That committee note the content of the reports for their assurance.
079/23	**LGBTQ+ Network Report**
	Mr White gave a presentation of recent success and challenges within the LGBTQ+ Network and invited members to ask any questions, key updates included: • Initiation of the Rainbow Badge Scheme. • Improvements to education and training methods to improve awareness. • Mention of inclusion in all Trust policies. • The Network meets every six weeks to discuss priorities and ways in which colleagues can improve their awareness. • Conversations were being held to distribute a survey to colleagues to provide feedback on their experiences as employees at the Trust.

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	Mr Hemans suggested it may be beneficial for the Trust to provide a counselling service to colleagues who may have undergone negative experiences. Ms Bond referenced the previous years staff survey results and suggested it may be beneficial to compare it to this year's data to identify where particular focus could be made to encourage colleagues to share their experiences for future learning. Mr Duffell thanked Mr White and the wider network for their efforts but cautioned the introduction of a counselling service provided by volunteers, sighting that counselling services were a professional entity and that colleagues would need sufficient training to undertake this. Members then held discussions around additional training opportunities being provided to staff, as well as services that are on offer from the Health and Wellbeing team to support staff at work. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
080/23	**Staff Survey Update**
	Ms Bond advised committee that the current response rate for the Staff Survey stood at 34%, with many teams increasing their figures compared to data released this time in 2022. There were no further comments from members.
081/23	**Model Hospital**
	Ms Belle introduced the item and gave a presentation on the Model Hospital proforma and gave members the opportunity to ask any questions. Mr Duffell advised that some key workforce metrics relating to his had not been presented to committee previously and suggested they be tabled twice per year for reference. Miss Barber queried any actions being taken from the presented data and whether any action plans could be devised to improve performance. Ms Bond advised that Nursing and Midwifery leaving figures were being reviewed to identify main reasons for termination, with a deep dive into this having taken place to compare against wider peers. Mr Duffell stressed the importance of benchmarking Trust figures against that of the national picture to ensure figures were heading in the right direction to allow any necessary mitigatory measures to be implemented.

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	Mr Hemans suggested a review take place into colleagues who leave the organisation due to work-life balance purposes. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
082/23	**Health and Wellbeing Update**
	Dr Radford introduced the item as read and highlighted the following points to committee for their reference: • The Committee were assured that a holistic staff wellbeing continued to be addressed by Occupational Health and Wellbeing teams and Directorate partners and has delivered wide-ranging Health and Wellbeing offers to the Trust. • The Healthy Attendance project has been part of delivering reduction in long term sickness absence since its inception and is contributing to the Cost improvement Programme again the financial year through targeted reduction of sickness absence within the registered nursing and midwifery workforce. • Overall, there was a 17% drop in sickness figures based on last year's data. • There had been an increase in activity in Occupational Health by 91% in 12 months which resulted in delays in specialist appointments. Committee recognised improvements made to Key Performance Indicators following the implementation of three new staff within the department. Mr Hemans referenced menopausal support and queried whether support was being provided jointly with Wolverhampton. Dr Radford advised that both Trusts were working collaboratively, but operated independently based on need. There were no further comments or questions from members. **RESOLVED** That committee note the contents of the report for their information.
083/23	**Performance Against Workforce Plan**
	Ms Bond introduced the item and assured the committee of the following points: • The Black Country Integrated Care Board (ICB) continues to measure

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	organisational performance against the workforce plan through comparison to the monthly provider workforce return (PWR). From October 2023 onwards the monthly ICB led assurance meetings which took place separately from a Finance and Workforce perspective were combined. • Internal budgetary control measures supplement external assurance measures by focusing on establishment control versus budgeted Whole Time Equivalent (WTE). This work has taken place during September and October at divisional level in collaboration with workforce partners and has focused on the identification, review and sustainable resolution of over-establishment hotspots. Divisional leadership teams are working through the outcome from these meetings to provide assurance that the overall substantive workforce will align to the budgeted establishment. • The approach to developing the 2024/2025 workforce plan had been revised based on the experience of the previous round and will be subject to increased internal governance processes to ensure alignment to the operating plan. Mr Duffell referred to the planning submission within the report and stated that use of bank and agency staff was above target, citing the importance of ensuring numbers at system level were accurate before submission. Mr Hemans queried how the Trust compared to others within the region. Mr Duffell advised that Wolverhampton were just below target, Dudley were on track and Sandwell were yet to provide assurance. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their information.
084/23	**Employment Relations Report**
	Ms Bond introduced the report and invited Mrs Bibi to give a brief overview of its contents as well as highlight any points to committee, which were as follows: • It was reported that 67% of cases involved colleagues from Black, Asian and ethnic minority backgrounds, which was not reflective of the 38% BAME representation across the Trust, resulting in an increase from 63% in quarter 1. • Committee noted that 7 out of the 10 staff excluded over quarter 2 were from a Black, Asian or other ethnic minority background, of these 4 remain actively excluded as of October 2023 compared to 2 white colleagues. This disproportionate impact reflects a number of cases where pre-registrant nurses have failed to achieve registration and were in breach of certificates of sponsorship.

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	• It was noted that the number of exclusions during this period has increased at 10 actives at the end of quarter 2 and that there continues to be a sustained increase in overall disciplinary investigations and formal investigation particularly in the clinical divisions. The committee also noted that there had been an increase in Police and Counter Fraud investigations, with all exclusions and restrictions being reviewed monthly at Exclusion Peer Review meeting. **RESOLVED** That committee note the contents of the report for their information.
085/23	**Trust Workforce Metrics**
	Ms Bond introduced the report as set out and highlighted the following assurance points to committee for reference: • Overall, Trust vacancy rates were within target at 4.8%. • Sickness Absence rates were reported to be within the target range at 4.9% in month and 5/7% rolling 12 months. • Mandatory Training Compliance rates were below the 90% target at 87% which is an increase from 85.94% in the previous month. • Appraisal Compliance rates had decreased further to 76.16% compared to 77.18% in August 2023. • The committee were assured that Indicators relating to vacancy rates, 12-month retention and in-month sickness absence meet the targets and agreed standards. Ms Bond advised committee that an appraisal deep-dive exercise would take place within the coming weeks to improve rates, with particular focus being made to corporate areas. Each member of the Executive Team has been requested to work with their relevant corporate areas within their portfolios to devise an action plan as a priority. Mr Duffell referred to the corporate metrics and suggested adding arrows to highlight whether areas above, at or below target for ease of reading. Committee noted that some colleagues, particularly within the Estates and Facilities Division, were having difficulty accessing training due to the nature of their roles. Ms Bond assured members this was being investigated and that some face-to-face training sessions were being held to support this, with the Manor Learning and Conference Centre offering venues to deliver additional sessions of training. There were no further comments from members.

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	RESOLVED That committee note the contents of the report for their information.
086/23	**My Academy Assurance Report**
	Ms Belle introduced the report as read and highlighted the following points to committee for their reference. • The Committee were assured that the learning management system known as 'My Academy Walsall' provides a learning and development platform using digital technology to support learners to demonstrate compliance with the 11 core mandatory subjects of the Skills for Health Core Skills Training Framework. • Members noted that My Academy provides real time access to each member of staff and all mangers regarding individual, team, department and organisation levels of compliance against each of the mandatory & statutory requirements. • The roll out of the service was reported as complete in that compliance against all mandatory and statutory training elements are accessible. Of the 11 required training standards, all can now be accessed via the platform with the exception of patient handling and Adult Basic Life Support requiring attendance at a face-to-face session. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their information.
087/23	**Items for Information**
	Having been circulated to members prior to the meeting, committee **resolved** to **note** the contents of the reports as set out, with Mr Duffell requesting feedback and any comments on the Provider Collaborative paper by 6th November 2023.
088/23	**Committee Escalations to Trust Board**
	RESOLVED That committee escalate the following points to Trust Board: • Nursing establishment figures at 4% vacancy rate. • Clinical fellowship programme updates and successes. • The Freedom to Speak Up report.

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	• Model Hospital Benchmarking. • Staff Survey position. • Mandatory training outliers and appraisal rates • Workforce plan
089/23	**Any other Business**
	There were no items of business raised by members for further discussion.
090/23	**Date and Time of the Next Meeting**
	Committee noted that the next meeting would take place on Monday 27th November 2023 at 13:30 via Microsoft Teams.

