Bundle Public Trust Board 6 April 2022

1 Chair's Welcome; Apologies and Confirmation of Quorum

Lead: Chair
Apologies received: Sally Rowe
In attendance:
Michelle Lawrence, Interim CQC Standards Assurance Lead for Walsall - observing
Mr Mirza Salman

2 Declarations of interest

Lead: Chair
Action: Board Members - Executive and Non Executive to declare any further conflicts of interest not already declared on the register of interests.

2. Public Declarations of Interest March 2022.docx

3 Minutes of the last meeting

Lead: Chair
Action: To APPROVE the minutes of the last meeting held on the 2nd February 2022

3. Public Board Minutes - 02.02.22 FINAL Draft.docx

4 Matters Arising

Lead: Chair
Action: To review any matters arising which are not already covered on the agenda.

5 Action Log

Lead: Chair
Action: To review and update outstanding actions (Action 150 and Action 151)

Action items (2).docx

6 Trust Values and Nolan Principles

7 Chair's Report - Verbal Report

Lead: Professor Steve Field
Action: To Inform

7.1 Trust Board Attendance for the Financial Year 2021/22

Lead: Chair
Action: To Inform

8 Chief Executive's Report

Lead: Professor David Loughton
Action: To Inform

Chief Executive Officer's Report 6 April 2022.docx

8.1 Chair's Trust Management Committee Report

Lead: David Loughton, Chief Executive
Action: To Inform

Chief Executive Officer's Report of TMC - 29 March 2022 6 April 2022.docx

9 Patient Story - Ashley's Story (see link in description)

Lead: Lisa Carroll
Action: To Inform
Youtube Link (please copy and play via your chrome browser)
https://www.youtube.com/watch?v=OE3MMxZ3qVM
Alternatively, please go to the video, highlight the url above (https.....VM) and right click on it, select 'go to' and it should take you to a new window and show the video.

10 IQPR (Section Heading)

Lead: Russell Caldicott

10.1 IQPR Executive Summary

Lead: Russell Caldicott
Action: To Inform and Assure

IQPR - Executive Summary.pdf

10.2 Quality, Patient Experience and Safety - Chairs Report

Lead: Dr Julian Parkes
Action: To Inform

QPES Chairs Board report 25_3_22.docx

10.2.1 IQPR - Quality, Patient Experience and Safety (Reference Pack for Information)

Action: To Inform

IQPR_QPES Reference Pack.pdf

10.3 Performance, Finance and Investment - Chair's Report

Lead: Paul Assinder
Action: To Inform

PFIC Chair's Assurance Report.docx

10.3.1 IQPR - Performance, Finance and Investment (Reference Pack for Information)

Action: To Inform

IQPR - PFIC Reference Pack.pdf

10.4 People and Organisation Development - Chair's Report

Lead: Junior Hemans
Action: To Inform

PODC Chair's Report.docx

10.4.1 IQPR - People and Organisation Development (Reference Pack for Information)

Action: To Inform

IQPR - PODC Reference Pack.pdf

11 Safe High Quality Care (section heading)

Section Heading

11.1 Director of Nursing Report

Lead: Lisa Carroll
Action: To Inform and Assure

11.2 DoN report to Public Trust Board 6th April 2022.docx

11.2 Patient Experience Bi-Monthly Report

Lead: Garry Perry
Action: To Inform and Assure

Patient Experience Bi Monthly Report Jan Feb 2022 (2).docx

11.3 Black Country Ockenden & Kirkup Bay Report - March 2022

11.4 Black Country Ockenden and Kirkup Bay Board-committee-report March 2022 v0.4 (2).docx

11.4 Appendix 1 Black County Ockenden and Kirkup Bay Board-committee-report March 2022 v0.4 (2).xlsx

11.4 Safeguarding Adults and Children - Quarterly Update Q3

Lead: Lisa Carroll
Action: To Assure

11.9 Safeguarding Quarterly Update Q3.docx

12 Care at Home, Work Closely with Partners (Section Heading)

Section Heading

12.1 Walsall Together Partnership Board

Lead: Mike Sharon
Action: To inform

Walsall Together Partnership Board Highlight Report.docx

12.2 Care at Home Executive Report

Lead: Matthew Dodds
Action: To Inform and Assure

Care at Home Report Mar 22 v2.docx

Care at Home Appendix 1.pdf

Care at Home - Appendix 2 Place Development.docx

12.3 Charitable Funds - Chair's Report

Lead: Paul Assinder
Action: To Advise

Chairs Report 14 March 2022 - Charitable Funds.docx

13 Use Resources Well (Section Heading)

13.1 Audit Committee - Chair's Report

Lead: Mary Martin
Action: To Inform

WHT Audit Committee Chairs Reports 07.02.22 meeting.docx

14 Value our Colleagues (Section Heading)

14.1 NHS National Staff Survey Results

Lead: Catherine Griffiths
Action: To Discuss and Inform

Trust Board 2021 NSS Results - April 2022.docx

Appendix 1. WHCT 2021 NSS Resource Pack Executive Summary - Short.pptx

14.2 Education and Training

Lead: Catherine Griffiths
Presenting: Claire Young on behalf of Louise Nickells
Action: to Assure

Trust Board WHT Education and Training Report April 2022.docx

14.3 Staff Story - International Nurses (Verbal Presentation)

Lead: Catherine Griffiths
Presenting: Aaron Bates
Action: For Information

15 Any Other Business

16 Date and Time of Next Meeting

Lead: Chair
Date of Next Meeting: Wednesday 8th June 2022

17 Questions from the Public/Commissioners

Lead: Chair

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD			
Declarations of Interest			
Report Author and Job Title:	Keith Wilshere Interim Trust Secretary	**Responsible Director:**	Steve Field Trust Board Chair
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	• The report presents a Register of Directors' interests to reflect the interests of the Trust Board members.		
Advise	• The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.		
Alert	• There are no alerts associated with this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	It is fundamental that staff at the Trust are transparent and adhere to both our local policy and guidance set out by NHS England and declare any appropriate conflicts of interest against the clearly defined rules.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Register of Directors Interests at March 2022

Name	Position held in Trust	Description of Interest
Professor Steve Field	Chair	Chair: Royal Wolverhampton NHS Trust
		Director: EJC Associates
		Trustee for Charity: Pathway Healthcare for Homeless People
		Trustee: Nishkam Healthcare Trust Birmingham
		Honorary Professor: University of Warwick
		Honorary Professor: University of Birmingham
Mr John Dunn	Vice Chair Non-executive Director	Non-Executive Director, Royal Wolverhampton NHS Trust
Ms Pamela Bradbury	Non-executive Director	STP Workforce Bureau (Vaccination Programme)
		Partner, Dr George Solomon is a Non-Executive Director at Dudley Integrated Health and Care Trust
Mr Junior Hemans	Non-executive Director	Non-Executive Director - Royal Wolverhampton NHS Trust
		Visiting Lecturer – University of Wolverhampton
		Director – Libran Enterprises (2011) Ltd
		Chair/Director - Wolverhampton African Caribbean Resource Centre
		Chair - Tuntum Housing Association (Nottingham)
		Company Secretary – The Kairos Experience Ltd.
		Member – Labour Party
		Mentor – Prince's Trust
		Spouse is a therapist at Royal Wolverhampton NHS Trust
Ms Mary Martin	Non-executive Director	Royal Wolverhampton NHS Trust - Non-Executive Director
		Trustee/Director, Non-Executive Member of the Board for the charity - Midlands Art Centre
		LTDTrustee/Director, Non-Executive - B:Music
		Director - Friday Bridge Management Company Ltd
		Non-Executive Director/Trustee - Extracare Charitable Trust (stood down 21 June 21)
Professor Louise Toner	Non-executive Director	Member - Birmingham and Solihull Workforce Action Board and Education Reform Workforce Group
		Associate Dean Faculty of Health, Education and Life, Birmingham City University
		Visiting Professor/Advisory Board Member, Lovely Professional University India
		Chair – Education Focus Group, Birmingham

Name	Position held in Trust	Description of Interest
		Commonwealth Associated
		Member – Royal College of Nursing – UK
		Member – Greater Birmingham Chamber of Commerce Commonwealth Group
		Teaching Fellow – Higher Education Academy
Mr Paul Assinder	Associate Non-executive Director	Director of Rodborough Consultancy Ltd.
		Governor of Solihull College & University Centre
		Honorary Lecturer, University of Wolverhampton
		Associate of Provex Solutions Ltd.
Mr Rajpal Virdee	Associate Non-executive Director	Lay Member, Employment Tribunal Birmingham
		Vice President of Pelsall Branch Conservative Party Association (from 19th June 2021)
Mrs Sally Rowe	Associate Non-Executive Director	Executive Director Children's Services - Walsall MBC
		Trustee of the Association of Directors of Children's Services
Dawn Brathwaite	Non-Executive Director	Consultant/Former Partner, Mills & Reeve LLP
Ofrah Muflahi	Associate Non-Executive Director	Board Member, Kidney Care UK (ceased position in March 2022)
		Professional Lead employed at Royal College of Nursing and Member
		Husband an employee of the Royal College of Nursing UK
		Member of the Q Community at Health Foundation
		Husband Director of OBD Consultants, Limited Company
		Member of the UK Oncology Nursing Society
		Member of the Seacole Grou
		Member of Health Inequalities Task Group at Coalition for Personalised Care
Dr Julian Parkes	Associate Non-Executive Director	Lead for Primary Care – Royal Wolverhampton NHS Trust
		Daughter – Nurse at Royal Wolverhampton NHS Trust
		Trustee, Windmill Community Church
Professor David Loughton	Interim Chief Executive	Chief Executive – Royal Wolverhampton NHS Trust
		Health policy advisor to the Labour and Conservative Parties
		Member – Dementia Health and Care Champion Group
		Member of Advisory Board – National Institute for Health Research

Name	Position held in Trust	Description of Interest
		Chair – West Midlands Cancer Alliance
Prof Ann-Marie Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive	Chief Nurse – Royal Wolverhampton NHS Trust
		Director – Ann-Marie Cannaby Limited
		Visiting Professor – Staffordshire University
		Honorary Fellow – La Trobe University, Victoria, Australia
		Teaching Fellow – Higher Education Academy
		Member – Royal College of Nursing
		Visiting Professor – Birmingham City University
		Principal Clinical Advisor – British Telecom
Mr Russell Caldicott	Director of Finance and Performance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
		Director of Plan 4 E-Health
Dr Manjeet Shehmar	Medical Director	Company Director Association of Early Pregnancies Units UK
		Executive Member Association of Early Pregnancy Units UK
		Private Practice Health Harmonie ceased August 2021
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd
		Chartered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT
		Sister in Law – Head of Specialist Services St Giles Hospice
Mrs Lisa Carroll	Director of Nursing	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research
		Spouse - RCPCH Assistant Officer for exams
		Spouse - Chair of NHS England/Improvement Children and Young People's Asthma Effective Preventative Medicines Group
		Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust (UHNM)
		Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM
		Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar

Name	Position held in Trust	Description of Interest
Ms Glenda Augustine	Director of Performance & Improvement	No interests to declare
Mr Mike Sharon	Interim Strategic Advisor to the Board	Strategic Advisor to the Trust Board - RWT
		Member of the Liberal Democrat Party
		Wife works as an independent trainer, coach and counsellor. Some of this work is for local NHS bodies (excluding RWT) Wife had undertaken work for Walsall Healthcare NHS Trust as a self-employed trainer.
Mr Matthew Dodd	Director of Transformation Walsall Together	Wife working as a Physiotherapy Assistant at Birmingham Community Health Care
Mr Kevin Bostock	Director of Assurance	Sole director of a limited company Libra Healthcare Management Limited trading as Governance, Risk, Compliance Solutions
Mr Kevin Stringer	Interim IT Director and SIRO	Chief Financial Officer and Deputy Chief Executive, Royal Wolverhampton NHS Trust
		Treasure, West Midlands Branch – Healthcare Financial Management Association
		Brother-in-law is the Managing Director and Midlands and Lancashire Commissioning Support Unit
		Member of CIMA (Chartered Institute of Management Accounts)
Sally Evans	Director of Communications and Stakeholder Engagement	Director of Communications and Stakeholder Engagement at Royal Wolverhampton NHS Trust
Simon Evans	Interim Chief Strategy Officer	Chief Strategy Officer at Royal Wolverhampton NHS Trust
Mr Keith Wilshere	Interim Company Secretary	Company Secretary at Royal Wolverhampton NHS Trust
		Sole owner, sole trader – Keith Wilshere Associates
		Secretary of Club which is a registered co-operative with the Financial Conduct Trustee, Director (The Royal British Legion Social Club – Beeston)
		Committee member of registered Charity and Limited Company – Foundation for Professional in Services for Adolescents (FPSA)

RECOMMENDATIONS

The Board is asked to note the report

MEETING OF THE PUBLIC TRUST BOARD
HELD ON WEDNESDAY, 2ND FEBRUARY 2022 AT 09.30AM
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members	
Prof. S Field CBE	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director; Vice Chair, Board of Directors
Mrs P Bradbury	Non-Executive Director
Mr J Hemans	Non-Executive Director
Ms M Martin	Non-Executive Director
Prof. L Toner	Non-Executive Director
Mr P Assinder	Associate Non-Executive Director
Mrs S Rowe	Non-Executive Director
Mr R Virdee	Associate Non-Executive Director
Prof. D Loughton CBE	Interim Chief Executive
Prof. A-M Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive
Mr R Caldicott	Director of Finance and Performance
Miss C Griffiths	Director of People and Culture
Dr M Shehmar	Medical Director
Mr K Bostock	Director of Assurance
Mr S Evans	Interim Chief Strategy Officer
Ms S Evans	Communications and Engagement Director

In attendance	
Mr W Roberts	Divisional Director of Operations – Division of Surgery
Mrs C Whyte	Deputy Director of Nursing
Ms A Wallett	Head of Infection Prevention and Control
Mr M Dodd	Director of Transformation, Walsall Together
Ms J Wright	Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health
Mr M Sharon	Strategic Advisor to the Board
Mr K Stringer	Chief Financial Officer – RWT
Mr K Wilshere	Interim Company Secretary
Ms C Bond	Deputy Director of People and Culture
Mr G Perry	
Dr J Parkes	Associate Non-executive Director elect (observer)
Mrs O Muflahi	Associate Non-executive Director elect (observer)
Mrs J Wilson	Staff Side Representative
Ms R Crossey	Head of Business Development and Planning
Mr C Lemord	UNISON representative
Mr R Gutteridge	Black Country Live & Birmingham Live
Ms M Arthur	Deputy Director of Assurance
Ms J Wright	Deputy Director of Midwifery and Gynaecology and Sexual Health
Ms M Lawrence	Interim CQC Standards Assurance Lead
Ms G Powell	Quality & Governance Manager, Mental Health Services, WHT
Ms R Crossey	Head of Business Development and Planning, WHT
Ms J Wilson	Joint Staff Side Lead
Ms L O'Brien	Chief Reporter, Express & Star
Ms A Farrer	Healthwatch, Walsall
Mrs J Kaur Toor	Senior Executive Assistant/Senior Operational Coordinator

Apologies

Mrs G Augustine	Director of Planning and Improvement
Mr N Hobbs	Chief Operating Officer
Ms L Carroll	Director of Nursing
Ms C Jones-Charles	Divisional Director of Midwifery, Gynaecology and Sexual Health

226/21	**Welcome, Apologies and Confirmation of Quorum**
	Prof. Field welcomed all to the meeting and noted the apologies provided.
227/21	**Declarations of Interest**
	Prof. Field confirmed there were no further interests declared in addition to those published. Mr Assinder confirmed that his interest as CEO at Dudley Metropolitan Borough Council was no longer a potential conflict as he had since retired from that position. Mrs Rowe declared an interest in the Patient Story as this patient was known to her in her role at Walsall Council. **Action: Mrs J K Toor to update the Declarations of interest for Mr Assinder.**
228/21	**Minutes of Last Meeting**
	Prof. Field confirmed that the minutes of the meeting held on 2nd December 2021 as received and approved as an accurate record. **Resolved: that the minutes of the last meeting be received and approved.**
229/21	**Matters Arising and Action Log**
	Prof. Field received the action log and noted that: Action 114: Volunteers – this action had now been completed. Action 110: Safe High Quality Care – this action had now been completed. **Action: Mrs J K Toor to close Actions 114 and 110.**
230/21	**Trust Values and Nolan Principles**
	Prof. Field asked the Board to note the Seven Principles of Public Life, the Nolan Principles, and the Trust Values and reiterated the importance of the principles. **Resolved: that the Trust Values and Nolan Principles be received and noted.**
231/21	**Chair's Report**
	Prof. Field presented the Chair's report and expressed his thanks to Trust staff for their remarkable work undertaken in extremely difficult and challenging times during the Covid-19 pandemic. Prof. Field reported that he had received a letter of thanks from the Chairman of West Midlands Ambulance Trust, praising the high quality work of staff in the handling the flow of patients through the system and the engagement with ambulance staff arriving at A&E department. He said that the letter commended the rapid handover of patients and the excellent leadership of Mr Hobbs, Dr Shehmar and Ms Carroll in supporting and enabling process. Prof Field said that the letter was to be circulated to the Board. Prof Loughton thanked Mr Will Roberts who had deputised for Mr Hobbs. **Resolved: that the Chair's Report be received and noted.**
232/21	**Independent Review of Leadership by NHS England/Improvement (NHSE/I)**
	Mr Dunn, Senior Independent Non-executive Director, advised that the report provided full transparency of the allegations made via the Speak Up Guardians and directly to NHS E/I in Spring 2021. He advised that NHSE/I Midlands had commissioned an investigation led by Dr Kathy McLean, and her full report had set out the findings of the independent review into the leadership of the Trust and the subsequent follow up actions and conclusions.

	Mr Dunn confirmed that the recommendations had been accepted and the report provided a review of the progress made against the recommendations, that these illustrated the significant improvements made by the leadership of the Trust, and that NHSE/I was content to suspend the monitoring process. Mr Hemans acknowledged the comments referred to, and recognised the improvement in performance within the organisation, relationships of the Board and key stakeholder partners. He said that the letter from the Chair of the Ambulance Trust further confirmed the improvements made and confirmed his continued support for the leadership of the Board. Mr Virdee echoed Mr Hemans comments and said the report provided assurance to staff and public that the Trust was on the right path. Mr Assinder agreed and paid tribute to the thoroughness of Dr McLean's report and the leadership of Prof Field and Prof Loughton during a difficult process, which he said had made the relationships between the members of the Board stronger in the process. Ms Martin added that the facilitated sessions provided by the Board during the past year had helped in getting to know Board colleagues and the Organisation, which had initially been difficult due to the restrictions during the Covid-19 pandemic. Ms Rowe said that the investigation demonstrated the willingness of the Trust to be a learning Organisation, continually improving to better support staff, patients and the people of Walsall. Mr Dunn asked the Board to note the report and the significant progress made. Prof Field thanked everyone for their comments. He said he was proud to be the Chair of the Trust and he looked forward to working with the Board and new members in continuing to provide the patients and residents of Walsall with safe, high-quality healthcare. He acknowledged the contribution of Prof Loughton, for his commitment to quality healthcare and his support to the staff. Prof Field thanked Mr Dunn for his consistency and values in his role as the Senior Independent Non-executive Director and for his wise counsel to the board during his tenure. **Resolved: that the Independent Review of Leadership Report be received and noted.**
233/21	**Chief Executive's Report**
	Prof. Loughton reported that eight Consultant Appointments had been made and that Dr Shehmar had been appointed as Medical Director. He said that his focus was on the quality of care provided for patients and that the Trust was on track to reduce the reliance on locum appointments through the combined approach with the Royal Wolverhampton Trust (RWT) and work with clinical departments. Prof Loughton highlighted the importance of partnerships with local universities in developing the workforce for the future. Prof Loughton reported that that he had undertaken a range of virtual meetings and contacts locally and nationally and a site visit to maternity services. He had joined the Deputy Lord Lieutenant and former Consultant Paediatrician's retirement dinner and had participated in a Joint Board Development session between The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) and presented the annual Staff Awards. Prof Loughton advised that he had held a virtual briefing meeting with Wendy Morton MP and Eddie Hughes MP and had participated in the virtual NHS Improvement/ England – Regional Roadshow. Mr Virdee referenced the recruitment of the new consultants, in which he had participated as a panel member, and said that he had been pleased to note the young, diverse and talented consultants that were keen to work at Walsall with the Trust's collaborative and innovative working practices. Dr Shehmar agreed and reported that several high calibre consultant appointments had

	been made and that she had support to recruit to the role of Lead for Consultant Development and Medical Mentorship. Prof Cannaby advised that the Trust had recruited ten Practice Educators, to work within Medicine and Surgery, providing provide educational support in practice. She said that the recruitment of international nurses was progressing well, and two clinical fellows were onsite supporting nurses, and several nursing roles were being undertaken across the Walsall and Wolverhampton sites. **Resolved: that the Chief Executive's Report be received and noted.**
STAFF STORY	
234/21	**Patient Story – Michelle**
	Mrs Whyte introduced the Patient Story from Michelle who had been a patient at Walsall Manor Hospital in November 2021 for a planned surgical procedure. In her story, Michelle explained the positive encounters she had had with staff and the departments she had experienced at the hospital. Michelle described how she had been welcomed by the staff, how they were well organised and professional and had put her at ease ahead of her surgery. She said she had felt confident in the clinical team and their patient centred approach had involved everyone from the surgeon to the nursing staff, and the cleaning staff, and she thanked them for their dedication and commitment. Ms Whyte said the video outlined the process from a patient viewpoint and their experience with members of staff. Ms Bradbury said it was a positive story and that the patient voice was important and asked that the video be shared with the staff involved. Ms Whyte said she would ensure it was. Mr Roberts highlighted the Trust's ability to create and protect a positive environment for elective care patients, despite the pandemic, and had continued to provide safe care. Prof Toner said she was pleased to hear the patient's positive experience at the Hospital. **Action: Ms Whyte to share Michelle's Patient Story with staff involved.** **Resolved: that the Patient Story be received and noted.**
PROVIDE SAFE, HIGH QUALITY CARE	
235/21	**Quality, Patient Experience and Safety Committee Report**
	Ms Bradbury, Chair of the Quality, Patient Experience & Safety Committee (QPES) confirmed that the January meeting had been stood down due to operational pressures, however she had continued to meet virtually with Dr Shehmar and Ms Carroll for updates and asked Dr Shehmar and Mrs Whyte on behalf Ms Carrol to provide further details. **Resolved: that the report from the Chair of the Quality, Patient Experience and Safety Committee be noted.**
236/21	**Safe High Quality Care Executive Report**
	Dr Shehmar reported that the work with the digital team to improve the performance around national targets, including VTE and mental capacity act, was progressing well and clinical teams had continued to ensure that data was captured through the improvement programme, that appeared to have had a positive impact. Dr Shehmar confirmed that the recruitment of the Mental Health Team had been completed and said that whilst it was a Red Board Assurance Framework (BAF) Risk, significant progress had been made and following the completion of staff training, she was expecting that the rating would be reduced. Dr Shehmar highlighted that a new risk had been added to the Risk Register related to patient harm. She stated that there was a risk of reputational damage and breach of

	Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy and a lack of audit assurance. She confirmed that a report from the medicines management, with audits from the divisions, had been presented to the Patient Safety Group with the progress made tracked. Dr Shehmar said that the appointment of a new governance lead for Pharmacy had taken place and would provide support to the divisions and care groups for the improvement work required, and raise the awareness and profile, supplemented with teaching and training. She added that innovative medicines management and storage on wards was being looked at, including automated systems, which would be confirmed in due course. Dr Shehmar reported that, following the external review from Health Education England (HEE) in November at which safety concerns had been raised, the concerns had been addressed and appropriate action taken. She said that a response had been submitted to NHSE outlining the actions taken and she was pleased to report that HEE had acknowledged, in writing, that they were satisfied with the actions taken regarding the safety concerns. She confirmed there was an improvement programme at the Acute Medical Unit and emergency pathways to ensure that the other concerns were addressed and that had been highlighted from other sources. Dr Shehmar said that, following a staffing review, additional substantive staff were being recruited to temporary medical posts. She advised that support was also being provided by Consultants from RWT which was having an impact on workforce Prof Field expressed his thanks to Dr Shehmar for her detailed report and the exemplary work undertaken since her appointment, including taking forward medical and clinical training, addressing historic patient safety issues and her engagement with the clinical workforce. Mr Hemans supported and echoed the comments of Prof Field and congratulated Dr Shehmar, saying he was pleased to hear the positive work around training and development of the workforce and valuing colleagues. Ms Whyte provided further details on the recruitment of international nurses and reported that 151 nurses had been recruited as of December 2021, of which 121 nurses were registered with the Nursing Medical Council (NMC). She highlighted key performance information including Falls incidents and Venous Thrombo-embolism (VTE) compliance and advised that Divisional teams were now reporting on their performance and plans to the Patient Safety Group (PSG). Mrs Whyte reported that the Trust's ceiling target for Clostridium difficile in 2021/22 29 and cases were below the trajectory, that the Mental Capacity Act Audit showed that 52% of patients who lacked capacity had a stage 2 assessment undertaken, a decrease in performance from the 70% in November 2021. She advised that Safeguarding Level 3 training remained below target for both adults and children and the Safeguarding Committee was monitoring progress in achieving higher compliance. Prof Cannaby added that she was pleased that issues and concerns previously raised by regulators had been addressed and improvements had been made and she thanked the Executive and Non-executive Directors involved in providing the governance and challenge around this work. Mrs Martin referenced the Executive Summary and continued pressures in paediatrics from Tier 4 (T4 CAMHS) mental health placements and asked for assurance that there was a stop gap plan and longer-term actions in place to address this. Ms Whyte stated that pressure had continued on the paediatric unit with young people requiring T4 placements as well as those with complex social care needs. She explained that, with mental health colleagues within the department that helped to keep all patients as safe as possible whilst waiting for appropriate placements. Mrs Rowe asked when the timeline for completion of Level 3 Safeguarding training would be known by the Board. Mrs Whyte advised that an action plan was reported to the Safeguarding Committee and that there had been several staff absences due to Covid-19 related sickness or self-isolation which had caused delays in training completion.

	Mr Assinder asked how the sepsis awareness training was administered and monitored. Dr Shehmar reported that there had been a number of sepsis campaigns and online training which were being monitored via the Electronic Staff Record (ESR) programme regarding compliance. Mr Dunn asked how staff were feeling after a challenging and difficult time. Dr Shehmar, Ms Whyte and Ms Griffiths explained that a range of initiatives and well-being programmes were in place for staff to support their physical and psychological working personal well-being. Mr Virdee referenced the vaccination programme and asked what the position was within the Organisation in light of the announcement from Government around non-vaccinated staff. Prof Loughton advised he was unable to provide information at this stage and was waiting for clarity and guidance on any changes in legislation and legislation implementation from the Government. Prof Field said he was proud of the vaccination programme that had been put in place and that this was a positive story. Prof Loughton urged anyone who had not yet been vaccinated to get vaccinated. **Resolved: that the Safe High-Quality Care Executive report be received and noted.**
237/21	**Maternity Update**
	Ms Wright reported that 1:1 care in labour had been maintained at 100% and the service had recently launched a new triage process and that 93% of women had been seen within 15 minutes of arrival and women reported feeling safe in the triage. She reported that caesarean section rates had declined in December 2021 and there were no new maternity Serious Incidents (SIs) and staff absences had remained a challenge in December 2021 due to sickness and Covid related reasons. Ms Wright said that the department was now fully established, and they were looking at ways of using resource differently to provide safer care within the maternity unit. Prof Cannaby congratulated the department on their good work and audit results which illustrated that the recruitment programme was paying dividends. Mr Virdee said he was pleased to hear the positive patient feedback and asked how the survey was being circulated to 'hard to reach' patients. Mrs Wright explained that a two-pronged approach had been taken which had included postal forms as well as speaking to women as they were leaving the department. **Resolved: that the Maternity Update be received and noted.** **There was a break from 11.10am to 11.20am.**
238/21	**Infection Prevention and Control (IPC)including Board Assurance Framework (BAF)**
	Ms Wallet highlighted the key areas included in a summary of progress against the IPC BAF that captured progress against the required actions. She said that the risk scores reflect the Quarter (Q) 1-3 position which had been briefly changed nationally in December 2021 and Q4 showed the current position. Ms Wallet reported that IPC audits were embedded in practice with a programme of work planned throughout the year. She advised that following a red rating in July 2021, NHSE/I had undertaken a planned IPC inspection in December 2021, and the feedback had been positive, with NHSE/I providing verbal confirmation at the time that the Trust would no longer be rated as red. Ms Wallett reported that the Trust was yet to receive the final report and added that improvements in general cleanliness had been seen through audits of the improved environment and the refurbishments, both recognised by NHSE/I. She advised that four wards in the old estate had been refurbished with four more planned for Spring 2022. Prof Field acknowledged the report which highlighted the improvement made to turnaround the service and congratulated Ms Wallet on her leadership. **Resolved: that the Infection Prevention and Control (IPC) Report including the IPC**

	Board Assurance Framework (BAF) Report be received and noted.
239/21	**Mortality Report**
	Dr Shehmar said that the Learning from Deaths report was part of the Safe High Quality Care (SHQC) Improvement Programme with learning monitored via the Mortality Surveillance Group. She explained that the report summarised the learning and improvements as a result of the learning from deaths programme to date. Dr Shehmar reported that there had been a total of 794 Covid positive deaths in the hospital as at 07.01.22 and Structured Judgement Reviews (SJRs) had been undertaken on 244 cases within the scope and outcomes fed into the incident reporting system and further reviewed. Dr Shehmar advised that during 2021/22, the services provided by medical examiner offices would be extended beyond acute trusts to provide independent scrutiny of all non-coronial deaths, wherever they occur. **Resolved: that the Mortality Report be received and noted.**
240/21	**Patient Experience Quarter 3 Report**
	Mr Perry reported that the average compliance rate for Quarter 3 had been 93%, an increase of 24% compared to the previous quarter and which reflected the work to adopt new standards and improve complaints handling. Mr Perry said that the Friends and Family Test hierarchy was being amended to better effect and members of the Patient Experience team had been assigned as support to areas where data collection was an issue. He said that learning from feedback and the changes made had been shared with the team and across the Trust and that details of improvements in care delivery, following patient feedback and lessons learnt from complaints, had been included in the quarterly Learning Matters bulletin. Mr Perry explained that in the last quarter they had initiated food surveys, mystery shopping feedback and analysis, and overseen the supportive visiting process which to date had delivered 2323 parcels to patients, 1397 video calls and 653 compassionate visits. Mr Perry reported that in November the team had been awarded £25k from the NHSE Voluntary Services Fund and the Trust had partnered with the Manor Farm Community Association who had been involved in the support and development of new volunteer roles and oversaw the transfer of the former Wingman Lounge to the new Manor Staff Well-being Lounge, which opened in January 2022. Ms Whyte congratulated Mr Perry and his team on their engagement with staff, patients and the general public and for their continued support. Mr Assinder referenced the excellent response to the Friends and Family Test given the continued pressures of the pandemic and asked if there had been any administrative issues. Mr Perry said that staff shortages on wards due to sickness had limited the ability respond to telephone calls. He said that his team have been working to support the wards with call handling and to continue to make improvements in this area. **Resolved: that the Patient Experience Quarter 3 Report be received and noted.**
USE RESOURCES WELL	
241/21	**Performance, Finance and Investment Committee Report**
	Mr Dunn, Chair of the Performance, Finance, and Investment Committee (PFIC) confirmed the January 2022. meeting had been cancelled due to the operational pressures and highlighted the good performance, as a result of the excellent preparation, funding and resourcing of the winter plan, with reference to recovery and the theatre productivity. Mr Dunn reported that the H2 financial plan had initially indicated a £5-6m risk however this was now expected to be around £2.7m or close to breakeven at year end. Mr Dunn acknowledged the good work of Mr Caldicott and his team and the strong performance position. Mr Dunn advised that as he was leaving his position as Non-Executive Director at the Trust, this would be his last PFIC report to the Board. Prof. Field thanked Mr Dunn

	for his chairing of the Committee. **Resolved: that the Chair's Report from the Performance, Finance, and Investment Committee Chair be received and noted.**
242/21	**Use Resources Well Executive Report**
	Mr Roberts said that December 2021 had seen the most challenging emergency care performance nationally, however he reported that operational performance and emergency care performance in the Trust had maintained as strong, relative to the rest of the NHS. Mr Roberts said that the Trust continued to deliver the best Ambulance Handover times (<30 minutes) in the West Midlands and had been in the Top 3 performing organisations for 12 consecutive months, with performance almost 10% better than the second best performing Trust in the West Midlands. Mr Roberts reported a slight deterioration in performance of the 4-hour Emergency Access Standard, although performance was higher than peers. Mr Roberts said that the 62-day Cancer performance had declined from over 80% throughout both October and December 2021 to 70.5% in December 2021. He said that the Trust remained amongst the best performing Trusts in the Midlands, ranking as 4th of 22 Acute Trusts. Mr Roberts said that following a period of significant improvement in waiting times for patients referred by their GPs on 2 week wait suspected cancer and breast symptomatic pathways, waiting times had now become a challenge. He said that mutual aid from RWT continued and waiting times have now reduced to 22 days as it was important that timely care for patients with cancer was given. Mr Roberts reported that the Trust had maintained performance against trajectory against the 18-week Referral To Treatment waiting time standard. He said that the number of patients waiting in excess of 52-weeks had deteriorated slightly and they had the lowest proportion of its elective waiting list waiting over 52-weeks in the combined West and East Midlands. Mr Roberts said that the plan for support from the Insourcing Team would be phased out over the coming months. Prof Field thanked Mr Roberts for his report and acknowledged his positive input to the operational team. Mr Sharon said it was important to acknowledge the partnership with Walsall Together in helping to achieve the performance results of the emergency department in maintaining flow into the hospital and diverting patients into the community care. Mr Assinder referenced the declining 62-day cancer performance and acknowledged the explanation presented and asked for details to be discussed further at the next PFIC meeting and to monitor the restoration of the service closely. Prof Loughton acknowledged the A&E performance and the input from the community and referred to the Trust also receiving ambulance transfers from other Trusts outside of the West Midlands to assist with delayed transfers. Mr Caldicott reported that the Trust had attained a small surplus of £0.3m to 31st December 2021, and the STP had also delivered a small surplus and they were forecasting attainment of financial plans for 2021/22 (to 31st March 2022). Mr Caldicott explained that the capital programme for 2021/22 was fully resourced and the Trust had been successful in securing an increase from the initial capital allocation to support essential ward refurbishments from the STP overall allocation. He said that the Trust was concluding the signing of the memorandum of association with the regulator in relation to securing funds transfer for the Emergency Department works which was on target to complete on time. Mr Caldicott reported the 2022/23 Plan submission had been deferred from February 2022 to April 2022, whilst further guidance was awaited and explained that the STP 2022/23 income allocations include a 1.1% efficiency and 57% reduction in Covid-19 funding and that provider income allocations are yet to be confirmed. Mr Caldicott thanked Mr Dunn for his Chairmanship of the PFIC Committee and his

	commitment to the Trust and that Mr Dunn's decision making had been to benefit the staff and patients. Mr Caldicott said he had enjoyed working with Mr Dunn for many years and wished him well for the future and looked forward to working with Mr Assinder going forward. Prof Field conveyed his thanks to Mr Dunn for his role not only as Chair of PFIC but as Senior Independent Non-Executive Director and he paid tribute to Mr Dunn's many years of ensuring the people of Walsall received the best outcomes from the Trust. He confirmed Mr Dunn would continue as a Non-executive Director at Royal Wolverhampton NHS Trust. **Resolved: that the Use Resources Well Executive Report be received and noted.**
VALUE OUR COLLEAGUES	
243/21	**People and Organisational Development Committee Report**
	Mr Hemans, Chair of the People and Organisational Development Committee confirmed the January meeting had been cancelled due to operational pressures and highlighted the continued success in recruiting local people from the localities which was important for the economy of Walsall and also to provide vital resources into the Trust. Mr Hemans acknowledged the continued hard work of the staff through challenging times to meet training obligations, stating that the Health and Wellbeing of the staff was of vital concern and that it was important to ensure that they provide an effective and responsive service to staff whenever required. **Resolved: that the highlight report from the Chair of the People and Organisational Development Committee be received and noted.**
244/21	**Value Our Colleagues Executive Report**
	Ms Griffiths said that a great deal of work had been undertaken regarding appraisal compliance, as it was important for staff career aspirations and development, and supported staff retention. She reported that the recent recruitment of 120 clinical support workers, many from local areas, and the leadership development work through the Faculty of Medical Leadership and Management's (FMLM) leadership had been completed, and there was a leadership development offer at RWT, led by the Director of Education and Training. Ms Griffiths said that the Management Development programme was also in place. Ms Griffiths reported that attendance levels had worsened over the last month, impacting workforce availability and creating pressures for those at work, although these absence rates were now starting to reduce. She said that the absence rate was attributable to COVID-19 and self-isolation requirements and underlying absences had been due to increased long-term sickness absence (LTS). Ms Griffiths reported that a focused approach to reducing LTS was in place with a strong focus on health and wellbeing chats and a proactive approach to LTS management. Mr Virdee asked if there were hot spots of long-term absence. Miss Griffiths agreed this would be provided for the next Committee meeting. Mrs Martin asked about benchmarking sickness absence and the impact of long covid. Miss Griffiths advised that some work was being undertaken to look at long Covid data to ensure it was being correctly coded. She said that benchmarking had indicated that the Trust was significantly higher than last year and were benchmarking through best practice with Wolverhampton. **Action: Ms Griffiths to provide update at next Committee on sickness hotspots in the Trust.** **Resolved: that the Value Our Colleagues Executive Report be received and noted.**
245/21	**Nursing and Midwifery Safer Staffing Assurance Framework Report and Workforce Safeguards Report**
	Ms Whyte said NHSE/I had released the report on "Winter 2021 preparedness: Nursing and midwifery safer staffing" and she outlined some of the actions that had been taken to ensure safe staffing, including the setting up of the Safe Staffing Hub tended by a mixed team of nursing, midwifery, clinical and community staff to monitor activity daily, the acuity on the ward and staffing levels and any 'red flags' raised in relation to staffing discussed

	and actions put in place including redeployment of staff. Ms Whyte expressed her thanks to all the ward managers, matrons, nurse specialists and the corporate nursing team who had worked in the clinical numbers to support the ward areas Mrs Whyte reported that the workforce paper provided information on the existing controls and actions being taken to ensure safe staffing levels were maintained across the Trust which included robust systems in place for detecting and responding to staff absence. **Resolved: that the Nursing and Midwifery Safer Staffing Assurance Framework Report and Workforce Safeguards Report be received and noted.**
CARE AT HOME	
246/21	**Walsall Together Partnership Board Report**
	Mr Dunn said that during his time as Interim Chair of the Walsall Together Partnership Board he had been impressed with the partnership working to problem solve, find solutions and develop the initiatives to manage patient flow. He acknowledged the leadership and efforts of Mr Dodd and Mr Sharon and their achievements in working with partners to move forward with a workshop. **Resolved: that the Chair of Walsall Together Partnership Board be received and noted.**
247/21	**Care at Home Executive Report**
	Mr Dodd presented the report outlining the key pressures in the community service including the shortages in capacity within the care home sector as homes were closed due to infection outbreaks (Covid-19) and staff absence due to Covid. He said the Partnership was closely involved in monitoring the impact on available beds and flow across the system, which had managed to maintain flow but also support to the homes in their business continuity arrangements. Mr Dodd said that the position required continued monitoring and that there was pressure in getting access to care homes in other boroughs for patients who were not residents of Walsall. Mr Dodd said that the focus on hospital discharges, by all system partners, in preparation for the anticipated surge in demand both over the Bank Holiday and Covid surges, had resulted in the numbers of patients at the Manor Hospital who were medically stable for discharge, reducing to 15 patients on 24/12/21. Mr Dodd said that due to the Omicron variant, there had been a surge of people seeking vaccination centres, and that the Saddlers Centre had the flexibility to manage this surge. He said that it had been very effective with a total of 228 thousand vaccines delivered, both with the service at the Centre and the Manor. He highlighted that the work of the Care Navigation Centre had been expanded and over 1000 calls had been taken during December from GPs, Ambulance 111, care homes and patients. Mr Sharon advised that they were progressing with the appointment for the Chair for Walsall Together with the interview process due to conclude on the 1st of March. Prof Field congratulated Mr Dodd on the fantastic work that had been undertaken, and said that they could be justifiably proud of the contribution Walsall Together had made over the difficult winter. **Resolved: that the Care at Home Executive Report be received and noted.**
GOVERNANCE AND WELL LED	
248/21	Care at Home BAF SO 02 and COVID-19 Board Assurance Framework
	Mr Bostock highlighted 7 risks on the strategy objective which were rated as high, 26 or 32 corporate risks were rated as high and 3 new risks added within the period and confirmed the risk score remained the same. Mr Bostock provided a post report update on the responsiveness of attending to actions and controls around the risks and said that due to the work undertaken by the Head of Risk Management, as at January 2022 all risk actions were on track.

	Mr Roberts presented the COVID-19 Board Assurance Framework and advised the risk score had been increased to 15 in view of the Omicron variant and advised of actions being taken to manage any further surge and working in conjunction with the NHSE/I regional team around planning assumptions and being supported by military deployment which was likely to end soon. **Resolved: that the Care at Home BAF SO 02 - and COVID-19 Board Assurance Framework be received and noted.**
249/21	**Charitable Funds Committee Highlight Report**
	Mr Assinder presented the report from the Charitable Funds Committee held 9 December 2021 and highlighted that the Committee had approved the 2020/21 Annual Report and Accounts. He advised that Mazars, the auditors who had attended the meeting, had congratulated the Charity on the thoroughness of its governance and had stated that they would be issuing a 'clean' and unqualified audit certificate. Mr Assinder said that Mazars were complementary of Mr Caldicott and his accounting team on production of their accounts and the quality of paperwork. Mr Assinder reported that Mr Judge, Investment Manager from Brewin Dolphin, investment brokers appointed in September 2021, had also attended the meeting and said that he had begun working to reshape the portfolio and made good early progress, which the Committee would keep under scrutiny. Ms Evans highlighted the hard work of both charities in particular the Well Wishers Charity in encouraging and supporting with members of the public and acknowledged the hard work of Mrs Westley, Fund Raising Manager and the finance team. Prof. Field advised that the work of the RWT charity was also doing well and it was good to have two-way learning. **Resolved: that the Charitable Funds Committee Highlight report be received and noted**
STRATEGIC AND PARTNERSHIP WORKING	
250/21	**Five Year Strategy Update**
	Mr Evans presented the report advising the current strategy ends in March 2022 and proposed an extension until August 2022. Mr Evans recommended the withdrawal of the corporate strategic objective '*to be rated Outstanding by 2022'* given the unfeasibility of the objective, the timeframe and the current operational and financial climate. He reported a joint strategy would be developed with RWT, for approval by the respective Trust Boards in August 2022 and he outlined the proposed timetable for the joint strategy development, confirming that an external company was undertaking internal and external engagement as part of the development of this strategy as well as completing a PESTLE analysis of the external environment. **Resolved: that the Five-Year Strategy Update be received and the proposals to extend the current Strategy until August 2022, the withdrawal of the corporate strategic objective '*to be rated Outstanding by 2022'* and the development of a joint strategy with the Royal Wolverhampton NHS Trust be approved.**
251/21	**Green Plan**
	Mr Evans presented the report, reporting that the Green Plan had established the Trust's sustainable vision, the targets and actions to achieve this vision to enable the Trust to implement the essential measures to reduce carbon emissions and contribute to the reduction in air pollution in the local area. Mr Evans said this was a new approach to move the sustainability agenda from an Estates and Facilities agenda to a Corporate agenda as sustainability involved every aspect of their business. Mr Evans confirmed the appointment of a joint Head of Sustainability across both Walsall Healthcare NHS Trust and Royal Wolverhampton NHS Trust. Mr Evans said he was securing a Lead Non Executive Director (NED) for the sustainability agenda and advised that Ms Martin was the Lead NED for the Green Plan at RWT and recommended that she was also the Lead NED for the Green Plan at Walsall, which she accepted.