Signed:

Committee Chair: Mr Junior Hemans

Date: Monday 27th November 2023

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Trust Management Committee

Date/time:	Thursday 26th October 2023
Venue:	Via Microsoft Teams
Quorate:	Yes
Chair:	Mr N Hobbs

Mr N Hobbs	Chief Operating Officer/ Deputy Chief Executive
Mr D Mortiboys	Interim Finance Director
Ms L Carroll	Chief Nursing Officer
Mr K Bostock	Group Chief Assurance Officer
Mr S Jackson	Director of Operations – Community
Ms K Geffen	Divisional Director of Nursing – Community
Mr F Ghazal	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
Ms S Webley	Divisional Director of Operations – Surgery
Ms K Rawlings	Divisional Director of Nursing – Surgery
Mr M Ncube	Divisional Director of Clinical Support Services
Ms S Giddings	Head of Midwifery
Ms C Bond	Interim Director of HR and OD
Ms P Boyle	Group Director of Research and Development
Ms J Longden	Divisional Director of Estates and Facilities
Ms S Chand	Deputy Director of Pharmacy
Ms K Salmon	Deputy Chief Strategy Officer
Ms T David-Eyen	Deputy Divisional Director of Women's, Children's & Clinical Support Services
Mr W Goude	Divisional Director of Surgery
Ms R Tomkins	Deputy Divisional Director of Nursing, Division of Medicine & Long-Term Conditions
Ms A Boden	Head of Infection Prevention and Control
Ms C Whyte	Deputy Chief Nursing Officer
Ms R Joshi	Deputy Divisional Director for MLTC
Mr S Mirza	Deputy Chief Medical Officer

In Attendance:

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
Dr J Odum	Group Chief Medical Officer
Mr K Wilshere	Group Company Secretary
Mr K Stringer	Group Chief Financial Officer/ Group Deputy Chief Executive
Mr A Duffell	Group Chief People Officer
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Mr S Evans	Group Chief Strategy Officer
Ms C Yale	Divisional Director of Nursing – Paediatrics and Neonates
Mr M Dodd	Interim Director of Transformation
Ms S Cartwright	Group Director of Place
Dr M Shehmar	Chief Medical Officer
Ms L Nickell	Group Director of Education and Training
Mr N Bruce	Group Director of Digital Technology
Dr N Usman	Divisional Director of Medicine and Long-Term Conditions
Ms J Wright	Director of Midwifery, Gynaecology and Sexual Health
Mr C Ward	Deputy Chief Nursing Officer

680/23	**Chair's welcome, Apologies and confirmation of Quorum**
	Mr Hobbs welcomed everyone to the meeting and apologies were received and noted.
681/23	**Minutes of Trust Management Committee held on 21 September 2023**
	Mr Hobbs confirmed the minutes of the meeting held 21 September 2023 as an accurate record. **Resolved: that the minutes of the last meeting held on 21 September be received and APPROVED.**

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682/23	**Matters Arising and Action Log**
	Mr Hobbs received the action log and updates were noted as follows. **Action 931 – Ms Wright and Mr Ghazal to provide an update on the laboratory process for Midstream Specimen of Urine (MSU) tests.** Mr Ghazal advised that the Trust had reviewed the process of actioning results, an audit would be conducted to seek assurance on the new process and the team would continue to explore an quality improvement project linking with pathology services to see how the Trust could receive automated results, notifications and treatment on results. This action was closed. **Action 930 – The Division of Medicine to provide assurance that the Healthcare Safety Investigation Branch (HSIB) letter has been acted upon through the MLTC governance route.** Mr Hobbs confirmed that the HSIB letter had been acted upon through the MLTC governance route. This action was closed. **Resolved: that the Action Log be reviewed and updates received and noted.**
683/23	**Policies, procedures for approval and information**
	Ms Long provided a summary of the policies report and asked that the listed policies be reviewed and approved. 1. Reversal of Edoxaban Associated Bleeding Trust wide Guideline V1 2. Reversal of Dabigatran Associates Bleeding Trust Wide Guideline V1 3. Reversal of Rivaroxaban/Apixaban Associated Bleeding Trust Wide Guideline V1 4. WHT-OP996 V7 Radiation Safety Policy for Walsall Healthcare NHS Trust 5. WHT-OP997 V2 Sepsis and Outreach Response Team Operating Policy 6. WHT-OP1001 V2 Uniform and Dress Policy 7. WHT-OP999 V1.1 Emergency Preparedness, Resilience and Response (EPRR) Policy 8. WHT-OP1000 V4.1 Business Continuity Management Policy 9. WHT-MP1003 V3 Enabling Policy for Pharmacists 10. Acute Oncology Initial Management National Guidelines Ms Usher advised that the WHT-OP1001 V2 Uniform and Dress Policy was not approved by the joint Staffside leads due to the policy wording surrounding facial piercings and trainers. Ms Carroll reported that the Uniform and Dress policy was an amalgamation of the previous clinical standards of dress policy and that a small nose piercing had been accepted as a societal norm and there were no clinical safety issues that had been identified. Mr Hobbs said the Trust needed a fit for purpose uniform policy and as chair of the Trust Management Committee, he delegated authority to Ms Carroll to approve any amendments made to the policy following a final review with Joint Staffside leads. **ACTION: Ms Carroll and Joint Staffside Leads to have a final review of the WHT-OP1001 V2 Uniform and Dress Policy. Ms Carroll was delegated authority by Chair of TMC to publish the final policy following that final review.** **Resolved: that the above listed policies be received and APPROVED and that Ms Carroll was delegated authority to approve WHT-OP1001 V2 Uniform and Dress Policy subject to a final review with Joint Staffside Leads.**
684/23	**Chief Nursing Officer Report**
	Ms Carroll advised that the Clinical Accreditation scheme continued and she had presented certificates to the Wards that had received accreditation. Ms Carroll reported that the Patient Experience Team had entered the Patient Experience National Network Awards (PENNA) and the Little Voices initiative was awarded as the overall winner. She said the Little Voices initiative had also won the gold award at the Infection Prevention Society Awards. Ms Caroll advised that the Trust had copyrighted the Little Voices Initiative and it was being written up for publication in the Journal for Paediatrics and Child Health. Mr Hobbs thanked all staff who had been involved in the Little Voices initiative and its success. Ms Carroll reported that agency cessation plans had seen a reduction in agency nursing staff across the Trust and a robust risk assessment process was in place to agree the use of agency staff in exceptional circumstances. She said that there had been an increased need to provide 1:1 care for mental health patients which had resulted in the Trust using agency staff. Mr Hobbs asked that divisional nursing leads continue to ensure that only appropriate bank shifts were booked. Ms Carroll advised that the Trust had reported 12 *C-Difficile* cases in September 23 of which 2 cases had been deemed avoidable. She said the Trust continued to focus on the improvement of antimicrobial prescribing. Ms Carroll reported that the Integrated Care Board (ICB) would visit the Trust in November 23 to do a focused visit on

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	Infection Prevention Control to review the Trusts practices associated with managing patients that present with diarrhoea, *C-Difficile* pathways, isolation management practices and themes around antibiotic prescribing. **Resolved: that the Chief Nursing Officer Report be received and noted.**
685/23	**Infection Prevention Report**
	Ms Boden reported that the Trust was the 5th highest Trust for *C-Difficile* cases per 100,000 bed days. She said despite the Trust's overall increase in *C-Difficile* cases throughout 2023 the Trust had seen a shift in the severity of illness of patients as the Trust continued to identify patients quicker and treat accordingly. Ms Boden advised that the Infection Prevention Society had published a poster on the Trust's work surrounding the introduction of nursing associates for stool sampling. She said the Trust had won the best poster at the event and other Trusts had enquired to work alongside the Trust to improve their sampling. Ms Boden reported that the Trust had identified multiple risk factors associated with antimicrobial prescribing leading to the onset of *C-Difficile.* She said that following review of the antibiotic formulary the antimicrobial stewardship team and pharmacist had identified significant themes of improvement. She said all the evidence of inappropriate prescribing had been collated and would be presented at the Medical Advisory Committee on the 7 November 23. Ms Boden advised that national benchmarking for other infections had highlighted the Trust as 29 out of 135 Trusts for Methicillin-resistant Staphylococcus aureus (MSSA), 50 out of 135 for Escherichia coli (E. coli), 11 out of 135 Trusts for Klebsiella pneumoniae and 16 out of 135 Trusts for Pseudomonas. She said that these figures highlighted that the Trust continued to demonstrate positive results from infection prevention and the prevention of sepsis as a result of healthcare associated infections. Ms Boden reported that the risk factor of *C-Difficile* with antibiotic prescribing was a clear focus that improvement was required. She said improvements had been seen following the implementation of antibiotic timeout sessions. Ms Boden advised that there had been updates to MicroGuide and these had been shared with all prescribers across the Trust. Mr Ghazal asked if Ms Boden could provide a breakdown of the *C-Difficile* rates at a divisional level. He said following the updates to MicroGuide the Trust would look at initiatives to address and initiate change of behaviour of clinicals regarding antibiotic prophylaxis. **ACTION: Ms Boden to provide a breakdown of *C-Difficile* rates at a divisional level.** Ms Joshi asked if Ms Boden could provide a summary of the key themes and analysis that could be shared with clinicians. Ms Boden advised that a snapshot of the fishbone analysis was available within the Infection Prevention Report which provided greater detail and summarised the key themes that had been identified. **Resolved: that the Infection Prevention Report be received and noted.**
686/23	**Midwifery Service Report**
	Ms Giddings reported that the Trust had maintained 1:1 care in labour throughout the reporting period. Ms Giddings advised that the QUAD Perinatal Culture and Leadership Development Programme would be launched cross Maternity Services 13 October 23. Ms Giddings advised that the current Maternity Support Workers (MSW) vacancy rate was 14.0wte and all posts had been put out for advertisement. She said that Midwifery Staffing remained on risk register with a score of 16. Ms Giddings reported that by November 23 the Trusts new band 5 midwives would have completed their supernumerary period. Ms Giddings advised that the Trusts midwifery staffing aligned with Ockenden recommendations. She reported that there had been no serious incidents during September 23 as a result of maternity staffing and there had been no medical gaps in September 23 Ms Giddings reported that the Trust's funded birth rate establishment was aligned to the Trust's birth rate plus requirements in September 23. She said the last birth rate plus review was in 2020 and a new review would need to be completed in 2023/24 as per Clinical Negligence Scheme for Trusts (CNST) requirements.

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	Ms Bond asked if the birth rate plus review had been scheduled for 2023/24. Ms Giddings advised that this had not yet been scheduled for 2023/24 and the funding would need to be reviewed ahead of the review commencing. **ACTION: Ms Wright and Ms Giddings to provide an updated timeline on the implementation of the Birth Rate Plus review.** Ms Giddings reported that 1 case had been accepted by Healthcare Safety Investigation Branch (HSIB) in September 23 which surrounded a baby that had been for therapeutic cooling at the level 3 unit and the MRI had since been cleared. Ms Giddings advised that the Trust's Perinatal Mortality rate had increased and this would stay remaining for 12 months as it was accumulated. Mr Ghazal said that the Trust had seen an increase in the still birth rate and perinatal mortality and the accurate definition was extended perinatal mortality rate as this included all still births plus neonatal deaths up to 28 days. He said this had been reported to the informatics team to ensure the information was added to the charts. Mr Ghazal advised that there had been a national increase in perinatal mortality and there was concern nationally of Trusts achieving the 50% reduction by 2025. He said the Trust had highlighted the concern to the Local Maternity and Neonatal System (LMNS) operation and delivery board and a thematic review would be conducted of all still births across the Integrated Care System. Mr Ghazal reported that the early identification and prevention of preeclampsia had been embedded into maternity mandatory training for obstetricians. He said the Trust would also be conducting a service review of maternal medicine and asking for an external peer review on perinatal mortality to identify the processes and resources and to ensure the Trust is following the learning identified. Ms Giddings advised that Ms Wright had met with community groups and Walsall Together to identify how the Trust could poverty proof maternity services to ensure that the poorest and most deprived communities could access care provided. Ms Giddings reported that the Trust was reporting a 60% compliance target against the Saving Babies Lives Care Bundle version 3 and the Trust's target was 70%. Ms Giddings advised that there had been 6 safety champion walks between January and October 23 and these had covered antenatal clinic, delivery suite and post-natal wards. She said that 20 actions had been identified during these walk abouts and 4 actions had since been closed. Ms Giddings reported that there had been 3 moderate incidents in September 23 and 1 serious incident. **Resolved: that the Midwifery Service Report be received and noted.**
687/23	**Learning From Deaths Report**
	Mr Mirza reported that the recently published Acute Hospital Summary hospital-level Mortality Indicator (SHMI) value was within the expected range. Mr Hobbs said that it was encouraging to see the Trust's SHMI value recorded at 0.9906. **ACTION: Mr Hobbs asked that the next Learning from Deaths Report include Hospital Standardised Mortality Ratio (HSMR) and SHMI data axes dating back to pre-Covid-19 2019/20.** Mr Mirza advised that following the rollout by the Medical Examiner team, 62% of GPs had signed up to the community process. He said that he had attended, with the Lead Medical Examiner, a Local Medical Committee (LMC) meeting to highlight the importance of GP colleagues joining the programme and its benefits. Mr Mirza reported that the Trust continued focused work surrounding perinatal mortality within the Division of Women's and Children. He said following a thematic review there had been opportunities of improvement highlighted surrounding maternal medicine, smoking cessation and the management of preeclampsia in early pregnancy and the division had met with senior executive colleagues to agree an action plan. Mr Mirza advised that the Trust was an outlier for colorectal cancer outcomes and Dr Shehmar had set up an improvement working group to identify issues surrounding pathways, governance, training and supervision and

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	culture. He said a new colorectal cancer lead had been appointed to move forward with the improvements required. Mr Mirza advised that Walsall Healthcare NHS Trust (WHT) was the only hospital within the Integrated Care System (ICS) that did not have a respiratory unit and the Trust would continue to seek support from the ICS to get this commissioned. He said the Respiratory Support Unit Business case would be escalated to the Quality Committee for members support. **ACTION: Mr Hobbs, Dr Shehmar and Ms Carroll to ensure that the Respiratory Support Unit Business case was on the ICBs strategic commissioning committee agenda.** Mr Hobbs thanked colleagues for the delivery of clinical improvement that had affected the Trusts standardises mortality rates. **Resolved: that the Learning from Deaths Report be received and noted.**
688/23	**Clinical Black Country Provider Collaboration Update – Verbal**
	Ms Salmon advised that the next Black Country Provider Collaboration Clinical Summit would take place 27 October 23 at GTG Training & Conference Centre. **Resolved: that the Clinical Black Country Provider Collaboration Update – Verbal be received and noted.**
689/23	**Walsall Together**
	Mr Jackson reported that Walsall Together continued to work with primary care services to further develop and strengthen the partnership. Mr Jackson advised that there was a continued focus to develop the system operating model to gain delegated consent to commission services from the Integrated Care Board (ICB) through Walsall Together. He said the Trust continued to assure the ICB around the partnerships ability to perform the role. Mr Jackson reported that the Walsall Integrated Care System had been cited in the NHS best practice framework for intermediate care. **Resolved: that the Walsall Together report be received and noted.**
	Divisional Reports (Section Heading)
690/23	**Divisional Quality and Governance Report – Medicines and Long-Term Conditions**
	Ms Joshi advised that the Trust had seen a significant reduction regarding pressure ulcers and no category 4 incidents had been reported. She said category 2 and unstageable incidents had also reduced. She reported that the Trust had seen an increase in the reporting of medication incidents focused on prescribing and omissions. She said the Trust continued to report reoccurring themes through the different forums to ensure care groups were cited on the themes. Ms Joshi advised that work was ongoing with the pharmacist and anti-microbial team to support the reduction of any medication related incidents. Ms Joshi advised that the Trust had reported the lowest number of falls in Medicines and Long-Term Conditions (MLTC) ever recorded and all medical wards were below the national falls per 1000 bed days. Ms Joshi reported that the Trust had ranked 9th Nationally against the emergency access standard and was 1st within the West Midlands for ambulance handover within 30 minutes. Ms Joshi advised that Venous Thromboembolism (VTE) assessment within 24 hours remained at 89% and 94% during admission and that an action plan was in place and work continued with the clinical leads for the care groups and VTE. Ms Joshi reported that Infection Prevention and Control had completed the urinary catheter audits within the inpatient wards and overall compliance was 79%. She said a ward action plan was in place to support the appropriate management of urinary catheters. Ms Joshi advised that there had been concerns surrounding the management of paediatric patients in line with the guidance of recognising the sick child and ensuing appropriate treatment. She said the acute transformation lead nurse was leading the improvement work. Ms Joshi reported that the Trust's medicines reconciliation performance was 33% which was due in part to some technical issues as some clinicians did not have access to summary care records which had resulted in difficulty of them being able to access patient information from GPs regarding current medication.

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	Mr Mirza advised that the Division of Medicine would need to present an updated spreadsheet regarding guidelines to the Divisional Quality Board Meeting in November 23. Mr Hobbs reported that there were increased pressures on suspected skin cancer pathways and routine dermatology pathways not aided by the low uptake of Teledermatology technology. He said the Division of Medicine would need to produce an operational proposal to present to Integrated Care Board colleagues. **Resolved: that the Divisional Quality and Governance Report – Medicines and Long-Term Conditions be received and noted.**
691/23	**Divisional Quality and Governance Report – Community Services**
	Ms Geffen advised that the plan to support in reach of therapy to Neonatal Unit was in development and a full business case had been completed for full therapy to support. She said that a post for the speech and language therapy team had been put out to advert pending the approval of the business case. Ms Geffen reported that the Integrated Care System had a projected budget deficit of £1.7M and the Trust continued to work with commissioners regarding the projected overspend. Ms Geffen advised that the Trust continued to monitor training compliance across the division due to reported inaccuracies through My Academy and Electronic Staff Record (ESR). She said the division had been recorded at 89% compliance. Ms Geffen reported that there was continuing pressure on the 0-19 service and the prioritisation plan that was in place. She said a safeguarding proposal had been agreed and would be presented to the Safeguarding Partnership Board for information. Ms Geffen advised that the post of the professional lead would be advertised due to retirement. Ms Geffen advised that there had been a decrease in community pressure ulcers for the third consecutive month and this had been a result of the tissue viability work that been conducted within localities. She said that there had been no insulin medication errors reported for localities within September 23. **Resolved: that the Divisional Quality and Governance Report – Community Services be received and noted.**
692/23	**Divisional Quality and Governance Report – Surgery**
	Mr Goude reported that the Trust continued to experience ongoing challenges with capacity for 2-week appointments for suspected cancer referrals in Breast and Skin. He said the Trust had requested mutual aid from Sandwell General Hospital for Breast and Telemedicine for Skin had been launched. Mr Goude advised that Venous thromboembolism (VTE) compliance had reduced from 91% compliance in August 23 to an overall compliance of 84% in September 23 due to IT challenges within the admissions lounge. Mr Goude reported that there had been concerns from Ears, Nose and Throat (ENT) colleagues surrounding the Black Country Provider Collaborative and Ms Salmon continued to support ENT colleagues with the proposal for ENT services. Mr Goude advised that the Trust had completed a review of all shoulder replacement procedures and all patients had been clinically reviewed. He said there had been no concerns raised surrounding wider elective upper limb practice or lower limb practice but concerns had been raised surrounding humeral fracture fixation and a review was ongoing. Mr Goude reported that a review of hand surgery had shown a 40% concern rate and these patients were receiving clinical review. Mr Goude reported that the Trust had appointed a lead for colorectal surgery to produce an improvement plan following issues raised from the National Audit of Bowel Cancer. He said the Trust had instigated daily consultant ward rounds for colorectal cancer patients on Ward 28. Mr Goude advised that there had been a spike of infections in lower limb joint replacements and a review was underway by the Infection Prevention team and actions would continue to be implemented. Mr Mirza asked if the lessons learnt from the Surgical Site Infections Cluster could be shared with other surgical specialities in other divisions. Mr Goude advised that the Trust had not identified a single root cause for the spike but issues surrounding theatre etiquette had been highlighted and improvement sessions with theatre teams had been planned.