	Resolved: that the Green Plan be received and approved and Ms Martin be confirmed as the Lead Non-executive Director.
252/21	**Improvement Programme Update**
	Mr Evans presented the report advising the Trust Board had received routine progress update reports on the status of the Improvement Programme since its inception in 2019 and the report provided the latest update position and made recommendations following the Executive-led review for each of the work streams as currently established. He reported that work to review the improvement plan was initially undertaken in June 2021, and as a result new categories were introduced to help classify the improvement programme within each work stream. Mr Evans reported that since November 2021 more detailed work had been undertaken with each Executive lead to understand the on-going commitment required to deliver the outstanding projects within each work stream. Mr Evans said it was proposed that the improvement programme be re-orientated so that it more accurately supported the priorities and needs of the organisation; The governance and Well-Led Theme still had a number of live projects which required continued oversight and where required, the improvement team would continue to support this work stream under the leadership of Mr Bostock as Director of Assurance. Mr Evans said that a number of schemes had already been moved out of existing work streams and were currently being supported by the Quality Improvement Team and he proposed all schemes continue and the monitoring and reporting of schemes be reported through the existing education committee and relevant sub-committees as appropriate. Mr Evans said that the Use of Resources Theme would grow to include all the existing projects that had been identified to have a cost saving or efficiency focus, plus any schemes that the division were currently working on as part of an efficiency programme. He proposed that an Efficiency Group be established, chaired by the Chief Operating Officer, with a specific agenda focussing on cost improvement and efficiency. Mr Evans also proposed a new Investment Group be established to provide a formal gateway assessment process for all business cases across the Organisation, which would be chaired by the Chief Strategy Officer, and whose membership would include Executive Directors, and supported by the planning PMO. He said that outcomes from the Investment Group would be reported through the Trust Management Committee, PFIC and the Trust Board. **Resolved: that the Improvement Programme Update be received, and the recommendations for the formation of an Investment Group be approved.**
CLOSING ITEMS	
253/21	**Any Other Business**
	Prof Field noted that no other business was raised. He acknowledged the improvement in the quality of reports, governance systems and clinical leadership that allowed the Non-Executive Directors to discharge their duty to challenge. He advised on the recruitment of three new Non-Executive Directors who would be introduced and welcomed at the next Trust Board meeting. He extended his thanks again to Mr Dunn for his work over the years. Mr Dunn thanked everyone for their good wishes and kind words and said he looked forward to continuing his Non-Executive Director role at RWT.
254/21	**Date and time of the next meeting**
	Prof Field confirmed that the next meeting was to take place on Wednesday 6th April 2022.
255/21	**Resolution**
	The Board resolved to invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960. **Resolved: that the resolution be approved.** **The meeting concluded at 12:56pm**

Walsall Healthcare NHS
NHS Trust

29 March 2022 09:24

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 02/02/2022 18 Value Our Colleagues Executive Report				
151.	Sickness hotspots in the Trust	Griffiths, Catherine	25/03/2022	Overdue
	Explanation action item Report on hotspots to be provided at PODC			
Public Trust Board 02/02/2022 8 Patient Story				
150.	Patient Story	Whyte, Caroline	25/03/2022	Overdue
	Explanation action item To be shared with staff involved with Michelle's care			

MEETING OF THE PUBLIC TRUST BOARD – 6 April 2022			
Chief Executive Officer's Report			
Report Author and Job Title:	Gayle Nightingale, Executive Assistant	**Responsible Director:**	Prof David Loughton, CBE, Chief Executive Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	Assurance relating to the appropriate activity of the Chief Executive Officer.		
Advise	The paper includes details of key activities undertaken since the last Trust Board meeting.		
Alert	None in this report.		
Recommendation	Members of the Trust Board are asked to note the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None in this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	None in this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

CHIEF EXECUTIVE OFFICER'S REPORT

1.0	**Review**
	This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.
2.0	**Consultants**
	There has been six Consultant Appointments since I last reported: **Dermatology** Dr David Jackson Dr Richard Jerrom **Radiology** Dr Prio Sada **General Anaesthetists** Dr Vasiliki Archontaki Dr Tarek Mohamed Dr Sarah Stavert
3.0	**Policies and Strategies**
	• There are no policy and strategy updates this month.
4.0	**Visits and Events**
	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • Since Monday 3 August 2020 I have participated in weekly calls with the Black Country and West Birmingham Strategic Transformation Partnership (STP) on the co-ordination of a collective Birmingham and the Black Country restoration and recovery plan and COVID-19 regional update • Since Tuesday 1 February 2022 I have participated in the virtual STP Gold Command weekly meetings • 20 January 2022 – participated in the virtual Joint Negotiation Committee (JNC) and participated in the Walsall Council-led Incident Management Partnership Team meeting • 21 January 2022 – virtual meet with Eddie Hughes MP and Wendy Morton MP • 24 January 2022 – virtual met with Helen Patterson – Chief Executive and Cllr Mike

	Bird – Leader, Walsall Council • 25 January 2022 – participated in the Junior Doctors Trust-wide Forum and participated in the Walsall Council Health and Well Being Board • 27 January 2022 – met with Pat Usher and Jane Wilson, Joint Trust-side Leads and • participated in the virtual STP Healthier Futures Partnership Board and participated in the West Midlands Combined Authority (WMCA) Health Roundtable event • 31 January 2022 – participated in the virtual Regional Cancer Board • 7 February 2022 – participated in the virtual Joint Liaison Committee with Skanska • 9 February 2022 – met virtually with Mandy Poonia – Chair and Aileen Farrer – Manager, Healthwatch • 11 February 2022 – met with Valerie Vaz MP • 15 February 2022 – participated in the virtual West Midlands Acute Provider meeting • 16 February 2022 – participated in the interviews for the Walsall Together Partnership Board Away session and chaired the Senior Managers Briefing • 17 February 2022 – participated in the virtual Joint Negotiation Committee (JNC) and virtual met with Helen Paterson – Chief Executive, Walsall Council • 18 February 2022 – participated in a virtual Institute of Health and Social Care Management (IHSCM) Advisory Board meeting and met with Eddie Hughes MP • 22 February 2022 – chaired the virtual Trust Management Committee (TMC) • 24 February 2022 – met with Pat Usher and Jane Wilson, Joint Trust-wide Leads • 28 February 2022 – participated in the Black Country Integrated Care System (ICS) Development session • 3 March 2022 – participated in the NHS England/ Improvement Black Country and West Birmingham Quarterly Review meeting and held a Consultant Meet and Greet with Dr Manjeet Shehmar, Medical Director • 4 March – participated in the ICS Masterclass session with David Meates (New Zealand Healthcare system) • 7 March 2022 – attended the Black Country Collaborative Clinical Summit • 8 March 2022 – met with Dr Julian Parkes - Non-Executive Director, as part of his induction and virtually met with Ofrah Muflahi – Associate NED, as part of her induction • 10 March 2022 – participated in the virtual NHS Providers Chairs and Chief Executives meeting and participated in a virtual ICS Development session • 14 March 2022 – participated in the virtual Walsall Proud Partnership (WPP) meeting • 15 March 2022 – chaired the virtual West Midlands Cancer Alliance Board • 18 March 2022 – met virtually with Helen Patterson – Chief Executive, Walsall Council and virtually met with Eddie Hughes MP and Wendy Morton MP and met with Louise Nickell – Director of Education and Training – RWT/ WHT and Jatinder Sharma – Principal and Chief Executive and Senior Team Members of Walsall College
5.0	**Board Matters**

	Three new Non-Executive Directors commenced at the Trust on 1 March 2022 - Dawn Braithwaite, Dr Julian Parkes and Ofrah Muflahi.

MEETING OF THE PUBLIC TRUST BOARD – 6 April 2022			
Chair's report of the Trust Management Committee (TMC) held on 29 March 2022 – to note this was a virtual meeting **AGENDA ITEM:**			
Report Author and Job Title:	Gayle Nightingale, Executive Assistant	**Responsible Director:**	Prof David Loughton, CBE, Chief Executive Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	None in this report.		
Advise	Matters discussed and reviewed at the most recent TMC.		
Alert	None in this report.		
Recommendation	Members of the Trust Board are asked to note the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None in this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	None in this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

1.0	**Key Current Issues/Topic Areas/ Innovation Items:**
	• There were none this month.
2.0	**Exception Reports**
	• There were none this month.
3.0	**Items to Note – all of the following reports were reviewed and noted in the meeting**
	• Director of Nursing Report • Safeguarding Adults and Children's Report • Midwifery Service Report • Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report • Divisional Quality and Governance Report – Surgery Report • Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report • Divisional Quality and Governance Report – Community Services Report • Workforce Key Performance Indicator Update Report • Walsall Together Update Report • Trust Financial Position (Revenue and Capital) - Month 11 Report • Committee Risk Register (CRR)/ Board Assurance Framework (BAF) Heat Map – Report • Urgent and Emergency Care Centre's Capital Build Update Report • Property Management Update Report
4.0	**Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting**
	• Education and Training (six monthly update) Report • Information Governance (IG) Toolkit Requirements (quarterly update) Report • Emergency Preparedness Risk Register (EPRR) Annual Assurance Mid-Point Report
5.0	**Business Cases – approved**
	• Walsall and Wolverhampton Urology Collaborative
6.0	**Policies approved**
	• Policy meeting - 8 March 2022 Report • WHT-CP907 V3 Immunoglobulin Policy • WHT-CP908 V1.1Transition of Children and Young People with Diabetes to Adult

	Services Policy • WHT-HS01 V2.1 Health and Safety Policy (Including Organisational Arrangements) Policy • WHT-MP03 V4 Medicines Reconciliation Policy • Management of Diabetic Ketoacidosis (DKA) in Adults Guideline • Pituitary Apoplexy Guideline • Commissioning Criteria Policy for the use of therapeutic immunoglobulin (Ig) England, 2021 Guideline
7.0	**Other items discussed**
	There were none this month.

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 6th April 2022**			
Integrated Quality and Performance Report (IQPR)			
Report Author and Job Title:	Dan Mortiboys, Operational Director of Finance	**Responsible Director:**	Russell Caldicott, Director of Finance and Performance
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		

Assure	This report introduces the Trust's Integrated, Quality & Performance Report (IQPR). Developed in conjunction with guidance from NHSEI (and use of reference sites) with Wolverhampton officers supporting the Performance team and myself in delivery of an IQPR for the Trust.
	