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	Ms Boden advised that the review had highlighted issues surrounding perioperative warming and how the Trust monitored ongoing temperatures of patients and this had not been an isolated theme across orthopaedics. She said this had been featured within the One Together Framework that had been shared within the Trust. Ms Boden reported that there was a gap in patient knowledge for the ongoing management of their wound following surgery. **ACTION: Mr Goude and Ms Boden to share the results of the Surgical Site Infections Cluster Report with Trust Management Committee members.** Mr Hobbs advised that the Trusts cancer performance for 62-day referral to treatment standard had been met by the Trust during July and August 23. He said the Trust was within the upper decile in the country and this was a fantastic achievement. Mr Hobbs said that the Trusts overall elective waiting list had incrementally reduced against a national backdrop of new record highs every month and was a real achievement and testament to the level of outpatient treatments and elective day case treatments that the Trust had delivered. **ACTION: Mr Ghazal suggested a trajectory of prompt training of anaesthetists in the Division of Surgery so that it could be addressed collaboratively with the Division of Women's, Children's and Clinical Support Services.** **Resolved: that the Divisional Quality and Governance Report -Surgery be received and noted.**
693/23	**Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services**
	Mr Ghazal reported on the ongoing workforce alerts within the Division affecting paediatric nursing, paediatric medics, pharmacy and the autism pathway. He said the Trust had plans for all and was awaiting verification around the funding from investment group. Mr Ghazal advised that the Trust had begun to use some of the winter plans as contingencies to mitigate high risk areas. Mr Ghazal advised that the Trust's Black Country Pathology Services (BCPS) performance had improved in September 23 and the Trust was working with the BCPS to assist the positive and negative predictive value of urgent requests on histology as some departments had reported a high negative rate of histology results that would affect the overall performance for 7 and 10 working days. Mr Ghazal reported that the PROMPT training was a Clinical Negligence Scheme for Trusts (CNST) requirement and the Trust was on trajectory to meet the requirement in all departments and would require support from anaesthetists to ensure compliance. He said he had been in contact with the Clinical Director of Anaesthetics to ensure they were fully engaged with the process. Mr Ghazal advised that the Division's guidelines position had improved and from 12 October 23 Maternity, Gynaecology and Sexual Health had reported 100% against guidelines. He said the Trust was working with paediatricians, clinical support services and pharmacy to continue to improve the guidelines position. Mr Ghazal reported that for the first time in two years the Trust had been able to achieve 100% review and work would continue to ensure the process of risk management was up to date. Mr Ghazal congratulated the Paediatrics and Children Services team for winning the Patient Experience Network National Awards (PENNA) award. **Resolved: that the Divisional Quality and Governance Report -Women's, Children's and Clinical Support Services be received and noted.**
694/23	**Chief Pharmacist Report**
	Dr Chand advised that the Trust had set up an improvement group around insulin which was a Trust wide multidisciplinary group to address concerns that had been raised from previous Care Quality Commission (CQC) visits. Dr Chand reported that the Trust had begun to use software to review off contract purchasing which allowed the Trust to claim back any monies from manufacturers. Dr Chand advised that the Electronic Prescribing and Medicines Administration (EPMA) business case had been approved and would proceed to NHS England for financial support.

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	Dr Chand reported that there had been a drop in medicines reconciliation over the last few months and this had been due to staffing issues the Trust was facing. Dr Chand advised that there had been concerns surrounding nitrous oxide management and a plan had been formulated to eliminate the risks by moving to cylinders. She said controlled drugs and ward 14 had been an issue and she had worked closely with nursing colleagues to put together an action plan to mitigate the risks. Dr Chand reported that the aseptic workforce capacity was over capacity and the Trust continued to try and resolve the issue by embedding a wider skill mix to support with aseptic work and eliminate some of the risks. Dr Chand advised that the Trust had recruited a pharmacist to support with pharmacy home care and this would have an impact on financial savings for the Trust as well as supporting and growing the pharmacy team. Mr Hobbs congratulated Dr Chand on her new permanent role as Director of Pharmacy. Ms Boyle thanked Dr Chand for her support of the research team which had resulted in the Trust being able to open more commercial clinical trials through pharmacy. Mr Roberts asked what further support Dr Chand needed from divisions to help with recruitment into the pharmacy department. Dr Chand advised that the pharmacy department required financial support to continue to grow and bring in pharmacists. **Resolved: that the Chief Pharmacist Report be received and noted.**
695/23	**Research and Development**
	Ms Boyle reported on strong commercial activity and said that the Research and Development team had been nominated and shortlisted for a research network award for commercial activities. Ms Boyle reported that the Trust had dedicated support available to staff who wanted to develop their own research and a group manager had been appointed for own account and sponsorship studies. Ms Boyle advised that the Trust had concluded its' second collaboration meeting with Aston University and research ideas from Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust had been shared with Aston University. Ms Boyle reported that the Trust had begun arrangements for a visit to the Centre for Biomechanics and Rehabilitation Technologies surrounding falls prevention which would become one of the Trust's academic units. Ms Boyle advised that the Trust had been unable to appoint to the Professor of Midwifery and Nursing Professor and would look to recruit an Associate Professor post which may attract more interest from staff. Ms Boyle reported that Ms Dexter had been appointed as Chair of the West Midlands Research and Development Forum. **Resolved: that the Research and Development Report be received and noted.**
	Finance Reports (Section Heading)
696/23	**Integrated Performance and Quality Report**
	Resolved: that the Integrated Performance and Quality Report be received and noted.
697/23	**Trust Financial Position – Month 6**
	Mr Mortiboys reported on the Trust's financial position, advising that the Trust had started the year with a revenue deficit budget of £14M and was now forecasting in the region of £31M. He said that NHS England did not accept the deficit plan or the current deficit position. Mr Mortiboys advised that Prof Loughton would meet with Mr Julian Kelly and senior figures from the Integrated Care Board (ICB) to further review the Trust's position. Mr Mortiboys advised that all divisions had been through a financial recovery process during October 23 and a deep dive into staff employed had been conducted. He said this process would be ongoing monthly until the financial position had settled. Mr Mortiboys reported that it would be more difficult to get funding for new staff to support key clinical investment areas that were overstaffed. Mr Mortiboys reported that the Trust would be implementing budget manager training to new staff members and to offer a refresh to staff who had previously attended training.

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	Mr Mortiboys advised that the Audit Committee and Trust Board would be revising standing financial instructions in December 23 to review how the Trust spent money and demonstrated control. Mr Mortiboys reported that the Trust was reviewing upgrading the requisition system to align with The Royal Wolverhampton NHS Trust (RWT) to ensure that the Trust met the compliance checks that NHS Midlands required. Mr Roberts asked if changing Standing Financial Instructions (SFIS) meant reduced thresholds for approval. Mr Mortiboys said that the SFIs would help to ensure that the Trust followed proper practice in line with NHS England expectations and that good practice was for purchase orders to be raised before money was spent. Mr Mortiboys reminded Trust Management Committee (TMC) colleagues on the importance of paying invoices on time as this could lead to suppliers withdrawing services as payment will not have been received on time. Mr Mortiboys advised that the Trust had been able to report within the agency cap and had been able to control the agency spend. He said this had highlighted grip and control within the Trust. Mr Mortiboys reported that the Trust had the opportunity to bid for extra capital resource in year to support schemes. He asked that colleagues that required medical equipment to highlight any opportunities that could be used in 2023/24. Ms Salmon asked how the Trust would deal with the revenue costs associated with the submission for capital. Mr Mortiboys advised that divisions would need to demonstrate a way to fund the revenue costs within their plan and that would be within the Trusts governance. **Resolved: that the Trust Financial Position – Month 6 be received and noted.**
698/23	**Contracting and Business Development Update – Verbal**
	Resolved: that the Contracting and Business Development Update – Verbal be received and noted.
	Business Cases (Section Heading)
699/23	**Post Implementation Reviews (PIR's) of previously approved cases**
	Ms Salmon advised that to align with good governance the Trust needed to have post implementation reviews (PIR's) of business cases to confirm what investment had been made and that risks had been reduced. She said the Trust needed to ensure that the business cases that were approved were robust. Ms Salmon reported that 3 PIR's had not been approved at investment group as there had been insufficient detail provided. She said the Trust would need to review 10 PIR's that had been submitted by November 23 as the Integrated Care Board would require the Trust to vote on the cases. Ms Salmon advised that the Trust would need to include a Quality Impact Assessment within the business case template and this would enable divisions to better highlight what the risks of not having the business case approved were. **Resolved: that the Post Implementation Reviews (PIR's) of previously approved cases be received and noted.**
	Workforce Summary (Section Heading)
700/23	**Workforce Metrics Report**
	Ms Bond thanked colleagues for helping to decrease the long-term sickness absence rate in October 23. She said the workforce team had completed an analysis of the four main divisions and the Trust averaged 220 staff on long-term sickness absence and each month 25% of the absences were closed. Ms Bond advised that the appraisal compliance rate was below target and work would continue with corporate departments to ensure a deep dive into the outstanding staff appraisals. Ms Bond reported that the Trust had reported its highest level of exclusions with 10 active exclusions and 1 restriction at the end of September 23. She said the number of exclusions had since decreased to 7 in October 23. Ms Bond encouraged colleagues to take part in the closing event for Black History Month on Tuesday 31 October 23. Ms Bond advised that influenza vaccination uptake was at 19% amongst substantive colleagues and 7% for the Covid-19 booster.

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	Ms Bond reported that the number of staff who had completed the staff survey had been recorded as 32% as of 26 October 23 and she thanked all colleagues who had completed the survey. She said the bank staff survey had been recorded at 12%. **Resolved: that the Workforce Metrics Report be received and noted.**
701/23	**My Academy Assurance Report**
	Ms Bond advised a deep dive into 'My Academy' compliance data was ongoing following a lack of confidence from several managers regarding the accuracy of the data that had been provided. She said the team were focused on solving the challenges that staff were facing. Ms Bond advised that a stakeholder group would be set up and a proposed membership and terms of reference would be shared. She said it would be a task and finish group that would run until the end of financial year 2023/24 and this would allow feedback from the investigations to be shared with stakeholders. Ms Bond reported that the Trust was completing an audit surrounding face to face sessions for life support and patient loading and handling to ensure paper time attendance sheets were added to the system to reflect compliance. Ms Bond advised that she would attend future divisional board meetings in November and December 23 to facilitate detailed discussions regarding the My Academy Assurance Report and gain feedback from divisions. **Resolved: that the My Academy Assurance Report be received and noted.**
702/23	**Schwartz Round Annual Update**
	Ms Bond presented the Schwartz Round Annual Update advising that Schwartz Rounds had been undertaken at the Trust on a monthly basis for the past 18 months and provided a structured forum for staff to come together to discuss the emotional and social aspects of working in healthcare. Ms Bond advised that the Schwartz Rounds had seen good attendance levels and encouraged colleagues to attend future Schwartz Rounds. **Resolved: that the Scwartz Round Annual Update be received and noted.**
703/23	**Estates Strategy and Capital Plan**
	Ms Longden reported that the Estates Strategy and Capital plan had been approved at the Finance and Productivity Committee held on 25 October 23. She said the Trust needed to ensure compliance with NHS England requirements to create a joined-up Black Country Integrated Care Board (ICB) Estates Strategy. Ms Longden advised that the toolkit to implement this had not yet been released. Ms Longden advised that there were ongoing pressures to access capital. **Resolved: that the Estates Strategy and Capital Plan be received and noted.**
704/23	**Corporate Risk Register**
	Mr Hobbs referred to Risk ID 208, 4 hour Emergency Access Standard and advised that in light of pressures during October 2023, he had asked Mr Roberts to review this risk. **Resolved: that the Corporate Risk Register be received and noted.**
705/23	**Any Other Business**
	Mr Bostock advised that the Patient Safety Incident Response Framework (PSIRF) would replace the current 2015 Serious Incident Framework from 1 November 23. He said any new reported serious incidents would go through the PSIRF process. Mr Bostock reported that any serious incident reported up until 23:59 on 31 October 23 would go through the Serious Incident Framework route with a Root Cause Analysis (RCA) and anything reported from 00:00 31 October 23 would go through PSRIF and would not necessarily require an RCA. Mr Bostock reported that there would be a series of communications shared with the Trust and training would be available for staff to attend and training delivered electronically through My Academy. He said he would be circulating the policies to each divisional leadership team. Mr Ghazal asked if incidents that had already been identified from 1 November 23 would move from the Serious Incident Framework (SI) to PSIRF or if they would be preserved on the SI framework. Mr Bostock advised that there would be a period of overlap and the 2015 SI Framework would continue until all cases that occurred before 00:00 on 31 October 23 had been resolved. He said that both systems would be operated from 1 November 23 but the Trust would cease to input any new incidents onto the SI framework from 31 October 23.

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	Ms Boden reported that NHS England had produced a PSIRF document for Infection Prevention and Control which was being discussed with Health Protection colleagues at the Integrated Care Board (ICB). She said that PSIRF would allow the Trust to not be as restricted with the review of cases and support better thematic analysis. **Resolved: that the update on PSIRF be received for information**
706/23	**Date Of Next Meeting**
	Mr Hobbs confirmed the next meeting of the Trust Management Committee would take place Thursday, 23 November 2023 09:00-11:00.

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Trust Management Committee

Date/time:	Thursday 21st September 2023
Venue:	Via Microsoft Teams
Quorate:	Yes
Chair:	Mr N Hobbs

Mr N Hobbs	Chief Operating Officer/ Deputy Chief Executive
Prof D Loughton	Group Chief Executive
Mr K Wilshere	Group Company Secretary
Mr D Mortiboys	Interim Finance Director
Dr M Shehmar	Chief Medical Officer
Ms L Carroll	Chief Nursing Officer
Mr C Ward	Deputy Chief Nursing Officer
Ms M Arthur	Group Deputy Director of Assurance
Ms M Metcalfe	Group Deputy Director of Assurance
Mr S Jackson	Director of Operations – Community
Ms K Geffen	Divisional Director of Nursing – Community
Mr F Ghazal	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
Ms S Webley	Divisional Director of Operations – Surgery
Ms K Rawlings	Divisional Director of Nursing – Surgery
Mr M Ncube	Divisional Director of Clinical Support Services
Ms J Wright	Director of Midwifery, Gynaecology and Sexual Health
Ms S Giddings	Head of Midwifery
Ms C Bond	Deputy Director of People and Culture
Mr N Bruce	Group Director of Digital Technology
Ms P Boyle	Group Director of Research and Development
Ms J Longden	Divisional Director of Estates and Facilities
Ms S Chand	Deputy Director of Pharmacy
Ms K Salmon	Deputy Chief Strategy Officer
Mr S Evans	Group Chief Strategy Officer
Ms T David-Eyen	Deputy Divisional Director of Women's, Children's & Clinical Support Services
Mr W Goude	Divisional Director of Surgery
Ms L Nickell	Group Director of Education and Training

In Attendance:

Ms S Smith	Head of Health and Safety
Ms T Faulker	Head of Communications
Ms E Stokes	Senior Administrator for Group Company Secretary
Ms J Toor	Senior Operational Coordinator for Group Company Secretary

Apologies:

Mr K Stringer	Group Chief Financial Officer/ Group Deputy Chief Executive
Dr J Odum	Group Chief Medical Officer
Mr A Duffell	Group Chief People Officer
Mr K Bostock	Group Chief Assurance Officer
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Ms S Cartwright	Group Director of PLACE
Ms R Tomkins	Deputy Divisional Director of Nursing, Division of Medicine & Long-Term Conditions
Ms C Yale	Divisional Director of Nursing – Paediatrics and Neonates
Ms C Whyte	Deputy Chief Nursing Officer
Mr M Dodd	Interim Director of Transformation
Dr N Usman	Divisional Director of Medicine and Long-Term Conditions
Ms C Griffiths	Chief People Officer
Ms A Boden	Head of Infection Prevention and Control

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642/23	**Chair's welcome, Apologies and confirmation of Quorum**
	Mr Hobbs welcomed everyone to the meeting and apologies were noted.
643/23	**Minutes of Trust Management Committee held on 20 July 2023**
	Mr Hobbs confirmed the minutes of the meeting held 20 July 2023 as an accurate record. **Resolved: that the minutes of the last meeting held on 20 July 2023 be received and APPROVED.**
644/23	**Matters Arising and Action Log**
	Mr Hobbs received the action log and updates were noted as follows. **Action 877** - Ms Boden to replicate the national overview chart for all organisms particularly for *C-Difficile* in the September Infection Prevention Control (IPC) Report. **Mr Hobbs confirmed that Ms Boden would provide this information in future IPC reports.** This action was closed. **Action 829 -** Mr Mortiboys to provide an appendix to future Research and Development (R&D) Report that sets out the income by department associated with commercial research. **Mr Hobbs confirmed that Mr Mortiboys would provide this information in future R&D reports.** This action was closed. **Action 880 -** Divisional Quality and Governance Report – Women's, Children's and Clinical Support services to provide an update on alternative quality assurance services following the withdrawal of University Hospital of Derby and Burton NHS Foundation Trust. **Mr Ghazal reported that the Trust was working with Black Country Pathology Services (BCPS) to develop a Service Level Agreement.** This action was closed. **Action 881 -** Ms Bond to include the NHS England Long Term Workforce plan into the September Workforce Metrics Report. **Ms Bond advised that the NHS England Long Term Workforce plan would be shared with Trust Management Committee Members.** This action was closed. **Action 878 -** Ms Wright to include the outcome of the perinatal mortality cases following thematic review in Septembers Midwifery Service Report. **Mr Hobbs confirmed that the outcome of the thematic review would be included within the September Midwifery Report.** This action was closed. **Resolved: that the Action Log be reviewed and updates received and noted.**
645/23	**TMC Terms of Reference**
	Mr Wilshere reported that comments and amendments to the TMC Terms of Reference had been received from TMC members. He advised that the approved Terms of Reference would also be presented to the Trust Board for approval at the meeting in October 23. Mr Hobbs advised that whilst Joint Staffside colleagues were not noted as formal members on the TMC Terms of Reference, they would continue to attend Trust Management Committee (TMC) meetings. **Resolved: that the TMC Terms of Reference be received and APPROVED.**
646/23	**Policies, procedures for approval and information**
	Mr Wilshere provided a summary of the policies report and asked that the listed policies be reviewed and approved. 1. WHT-IP992 V4 Surveillance of Alert OrganismsPolicy 2. WHT-IP993 V2 Extended Spectrum Beta-Lactamase Producing Organisms (ESBL) Policy 3. WHT-MH927 V2 Rapid Tranquillisation Policy 4. WHT-OP985 V3 Charitable Funds Policy 5. WHT-OP994 V2 Safekeeping of Patient's Monies and Property Policy 6. WHT-OP995 V5 NHS Model Complaints Handling Procedure 7. WHT-CP947 V2 Admission Criteria Policy for Critical Care Unit (ICU/HDU). 8. WHT-HR13 V2 Maintaining High Professional Standards - Disciplinary and Management of Performance Procedure for Medical Staff 9. RCOG National Guideline. Management of Endometrial Hyperplasia Feb 2016 **Resolved: that the above listed policies be received and APPROVED.**