	The Trust endorsed the format for the IQPR through Executive, Trust Management Committee, Chairs of sub-Committees, Performance Finance & Information Committee and Trust Board, key elements being:
	
	• Statistical Process Charts (SPC) are used within the report to model performance, with a key to symbols contained within the front cover of the report
	• The report contains a one-page summary that references by quadrant key messages produced by each lead Executive for Quality, Workforce, Performance and Finance
	• The report then includes the Committee highlight reports, for presentation by Chairs of Committee to Board
	• Then a table of key focused metrics (8 to 10 only) for each domain as determined by relevant sub-committee is included in the report (these can vary at sub-Committee discretion)
	• The table is traffic lighted based on delivery of targeted performance and a positive assurance from the Statistical Process Charts (SPC) modelling
	  • Green – on trajectory and SPC no concerns
	  • Amber – off trajectory or SPC concerns (one only)
	  • Red – off target and SPC showing concerns
	• The charts are also contained within the pack for each key metric referred to within each domain of the report
	• It is of note, the traffic light system will therefore not indicate red if away from national target, we avoid being red for example on ED 95% performance when the industry is not attaining this level of performance. Targets will need to carefully be assessed if not referencing national required metrics
	• Each metric (where possible to do so) has a detailed SPC chart, with narrative explaining positioning and action being taken where needed
	
	Trust Board members can now use the report to receive assurance on action being taken to support enhanced quality and performance.		

Advise	Key elements to note: • The report relies on timely completion of data to assess accurately monthly performance (new metrics / targets determination and updated narrative supplied to the performance teams). • The rag rating of performance relies on targets that may not necessarily be the national required targets for attainment (the report will sight members on national targeted performance though within the table). We will need to be vigilant as to the rational for why we would agree for targets to not reflect national requirements. • The rationalising of metrics requires sub-committees to prioritise and escalate emerging issues (de-escalating and escalating to maintain the ability of the Board to apply focus) and not be caught out by a subsequent performance or quality issue that wasn't part of the escalation pack to Board (sub-committee effective scrutiny a really important component). The importance of ensuring data presented is robust and timely, and Trust Board able to focus on key issues escalated through sub-committee supports this prioritisation of metrics. National metrics identified in the tables offers the reader the opportunity to seek assurance if a target is not at that expected nationally.	
Alert	The report alerts members of success within the Trust. However, it is also a means of articulating where support is required to enhance current service, enabling Board members to seek assurance following these aspects being highlighted by sub-committees and the Executive. Whilst members have endorsed the IQPR, this is the first time the format and report has been used within the Board setting; it is therefore important to learn from feedback following the meeting how we can enhance the use of the report for future Board meetings.	
Mitigate risk included in the BAF or Trust Risk Registers	IQPR enables enhanced focus. Quality and performance reported alongside risks to attainment of the wider Trust objectives in one place in a focused way (supporting BAF delivery).	
Resource implications	Implications associated with the capture and reporting of performance.	
Legal and/or Equality & Diversity implications	There are no legal, equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Walsall Healthcare NHS
NHS Trust

Integrated Quality & Performance Report

February 2022

Caring for Walsall together

How to Interpret SPC (Statistical Process Control) charts

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Walsall Healthcare NHS
NHS Trust

EXECUTIVE SUMMARY

QUALITY	PERFORMANCE
Trust wide CQC action plan with responsible executive directors and identified leads has been established. Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels remains at a score of 15 and international nurse recruitment continues at pace. VTE compliance is 93.22%, an improvement from 91.49% in January 2022. Divisional teams continue to report on their performance and improvement plans report into Patient Safety Group (PSG). The prevalence of timely observations in February 2022 was 87.89%, an increase from 86.28% in Janury 2022 and is above trust target. Falls per 1000 bed days was 3.79% In February 2022 and in line with the previous consistent performance apart from a increase that was noted in Janury 2022. which was a deterioration in performance compared to December 2021 (3.53%). A deep dive review was undertaken which identified an increase with frequent fallers. Work is being progressed via the falls accountability meeting. The Trust target for Clostridium difficile 2021/22 had been internally agreed again at 29 cases and cases are in line with the trajectory. The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 58.57% by E-sepsis audit in January 2022. The inpatient adult E-sepsis compliance for January 2022 was 32.89%. Manual audits have consistently shown higher levels of compliance. Data not currently available for February 2022. Mental Capacity Act Audit shows that 45.71% of patients who lacked capacity had a stage 2 assessment undertaken, a decline from 52.03% in January 2022. Safeguarding adults and children's training is achieving trust target for all level 1 and level 2 training. Level 3 adult and children's training remains below trust target. Improvement plans report into safeguarding committee.	The Trust continues to deliver some of the best Ambulance Handover times (<30 minutes) in the West Midlands, being the top performer for 11 out of the last 12 months. This has been achieved despite sustained high number of Type 1 ED attendances and whilst supporting neighbouring Trusts with mutual aid. 4-hour Emergency Access Standard performance in February 2022 had 77.5% of patients admitted or discharged within 4 hours of arrival to ED. The Trust was ranked 22nd nationally out of 111 Trusts, with 10 of the last 12 months being in the Upper quartile nationally. In January 2022, for 62-day Cancer performance the Trust was materially better than the West Midlands average (48.3%) and in line with the national average (61.8%) with 62.5% of our patients treated within 62 days of GP referral. Despite recent challenges in the sonography and MRI service, the Trust's 6 Week Wait (DM01) Diagnostics performance remains strong and is 20th best (January 2022 reporting), out of 122 reporting general acute Trusts. Board should note the following risks: The Trust's 18-week RTT performance remains in line with trajectory with 63.25% of patients waiting under 18 weeks at the end of February 2022, but the national ranking position has slipped to 67th (out of 122 reporting Trusts) for January 2022 performance. The 52-week waiting time performance is 7th best in the Midlands (out of 20 Midlands Trusts). The Trust now has 856 patients waiting in excess of 52-weeks as at the end of January 2022. Patients referred by their GP on 2 week wait suspected cancer and Breast symptomatic pathways are experiencing longer waiting times. Outpatient waiting times have been challenged for some months, exacerbated by unexpected sickness absence from one of our breast surgeons during the Winter
WORKFORCE	**FINANCE**
Cold, Cough, Flu – Influenza related illnesses increased by 84% during 21/22 vs 20/21; contributing to short-term absence rises. Training compliance remains within an improved trend, but has fallen back into the 24 month performance range, and missed the 90% target for the first time since summer 2021. A fall in training completion amongst medical colleagues, specifically amongst level 3 Safeguarding competencies, have disproportionately contributed to a short-term decline in compliance rates. Annual appraisal compliance also within an improved trend, with a 3rd month of noted improvement. Revised PDR processes and paperwork are being published on the intranet. Targeted emails will be sent out to people with outstanding PDRs during Mar-22.	The Trust has attained a surplus of c£0.6m as at the 28th February 2022, on plan to attain a surplus at close of the financial year (31st March 2022). However, the Sustainability & Transformation Partnership has exceeded plans and is forecasting a c£23m surplus. The risk share entitles the Trust to receive a share of this surplus and as such the Trust is forecasting attainment of a c£3m surplus for the year. The Trust secured and is in the process of completing large capital schemes, to include ward refurbishments, theatre upgrades and the development of the New Emergency Department. The programme for 2021/22 fully resourced and on plan to deliver for the current financial year, with cash holdings totalling c£42m. The Trust enters 2022/23 with clear risks to revenue and capital, with income reduced by 57% of Covid-19 resource and an efficiency ask. To maintain financial balance the Trust will need to deliver an efficiency programme, cease agency and reduce Covid-19 costs. In addition, the capital allocation is insufficient to resource the programme for 2022/23 and additional discussions are ongoing to secure further resource allocations. The Trust was required to submit a draft financial plan as of the 17th March 2022, with the STP plans articulating a £48m deficit and the Trust plan (as part of the £48m deficit) a £6.6m deficit. The Executive continue to work to develop financial plans that live within the resources for both capital and revenue for 2022/23, with a final submission required by the 28th April 2022.

Trust Board
Chairs Assurance Report

Walsall Healthcare NHS
NHS Trust

Name of Committee/Group:	Quality, Patient Experience and Safety (QPES)
Date(s) of Committee/Group Meetings	25th March 2022
Chair of Committee/Group:	Dr Julian Parkes
Date of Report:	27th March 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Wait time for "2 week wait" for symptomatic breast and suspected cancer now 3 weeks • Workforce gaps in Health visiting • Waiting time for domiciliary phlebotomy remains at 240 cases • Mental Capacity Audit shows 45.71% who lacked capacity had stage 2 audit and discussion with patient's relatives or attorney decreased to 47.44% • Percentage of patients who receive antibiotics within 1 hr of screening for sepsis are low at 57.35% in ED and 42.07% for inpatients • Level 3 adult and children's safeguarding remains below target at 85%
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Trust Outpatient activity 85% of pre-COVID activity • VTE Compliance is stable but below target at 93.22% • Weekly CD audits continue and where there is noncompliance, an incident is raised • Continued progress against the backlog in Serious Incident investigations
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• MRSA/MSSA bacteraemia, C diff cases, gram negative bacteraemia and pseudomonas are low and below trajectory • Timely observations are above target at 87.89% • Falls per 1000 bed days reduced to 3.79% • 1 to 1 care in established labour remains at 100% • Level 1 and 2 adult and children's safeguarding above target • Compliance against Ockenden and Kirkup Bay maternity reports noted
Recommendation(s) to the Board/Committee	That the Board note the report and matters of concern
Changes to BAF Risk(s) & TRR Risk(s) agreed	None
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Task and finish group looking at Health Visiting provision in light of workforce gaps

ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	Presentations received included • Community Services Report • Serious Incident Update • Infection Control Action Plan • Safeguarding Quarterly Update • Patient Experience Report • Health Care Acquired Infection COVID deaths review COVID-19 Acute Services Access/ Restoration and Recovery update
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Safe High Quality Care Oversight Report • Maternity Services Update
Matters presented for information or noting	• Infection Prevention and Control Committee • Patient Safety Group • Patient Experience Group
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of Reference received
Items for Reference Pack	

Walsall Healthcare NHS
NHS Trust

QPES

		Reporting Period	Actual	Trajectory	2021/22 Target	SPC Assurance	SPC Variation
QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE							
No.	Clostridium Difficile - No. of cases	Feb-22	1	2	33	?	
No.	MRSA - No. of Cases	Feb-22	0	0	0	?	L
%	VTE Risk Assessment	Feb-22	93.24%		95.00%	?	
%	Sepsis - % of patients screened who received antibiotics within 1 hour - ED (Manual Audit)	Jan-22	90.91%		90.00%	Not enough data to generate SPC	
No.	Falls - No. of falls resulting in severe injury or death	Feb-22	0	0	0	?	
Rate	Falls - Rate per 1000 Beddays	Feb-22	3.79	6.10	6.10	?	
Ave	National Never Events	Feb-22	0	0	0	?	
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	Feb-22	12				
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Feb-22	1				
Rate	Midwife to Birth Ratio	Feb-22	28.7	28	28	?	
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	Feb-22	12				
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	Feb-22	17				

Metric Name: Clostridium Difficile - No. of Cases

MONTH

	Actual	Traj.
Apr	1	3
May	3	3
Jun	5	3
Jul	2	3
Aug	4	3
Sep	3	3
Oct	0	3
Nov	1	3
Dec	2	3
Jan	3	2
Feb	1	2
Mar		2