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647/23	**DSPT Action Plan Update**
	Ms Arthur reported that the Trust had declared compliance with 96 of the 113 mandatory Data Security and Protection Toolkit (DSPT) assertions on 30 June 23. She said that the Trust had 17 mandatory assertions remaining to require the Trust to evidence achievement and said that work was ongoing against these. Ms Arthur advised that a Board Development Session to deliver the DSPT Plan to the Trust Board was to be scheduled for early in the New Year and would be provided by an external provider. **Resolved: that the DSPT Action Plan Update was received and noted.**
648/23	**Chief Nursing Officer Report**
	Ms Carroll advised that the Trust had reported 1 serious harm fall in July 23 and investigation continued through the Serious Incident process. Mr Carroll reported that the Trust continued to improve observations on time and had been in excess of the Trust's target for the past 4 months. Ms Carroll advised that 41% of clinical staff had completed the Deteriorating Patients E-Learning Package and progress would be further monitored through the Patient Safety Group. Ms Carroll reported that the Trust was below target for the completion of Safeguarding Adult and Children's training level 3. She said the training had moved online and had been reduced to 2 hours rather than a full day of training. Ms Carroll advised that Ms Bond and her team continued to review the discrepancies between the completion of training recorded by divisions in correlation with the training registered on My Academy. Ms Carroll advised that the Nursing and Midwifery vacancy rate had increased from June and was recorded at 1.94% in July 23. She said the Clinical Fellowship for Nurses (CFN) programme continued for the financial year 2023/24 with an additional 13 nurses due to arrive in October 23 before the programme ends in November 23. Ms Carroll reported that agency cessation plans continued to see a reduction in the usage of agency nursing staff with a robust risk assessment process in place for the agreement of agency use. **Resolved: that the Chief Nursing Officer report be received and noted.**
649/23	**Biannual Skill Mix Review – June 2023 Data**
	Ms Carroll advised that the Biannual Skill Mix Review took place in January and June of every year and the June 23 data was presented to Trust Management Committee Members for information. She said the Trust used the Safer Nursing Care Tool (SNCT) and the collected data was reviewed by ward managers, matrons and divisional directors of nursing. Ms Carroll reported that the review found no staffing concerns in the 17 adult Ward areas that had been reviewed. She said the changes to the skill mix that had been agreed by Trust Board in June 22 had since been aligned to the wards that had required the changes. Mr Roberts asked if future reviews would include the ward clerk establishments. Ms Carroll advised that the Trust had plans to review the clinical workforce and ward clerks would be reviewed separately as they could not be reviewed using the SNCT. **Resolved: that the Biannual Skill Mix Review – June 2023 Data be received and noted.**
650/23	**Infection Prevention Report**
	Ms Carroll advised that national benchmarking data had highlighted the Trust as being 119/136 Trusts for *C.Difficile* cases which was not a good position for the Trust. She said the Trust had undertaken a 'fishbone' analysis on the recommendation of national experts and this had identified several contributory factors. Ms Caroll reported that the Infection Prevention Committee continued to work closely with the sepsis team to ensure the delivery of antibiotics within an hour for sepsis patients. Ms Carroll reported that 20/50 cases of *C.Difficile* had been associated with antibiotic treatment for healthcare acquired pneumonia which was a driver towards the business case for a mouth care team to prevent pneumonia.

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	Ms Carroll advised that following the increase in timely sampling the Trust had identified an increase in community prevalence and the Trust would continue to work with the Integrated Care Board (ICB) to support General Practice prescribing. Dr Shehmar said that it was important that clinical teams had clear oversight over the prescribing practice for broad spectrum antibiotics. She said that new doctors needed to be aware of how to access MicroGuide and the prescribing guidance available. **ACTION: Ms Boden to provide assurance from the Infection Prevention Committee of divisional oversight of prescribing practice and the access of MicroGuide for all prescribers.** Mr Hobbs asked for assurance regarding the limited Surgical Site Infection (SSI) surveillance due to the Trust not having a dedicated SSI surveillance team. Ms Carroll advised that the SSI's had been reviewed and Ms Boden continued to work alongside the surgical division. **Resolved: that the Infection Prevention Report be received and noted.**
651/23	**Midwifery Service Report**
	Mr Hobbs welcomed Ms Giddings as the new Head of Midwifery. Ms Wright advised that Midwifery Staffing remained on the risk register with a score of 16 and the Trust would be able to decrease this risk following the transition of fellowship midwives into substantive posts and the arrival of recently appointed midwives. She said the Trust still had maternity support worker vacancies and had completed the management of change process to ensure the support workers that were already in place were offered substantive positions. Ms Wright reported that the Trust was able to maintain 1:1 care in labour despite recent shortfalls in staffing. Ms Wright advised that recent National Institute for Health and Care Excellence (NICE) guidance specified that women should be booked by 10/40 weeks. She said Walsall Healthcare NHS Trust (WHT) was reporting at 42% compared to the national target of booking 85% of women by this gestation. She reported that following investigations into why the rate was at 42%, it had been found that staff had misinterpreted the guidance and had believed the 1st appointment had to be made by 10/40 not the complete booking. Ms Wright reported that the Trust had conducted a review into perinatal mortality cases following an increase from 2.76:1000 to 3.56:1000. She said the themes identified from the review had been formed into an action plan and that the themes would continue to be addressed through increased education and development. Ms Wright advised that the Trust had seen an increase in Preterm births in April 23. She said following a review no care issues had been identified. She said that WHT was not an outlier and had the 2nd lowest preterm birth rate in the Local Maternity and Neonatal System (LMNS). Mr Hobbs commended the preterm birth review as it highlighted good examples of the governance process. Ms Wright reported that the new LMNS preterm birth lead had been appointed and would be conducting an independent review. Mr Hobbs asked if the Healthcare Safety Investigation Branch (HSIB) letter the Trust had received had been formalised through the medicine governance process. Ms Wright advised that the HSIB letter had been raised at the last Serious Incident committee meeting. **ACTION: The Division of Medicine to provide assurance that the HSIB letter has been acted upon through the MLTC governance route.** Dr Shehmar reported that the Trust had been identified as an outlier for smoking cessation. She asked when the review into patients who smoke throughout pregnancy would be completed. Ms Wright advised that the Trust had a session scheduled for October 23 to engage with service users in the community. Mr Ghazal advised that the Trust only provided smoking cessation services to WHT patients and the Trust would continue to work with the LMNS to ensure all patients had access to the service irrespective of where they lived.

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	Dr Shehmar asked for assurance following the perinatal mortality thematic review that the actions of abnormal midstream specimen of urine (MSU) could have been automated from the labs. **ACTION: Ms Wright and Mr Ghazal to provide an update on the laboratory process for MSU tests.** **Resolved: that the Midwifery Service Report be received and noted.**
652/23	**Patient Voice Report (and Annual Complaints Report)**
	Ms Carroll advised that the Patient Relations and Experience Team had been shortlisted for 2 Patient Experience Network (PEN) awards for 'Little Voices and 'Manor Lounge'. Ms Carroll reported that the Trust had seen an increase in complaints relating to staff attitude which had included families reporting a lack of empathy and being spoken to in a rude manner. Ms Carroll advised that the Patient Relations and Experience Team had organised a customer care training session in October 23 to support staff with delivering good customer care. Ms Bond advised that advised that the last pilot session of the Civility and Respect Programme had been scheduled and an update would be presented to the Trust Management Committee (TMC) in October 23. **Resolved: that the Patient Voice Report (and Annual Complaints Report) be received and noted.**
	Divisional Reports (Section heading)
653/23	**Divisional Quality and Governance Report – Medicines and Long-Term Conditions**
	Mr Roberts advised that Venous thromboembolism (VTE) improvement remained a focus within the division with increased scrutiny surrounding accountability for individual practise alongside the improvement plan. Mr Roberts reported that Paediatrics sepsis management in the Emergency Department remained an area requiring improvement. He said the Trust would continue to track the accuracy of information against genuine improvement. Mr Roberts advised that the Trust would continue to look at the introduction of Bioquell pods in wards that had difficulty in isolating patients to ensure earlier isolation of patients with infections. Mr Roberts reported that the Medicine Division had undertaken a recent away day which had allowed the division to reflect on the areas that had seen significant improvements across the division. **Resolved: that the Divisional Quality and Governance Report – Medicines and Long-Term Conditions be received and noted.**
654/23	**Divisional Quality and Governance Report – Community Services**
	Ms Geffen advised that the Council was scoping interest from the market for the Healthy Child Programme (HCP) contract. She said the deadline for the pre-market engagement questionnaire was 11 September 23 which the Trust had completed and submitted. Ms Geffen reported that the Trust was waiting to see if there would be a tender release with a provisional date of 16 October 23. Ms Cartwright reported that following recent conversations with the Director of Public Health, the Council had indicated that the Trust's contract would be extended without going to full tender and the Trust was awaiting confirmation of this agreement. She said this had nothing to do with the quality of services the Trust provided and was due to the contractual terms coming to an end. Ms Geffen advised that the Division continued to monitor training compliance which currently sat at 89% due to the inaccuracies through My Academy and Electronic Staff Record (ESR). Ms Geffen reported that the Trust had 20 trained vaccinators across community to deliver Covid-19 and Flu vaccinations. Ms Geffen advised that the central community nursing triage went live on 11 September 23 and said this had supported capacity and patient outcomes. Dr Shehmar reported that the Community Division still had gaps with insulin prescribing and insulin errors and asked what areas within the Division still required focussed work. Ms Geffen advised that a programme of work

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	within the community nursing plan was underway, supported by the National Team for Community Nursing to help delegate and support issues that continued to arise. Ms Geffen reported that the Safer Staffing Tool for Community would be launched in 2023 and would include guidance surrounding insulin capacity and demand and the management of long-term conditions. **Resolved: that the Divisional Quality and Governance Report – Surgery be received and noted.**
655/23	**Divisional Quality and Governance Report – Surgery**
	Mr Goude advised that the Trusts 62-day referral to treatment standard had been met for the first time in 3 years. He said the Trust was ahead of trajectory to meet the 65-week wait target for elective care by March 24. Mr Goude reported that the Trust had received good feedback from the West Midlands Children in Surgery Network outlining the Trusts performance as the best in the Country against Getting It Right First Time (GIRFT) standard for day case tonsillectomy rates. He said the Trust's theatre utilisation performance remained amongst the best in the Country. Mr Goude advised that medicines management compliance was at 94% and further improvement was required. He said that venous thromboembolism (VTE) compliance had improved by 4% since July 23 and overall compliance for August 23 had been reported at 91%. Mr Goude reported that diagnostic delays in endoscopy had increased patient overall cancer pathway timeliness. He said an escalation process had been established between the Division of Surgery and Medicine and Long-Term Conditions to ensure the escalation of patients due to exceed their target date. Mr Goude advised that the Division of Surgery had 7 Duty of Candour responses overdue which had been escalated. Dr Shehmar advised that she had met with Mr Bostock and Dr Mckaig to further escalate the Duty of Candour Responses with The Royal Wolverhampton NHS Trust (RWT). Mr Goude reported that the Division of Surgery had 435 overdue reported incidents and work continued with the quality assurance team to review the reported incidents. Mr Goude advised that the Trust had been highlighted for outlying adverse outcomes in colorectal surgery in several areas. He said this had been escalated and a review had been undertaken by Mr Silverman and the findings had been presented in August 23 to multiple stakeholders. Mr Goude reported that the Division was working with the executive team to formulate an action plan. **Resolved: that the Divisional Quality and Governance Report – Surgery be received and noted.**
656/23	**Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services**
	Mr Ghazal reported on the Trust's concern on the turnaround times for urgent histology results within the Black Country Pathology Services (BCPS). He said the Trust continued to have regular discussions with the BCPS and the Division had set up a working group linked specifically to Walsall Healthcare NHS Trust (WHT) performance with the involvement of the cancer services and BCPS. Mr Ghazal advised on the Division's Referral-to-Treatment (RTT) performance and the Division had seen deterioration in the admitted and non-admitted pathways in Gynaecology and Haematology. He said the Integrated Care Partnership (ICP) would need to escalate concerns and the impact industrial action would have across the Black Country. Mr Ghazal reported that the Trust had seen a large volume of referrals within the autism pathway. He said the care group had developed an option appraisal and this would be presented to investment group to address the issues within the autism pathway. Mr Ghazal advised that paediatrics had seen increased activity and a business case had been developed for the nursing element and would be submitted to investment group in October 23. Mr Ghazal advised that the Trust had developed a new service offering day case hysterectomy surgery for women at WHT. He said this service was only provided in 30% of Trusts nationally and had been highlighted as a success story through the Integrated Care Board (ICB) with a video highlighting the pathway. He said patient stories on accessing the service would be shared at the Black Country Clinical Summit in October 23. Mr Ghazal reported

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	that the Trust would work with the ICB to ensure that all women within the Black Country had access to the service. Dr Shehmar asked if the implementation of the Paediatric Early Warning System (PEWS) would ensure the Trust was using the same scoring system as Birmingham Children's Hospital (BCH) as there had been discrepancies between WHT and BCH. Mr Ghazal reported that the Trust had submitted a paper to change PEWS to System-wide Paediatric Observation Tracking (SPOT) option appraisals and this had been appraised by the care groups and patient safety group. He said this was the preferred option as it was not directly linked to vital pack and would require the Trust to withdraw from vital pack in paediatrics which had been essential in improving sepsis compliance. Dr Shehmar asked if work had begun against the 25 actions that had been highlighted with Surgery in Children (SiC) peer review. Mr Hobbs asked that the actions were addressed through Children and Young People (CYP) Group. **Resolved: that the Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services be received and noted.**
657/23	**Research and Development**
	Ms Boyle advised that commercial research within the Trust continued to expand and the Trust had met the target set following Lord O'Shaughnessy recommendation of doubling the number of commercial recruits. Ms Boyle reported that the maternity hybrid role funded by the Clinical Research Network had been successful but the Trust had been informed that funding would cease in December 23. She said the Trust had been in conversation with the Clinical Research Network to see if funding could be extended. Ms Boyle reported on a clinical incident relating to a Walsall Healthcare NHS Trust (WHT) trial which had been escalated to the Medical Director and Group Director of Research, and advised that there had been no patient harm reported. She said that an incident form and Duty of Candour had been completed and lessons learnt would be shared following completion of the findings. Dr Shehmar reported that immediate lessons from the incident had highlighted that research patients needed to be highlighted clearly on theatre lists. Ms Boyle reported that future finance reports would include drug savings as well as system wide savings due to less activity. Dr Shehmar asked that the divisions provided up to date contact details for visiting clinicians to ensure they were included on the Research and Development email circulation list. Mr Hobbs commended dermatology and renal for the volume of studies that had been undertaken. **Resolved: that the Research and Development report be received and noted.**
	Finance Reports (Section heading)
658/23	**Integrated Performance and Quality Report**
	Mr Mortiboys advised that the Integrated Performance and Quality Report (IQPR) would be changed to align with the current strategy. **Resolved: that the Integrated Performance and Quality Report be received and noted.**
659/23	**Trust Financial Position - Month 5**
	Mr Mortiboys reported on the Trust's deficit in actual and percentage terms. He said the Trust was under increased scrutiny from the Integrated Care Board (ICB) and regional team. Mr Mortiboys advised that at the end of Month 5, the Trust had a £16M deficit with a forecasted deficit of £14M for 2023/24. He said the Trust had been required to complete several checklists surrounding controls and the ICB had asked that any non-pay expenditure not in budget that totalled £10K receive ICB level scrutiny. Mr Mortiboys reported that the Trust could only put inflation within the budget that was in line with National guidance and said that this was less than what the Trust had experienced. He said that against the revised plan the Trust would be £4.5M adverse.

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	Mr Mortiboys advised that following analysis the Trust had identified that there were more staff in several areas than in the financial plan. He said that following divisional performance reviews himself and Ms Carroll were confident that the financial plan nursing headcount would be in line with the financial plan and a continued focus would remain on this throughout 2023/24. Mr Mortiboys reported that the Trust continued to spend less on agency staff however, the Trust was still above the agency cap set by NHS England and work would continue to decrease this. Mr Mortiboys advised that the Trust's Cost Improvement Programme (CIP) continued to progress and was at 80% of the Trust's required target. He said 64% of this was recurrent and there would be a continued focus to achieve the 90% target. Mr Mortiboys reported that the Trust been in dispute with the ICB regarding community services and following protracted negotiation the Trust had secured 94% of the funding required. Mr Hobbs advised that the Trust needed to continue to work to be in the strongest possible financial position for the remainder of 2023/24. **Resolved: that the Trust Financial Position – Month 5 be received and noted.**
660/23	**Contracting and Business Development Update - Verbal**
	Mr Mortiboys reported that the Trust would be contacting local Integrated Care Boards (ICB) to advise them of the level of emergency demand that the Trust was taking. He said this was considerably less than the funding that the ICB had provided and the Trust would look to seek increased income 2023/24 and 2024/25. **Resolved: that the Contracting and Trust Financial Position – Month 5 be received and noted.**
661/23	**Annual Health and Safety Report**
	Ms Smith reported that 100% of quoracy and convening had been achieved by the Health and Safety Committee during 2022/23. Ms Smith advised that the Health and Safety Committee would continue to focus on improved divisional and specialist assurance and scrutiny of statutory performance. She said that there had been a reduction in external Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents by 53% compared to the previous financial year. Ms Smith reported that Health and Safety incident reporting had increased by 3% compared with the previous financial year and violence and aggression reporting had decreased by 5%. She said work would continue to focus on consistent post incident investigations and focus on frequently cited incidents. Ms Smith advised that the Trust would continue to prioritise new staff and students following the end of the Ashfield Healthcare contract that had been funded by the Department of Health and Social Care which had resulted in a reduction of the Health and Safety team. Ms Smith reported that the Trust had secured funding for Institution of Occupational Safety and Health (IOSH) training for Executives and Directors and the course had been delivered in June 23. She said that Conflict Resolution and Load Handling Training had exceeded the Key Performance Indicator (KPI) at 95% and 93%. Ms Smith advised that Mandatory safety training compliance had failed to achieve the KPI ending the year at 88% and the Trust would continue to work to increase the compliance of training. Ms Smith reported that following the inspection of the Trust's Sharp Safety Management System by the Health and Safety Executive (HSE) on 11 and 12 January 23, the Trust had received a notice of contravention informing the Trust of actions that were required for improvement. Ms Smith advised that following this a new Sharp Safety Management Policy, mandatory sharps training and a revised non-safe sharp risk assessment had been developed and further work would continue to embed these processes across the Trust. Ms Arthur advised that the Trust required divisional support surrounding the Sharps Management action plan that had been circulated following the HSE visit.