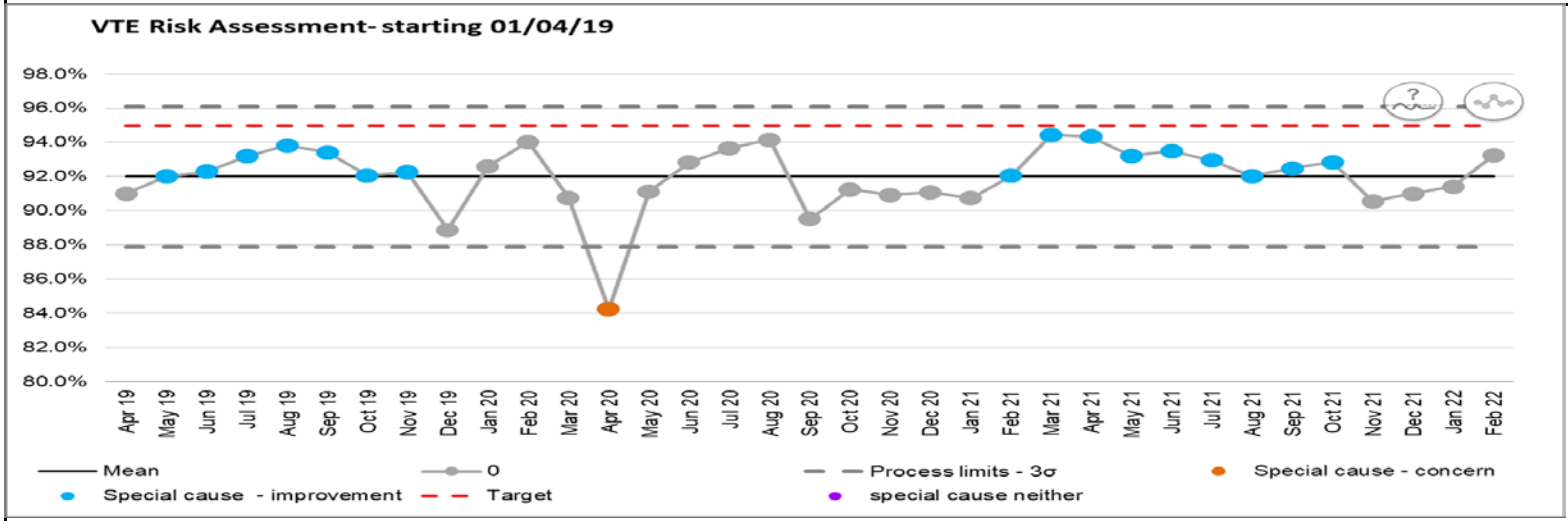
CUMULATIVE

	Actual	Traj.
Apr	1	3
May	4	6
Jun	9	9
Jul	11	12
Aug	15	15
Sep	18	18
Oct	18	21
Nov	19	24
Dec	21	27
Jan	24	29
Feb	25	31
Mar		33

Month
Feb-22
Variance Type
Target
No more than 33 cases
Target Achievement
Variation Indicates Consistently Passing the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Minimise rates of Clostridium difficile The Trust target for 2021/22 had been internally agreed again at 29 cases; the national targets have now been released and have been set at 33 cases	No significant variance and year to date cases remain below year to date projected cases.	1 case of C.Diff was reported in February 2022. .	The case has been investigated by the infection prevention and control team who concluded that the case was unavoidable	N/A

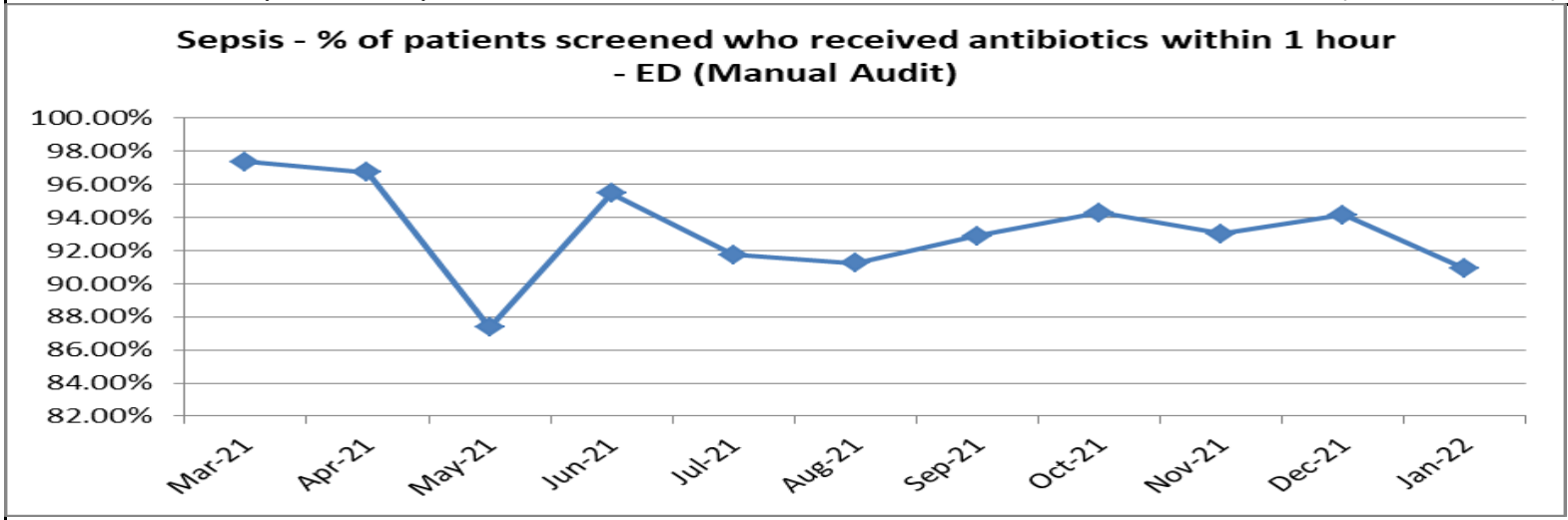
Metric Name: VTE Risk Assessment



Month
Feb-22
Variance Type
Common Cause - No Significant Change
Target
95.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE (agreed cohorts applied)	Initial improvements in compliance have not been maintained and performance remains below the trust target of 95%. However, there is an upward trend for the past 3 months.	VTE compliance for February 2022 was 93.22% , which continues to be under the 95% target for compliance. Monthly reports continue to be sent to Divisions, in addition to the daily reporting to consultants..	Audits have shown a number of process and IT issues which are now being worked through in QI projects.	Hospital acquired thrombosis (HATS) are reported on Safeguard and discussed at Divisional Quality Boards. HATS are also reported to the Thrombosis Group and each Division continues to report on the outcome of investigations.

Metric Name: Sepsis - % of patients screened who received antibiotics within 1 Hour - ED (Manual Audit)



Month
Jan-22
Variance Type
Target
90.00%
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Limited data to report against, no statistical variance. The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 90.91% by manual audit in January 2022, February data not available at the time of writing this report.	Work has progressed with aligning the E-sepsis data with manual audits showing user error exacerbated by a non-user friendly interface. The digital team are addressing this with System C to resolve issues. The reporting contained too much detail making the usefulness complicated.	A Trust sepsis team has been established to increase awareness and respond to sepsis alerted patients. The PBI report has been refreshed to focus on the Antibiotics within the hour and is currently in draft. Additional training to be provided to ED staff. Review of 4.3 vitals upgrade required.	Manual audits are being carried out to provide assurance while work continues with the IT team to optimise the use of the E sepsis System C tool to provide a robust overview of sepsis management

Trust Board Meeting
Committee Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee:	Performance Finance and Investment Committee
Date(s) of Committee Meetings since last	Wednesday 30th March 2022
Chair of Committee:	Mr Paul Assinder, Non-Executive Director
Date of Report:	Wednesday 30th March 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	Members received updates on the development of the business plans for the Trust for 2022/23 of note elements being: <u>Financial Plan 2022/23</u> • The Committee noted that the income settlement for 2022/23 is essentially 'flat cash' and also assumes a switch between COVID pressure and Elective activity, within this envelope. • The current draft of financial plan shows a £6.6m deficit position, inclusive of £5.3m efficiency programme delivery. • Within the financial plan the Efficiency Programme shows identification of £4.1m of potential savings against a target of £5.3m. Of the identified schemes £2.7m is risk rated red. • There are developments totalling £21.5m the have been highlighted through the budget setting process, not yet included within the financial plan. This will need to be worked through and prioritised and will likely create further pressure on the plan. • The Committee sought clarity on any impact to quality, as well as activity, in the overall clinical offering for 2022/23. • The Committee noted risks to the financial plan in respect of Inflation; the efficiency programme; the Elective Recovery expectation; Winter preparedness; and the income settlement (risk associated with the overall STP being in deficit). • Within the Capital programme for 2022/23 there is a challenge to secure additional resource to fulfil the Theatres programme of work. <u>Performance Issues</u> • Concerns were raised by Committee regarding waiting times for patients presenting with suspected breast cancer, this has recently been exacerbated by sickness in the team.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	The matters below are those which Committee members wish to bring to the attention of the Board: • The business case for Urology Service Collaboration with Royal Wolverhampton NHS Trust was presented and endorsed by the Committee, for progression to Trust Board. • The Committee received the Mid-Point Assurance Report for Emergency Preparedness, Resilience and Response. The Trust's self-assessment showed that 4 of the 5 elements that previously showed partial compliance were now fully compliant giving an overall assessment of Substantial Compliance for the Organisation.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	Key elements to highlight to members are: 2021/22 Financial Position • The Committee received a report on the current year financial position which shows good performance, with a surplus of £0.6m at Month 11 and a forecast surplus of c£3m at the year end (in part due to additional income receipts expected in M12). • Capital Performance is positive with ward refurbishment and theatres upgrades complete. The Emergency Department remains on plan to open in October 2022. • The Cash position remains strong 2021/22 Performance • In the elective pathways, good progress has been made in diagnostic waiting times. • A strong position was also presented for admission avoidance with increasing activity seen through the Care Navigation Centre. It was noted that Longacre's Consulting have been commissioned to produce an analysis of the impact of this work on acute admission avoidance etc. • In Urgent and Emergency Care the Trust continues to deliver the best ambulance handover times in the West Midlands and is within the upper quartile for the Emergency Access Standard
Recommendation(s) to the Board/Committee	• Trust Board members are asked to note the contents of the report. • Final submission of the 22/23 plan is due on 28th April. Committee is seeking delegation from Trust Board for the endorsement of this plan prior to the submission deadline.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• There were no agreed changes
ACTIONS **Significant follow up action commissioned (including discussions with other Board**	• It was agreed to hold a dedicated session for members of the Committee and other NEDs potentially, to review the prioritisation of proposed service developments, noted above, ahead of presentation of the final plan submission for endorsement by the Board.
ACTIVITY SUMMARY **Major agenda items discussed**	• The Urology Walsall and Wolverhampton Collaboration Business Case was presented to members for approval, this was endorsed for consideration by the Board.
Matters presented for information or noting	The following items were presented for information: • Emergency Department Build Update • Corporate Risk Register