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	Ms Smith advised that managers engagement and compliance with the Trust-safety management system was low and completed returns for the Managers Health and Safety toolkit had not reached the KPI of 100%. She said this adversely impacted the assessment of compliance and Trust assurance and would require target improvement in 2023/24. Ms Arthur reported that the Trust's reduced level of evidence of assurance for health and safety affected the Trust's risk profile for compliance with regulation. Mr Hobbs emphasised the importance of divisional and corporate leadership teams engagement with Health and Safety training. **Resolved: that the Annual Health and Safety Report be received and noted.**
662/23	**Walsall Together**
	Resolved: that the Walsall Together report be received and noted.
	Workforce Summary (Section heading)
663/23	**Workforce Metrics**
	Ms Bond advised that work was ongoing regarding the credibility of mandatory training data and reassurance was being sought following the completion of manual work by managers and service areas. She said that following the implementation of My Academy several training modules had been updated and reviewed. Ms Bond reported that the Trust would begin work on a line-by-line service and divisional level to understand the differences and the training outstanding. She said that My Academy was rolled out from Electronic Staff Records (ESR) and there were structural issues with the hierarchies in ESR. Ms Bond advised that following work completed by subject matter experts, regarding the profiles of staff required to complete different elements of training, there had been a shift in data and this had not flowed to reflect the outcomes. Ms Bond advised that there had been a decline in annual appraisal completion rates amongst Corporate and Estates colleagues. She said work would continue to support senior leaders in those areas to understand the challenges that had resulted in the decline. Ms Bond reported that paper versions of the Staff Survey had been distributed across the Trust and the digital version would be shared with staff by 22 September 23. She said the Trust would push to exceed the 53% completion target recorded in 2022. Ms Bond advised that an additional adapted survey would be shared with regular bank workers. Ms Bond advised that the Flu Vaccination Hub had been set up within the Trust and over 200 staff members had received their flu vaccination within the first week and work would continue to support and encourage colleagues to receive the vaccination. **Resolved: that the Workforce Metrics report be received and noted.**
	Business Cases (Section heading)
664/23	**Business Case - Respiratory Expansion - Verbal**
	Mr Evans advised that the Respiratory Expansion business case had been to investment group and had been approved. He said there were outstanding questions for the business case that would be resolved at the Extraordinary Investment Group Meeting scheduled for 21 September 23. Mr Hobbs asked that Trust Management Committee (TMC) colleagues delegate the approval of the 3 business cases (minute reference 664/23, 665/23, 666/23) to the Extraordinary Investment Group meeting to be held 21 September 23 to ensure the level and detail of diligence was completed. **Resolved: that the Business Case – Respiratory Expansion be received and delegated to the Extraordinary Investment Group meeting 21 September 23 for approval.**
665/23	**Business Case - Gastroenterology Expansion - Verbal**
	Mr Evans advised that the Gastroenterology Expansion business case had been to investment group and had been approved. He said there were outstanding questions for the business case that would be resolved at the Extraordinary Investment Group meeting scheduled for 21 September 23.

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	Resolved: that the Business Case – Gastroenterology Expansion be received and delegated to the Extraordinary Investment Group meeting 21 September 23 for approval.
666/23	**Business Case - Frontline Digitisation - Verbal**
	Mr Evans advised that the Frontline Digitisation business case would be presented to the Extraordinary Investment Group meeting 21 September 23. **Resolved: that the Business Case –Frontline Digitisation be received and delegated to the Extraordinary Investment Group meeting 21 September 23 for approval.**
667/23	**Black Country Provider Collaboration Update - Verbal**
	Mr Evans advised that the next clinical seminar would take place on 27 October 23. Mr Evans reported that the work to secure the North Hub at Cannock Chase Hospital through Targeted Investment Fund (TIF) would no longer proceed with NHS England. He said the Trust would continue to look at alternative sources to secure funding as this would support elective capacity. **Resolved: that the Black Country Provider Collaboration Update – Verbal be received and noted.**
668/23	**Quality Improvement Team Update**
	Ms Salmon reported that an event had been held with Executives, Non-Executive Directors and Senior Leaders across Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust on 13 July 23 to review the recently published 'Delivery of Continuous Improvement Review'. She said the attendees completed the maturity self-assessment and agreed the Trusts current rating for the 5 organisational factors associated with a successful improvement system and culture as defined by NHS Improving Patient Care Together (IMPACT) which would be presented to Trust Board meeting in October 23 for approval. Ms Salmon advised that an intensivist Quality Improvement (QI) clinical fellow had joined the Trust and their rota would be 50% clinical and 50% QI supporting other trainees. **Resolved: that the Quality Improvement Team Update be received and noted.**
669/23	**Sustainability Report and Green Plan Update**
	Mr Evans advised that the Trust would continue to implement reduction measures to ensure the level of anaesthetic gases were within the national target. Mr Evans reported that the Trust would be unlikely to deliver the change of all owned and/or leased fleet vehicles to Low Emissions Vehicle (LEV). He said capital funding would be required to transition 90% of the Trust owned and/or leaded vehicles. **Resolved: that the Sustainability Report and Green Plan Update be received and noted.**
670/23	**Property Management update**
	Resolved: that the Property Management Update be received and noted.
671/23	**Property Update - Eldon Court**
	Ms Longden reported that the Trust had leased three units at Eldon Court from a private landlord through NHS Property Services. She said the property had housed numerous teams over the years including IT and District Nursing. Ms Longden advised that the property had been vacant since September 21 and was no longer fit for purpose. Ms Longden advised that the location of property was difficult for staff to reach and there was insufficient parking which had resulted in surrounding streets becoming congested with parked cars. Ms Longden asked that Trust Management Committee colleagues approve the plan for the Trust to dispose of the property due to the issues with location and length of time that the property had been vacant. She said the Trust may be liable to a dilapidations cost of £47,935.58 to return the property to its original condition. **Resolved: that the plans for the Trust to dispose of the property, Eldon Court be received and APPROVED.**
672/23	**EPRR Self-assessment Core Standards**
	Mr Hobbs confirmed Mr Ferris as the new head of Emergency Preparedness, Resilience and Response (EPRR). Mr Hobbs advised that Trust Management Committee were asked to approve the EPRR assurance self-assessment rating overall of partial compliance. He said the report detailed the moderation process with

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	Integrated Care Board (ICB) and NHS England colleagues and the actions that were required to improve in areas where the Trust was not yet fully compliant. **Resolved: that the EPRR Self-assessment core Standards be received and APPROVED.**
674/23	**Urgent & Emergency Care Resilience: Winter Plan 2023/24**
	Mr Roberts advised that the Trust had undertaken a number of initiatives to be able to deliver the Winter Plan 2023/24 and were working to a financial envelope of £1.37M within the Winter Plan alongside the expected envelope from NHS Midlands of £150K. Mr Roberts reported that the Trust expected a bed shortfall before the impact of the Winter plan between 40 and 77 beds and after mitigations between 11 and 48 beds. He said the Trust had put forward a request to open 21 additional inpatient overnight beds for a period of 12 weeks to help mitigate the shortfall. Mr Hobbs advised that option 1 of the Winter plan would leave the Trust exposed with a lack of resilience going into winter if the Trust was to see similar patterns of infectious diseases. He said the Trust recommended option 2 and this would be subject to securing external funding. Mr Hobbs reported that formal approval of the Winter Plan 2023/24 would be recorded at Finance and Productivity Committee 27 September 23. **Resolved: that the Urgent & Emergency Care Resilience: Winter Plan 2023/24 be received and noted.**
675/23	**Digital Strategy and Programme Update**
	Mr Bruce thanked colleagues for the considerable work that had been completed to evolve the benefits realisation of the Frontline Digitisation business case. He said the case was underpinned by £2.7M in year 1 and £4.2M in year 2 of capital allocation from NHS England. Mr Bruce advised that the programme of work was designed to meet the digital core foundations and the minimal digital foundations laid out to all Trusts across the Country to be achieved by March 25. Mr Bruce reported that the Trust had secured £140K implementation resource funding from the Integrated Care Board to roll out the Patient Engagement Portal. He said this would see convergence across the region as all Trusts would use the same portal. Mr Bruce advised that great progress continued with Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) partnership with a number of key strategic platforms blended together. Mr Bruce reported that all the core platforms remained consistent with the trajectory of core capabilities needed for the Digital Core Foundations and objectives for NHS England. **Resolved: that the Digital Strategy and Programme Update be received and noted.**
676/23	**Board Assurance Framework and Heat Map**
	Resolved: that the Board Assurance Framework and Heat Map be received and noted.
677/23	**Executive Walkabout Action Summary Update Report**
	Resolved: that the Executive Walkabout Action Summary Update Report be received and noted.
678/23	**Any other business**
	Mr Hobbs wished Ms Griffiths luck with her upcoming 12-month secondment at the Midland Metropolitan University Hospital. He thanked Ms Griffiths for her contribution to Trust Management Committee meetings. Mr Hobbs advised that Mr Duffell would formally confirm interim arrangements.
679/23	**Date of next meeting: Thursday, 26 October 2023 - 09.00 - 1100**
	Mr Hobbs confirmed the next meeting of the Trust Management Committee would take place Thursday, 26 October 2023 09:00-11:00.

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