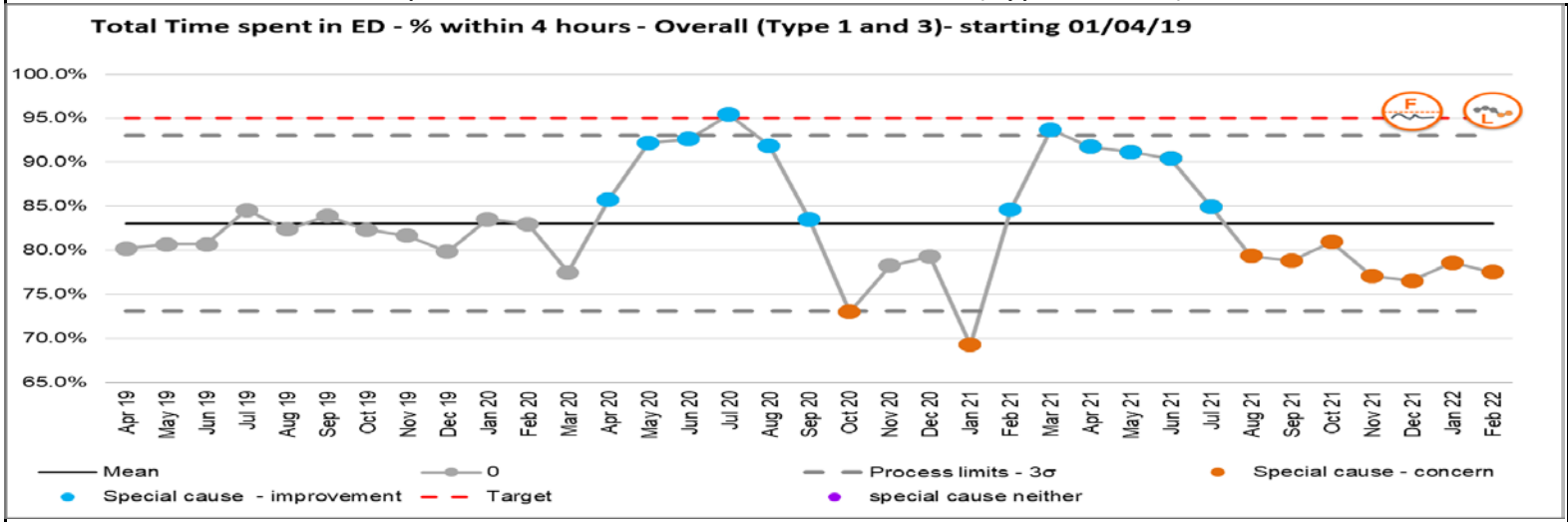
Self-evaluation/ Terms of Reference/ Future Work Plan	
Items for Reference Pack	Not applicable

PFIC

		Reporting Period	Actual	Trajectory	2021/22 Target	SPC Assurance	SPC Variation
PERFORMANCE, FINANCE & INVESTMENT COMMITTEE							
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Feb-22	63.25%	62.93%	92.00%		
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	Feb-22	858	963	0		
%	Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED	Feb-22	94.11%		95.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment	Jan-22	49.94%		93.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	Jan-22	10.34%		93.00%		
%	Cancer - 62 day referral to treatment from screening	Jan-22	100.00%		90.00%		
%	Cancer - 62 day referral to treatment of all cancers	Jan-22	62.50%		85.00%		
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test	Feb-22	5.26%		1.00%		
%	Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)	Feb-22	77.53%	Traj avail Mar-22	95.00%		
%	Locality Teams - % of Hours Demand Unmet	Feb-22	15.01%	20.00%	20.00%	Not enough data to generate SPC	
Ave	MSFD - Average number of MSFD in WMH	Feb-22	46	50	50		
%	Rapid Response - 2 Hour Response Rate	Feb-22	93.60%	95.00%	95.00%		

		Reporting Period	Actual	Trajectory	2021/22 Target	SPC Assurance	SPC Variation
%	Rapid Response - % Admission Avoidance	Feb-22	91.30%	87.00%	87.00%	Not enough data to generate SPC	
£	Total Income (£000's)	Jan-22	30285	See Financial Performance for further detail			
£	Total Expenditure (£000's)	Jan-22	30111	See Financial Performance for further detail			
£	Total Temporary Staffing Spend (£000's)	Jan-22	3953	See Financial Performance for further detail			
£	Capital Expenditure Spend (£000's)	Dec-21	3468.2	See Financial Performance for further detail			

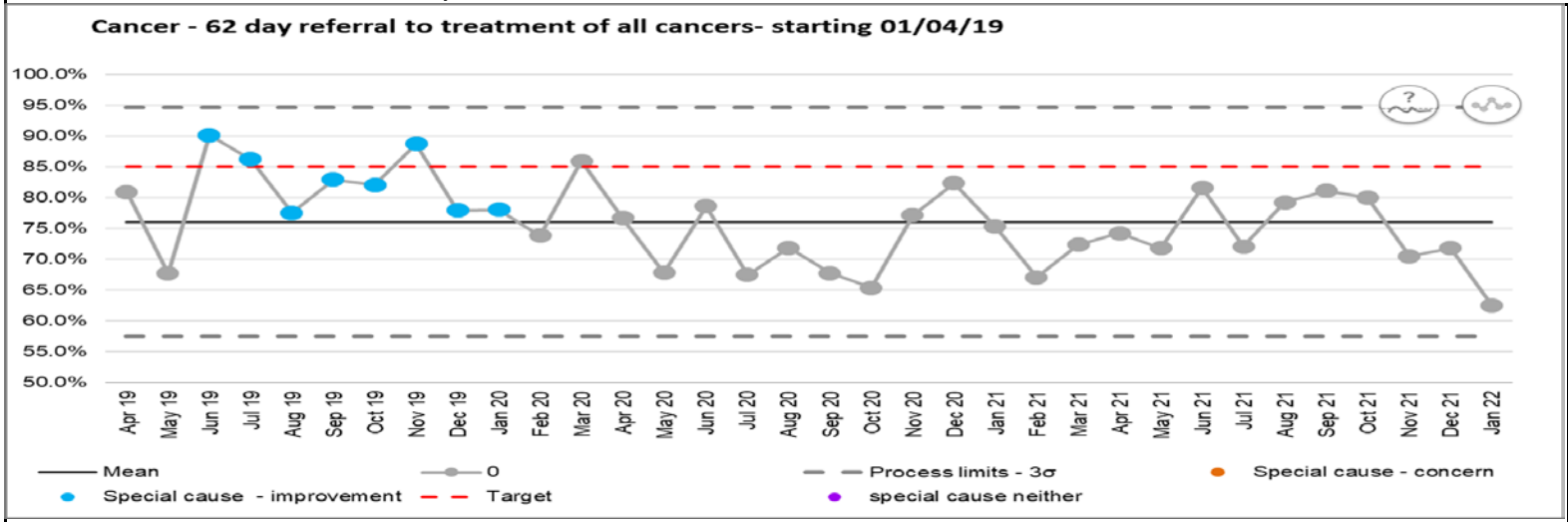
Metric Name: Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)



Month
Feb-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
95.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of A+E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A+E department	Statistical special cause concern from August to date , performance continues to be lower than the average (7 data points). Februarys reported performance is 77.5%.	Non-admitted patient breaches continue to be a large problem with Wait To Be Seen regularly exceeding 2 hours in the afternoon.	Revision of the rota by the new Rota coordinator. ED away day March 2022 “resetting standards”. Following a visit to Sherwood the team plan to run several PDSAs; running the department in sub-sections with senior decision makers to ensure investigations and diagnostics are front loaded.	UTC has extended opening hours until 03:00 ED away Day March 2022 resetting standards in the team Learning from Trust – visit to Sherwood. Care navigation centre supporting in avoiding inappropriate attendances.

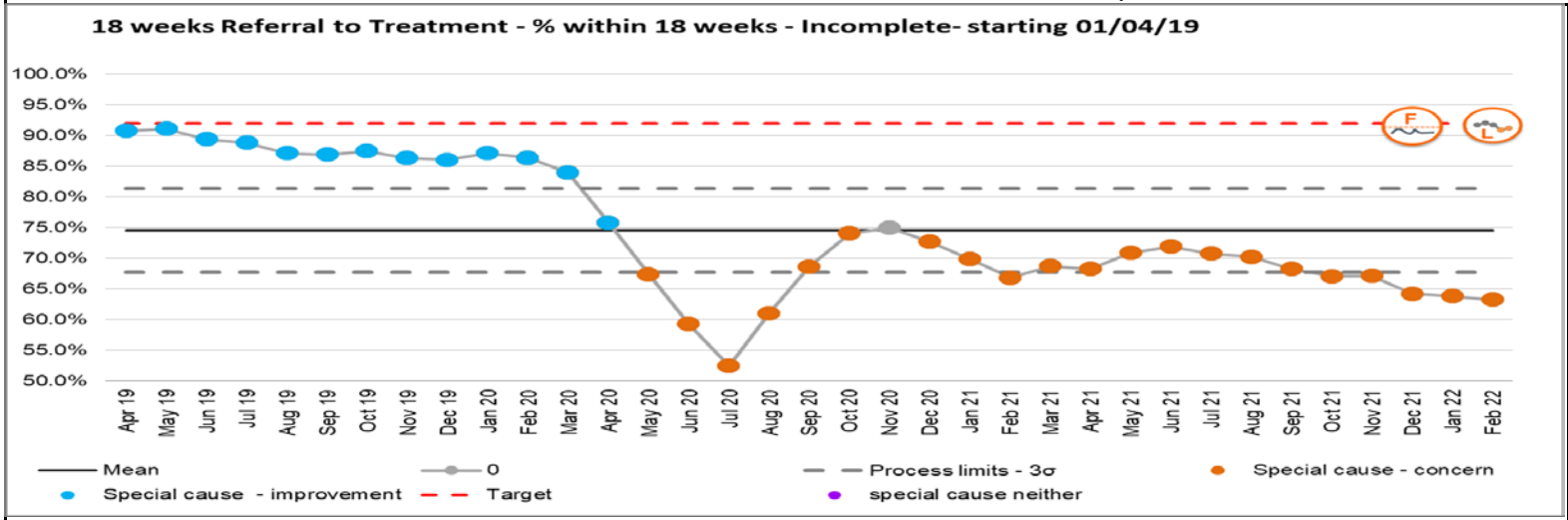
Metric Name: Cancer - 62 day referral to treatment of all cancers



Month
Jan-22
Variance Type
Common Cause - No Significant Change
Target
85.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	No statistical variation. Unfortunately, January's performance shows a deteriorating position with a performance of 62.5%.	There was a particularly worsening performance for breast this month, which is related to the lengthened first appointment waiting time (2 week wait standard) experienced in the later part of 2021. This has since improved, though not to the standard of 14 days (currently 22 days).	Breast Service working in conjunction with ICS to undertake a review to ensure all four breast services are standardised, with a view to proceeding to implement a single point of referral for 2WW patients across the ICS. Mutual aid support from RWT continues.	£75,333 introduced to support capacity for urgent CT lung capacity within 72 hours. ICS commission review of pathways, interviews planned with MDT leads for Breast, Colorectal, Skin & Urology. Provision reports will be available during March.

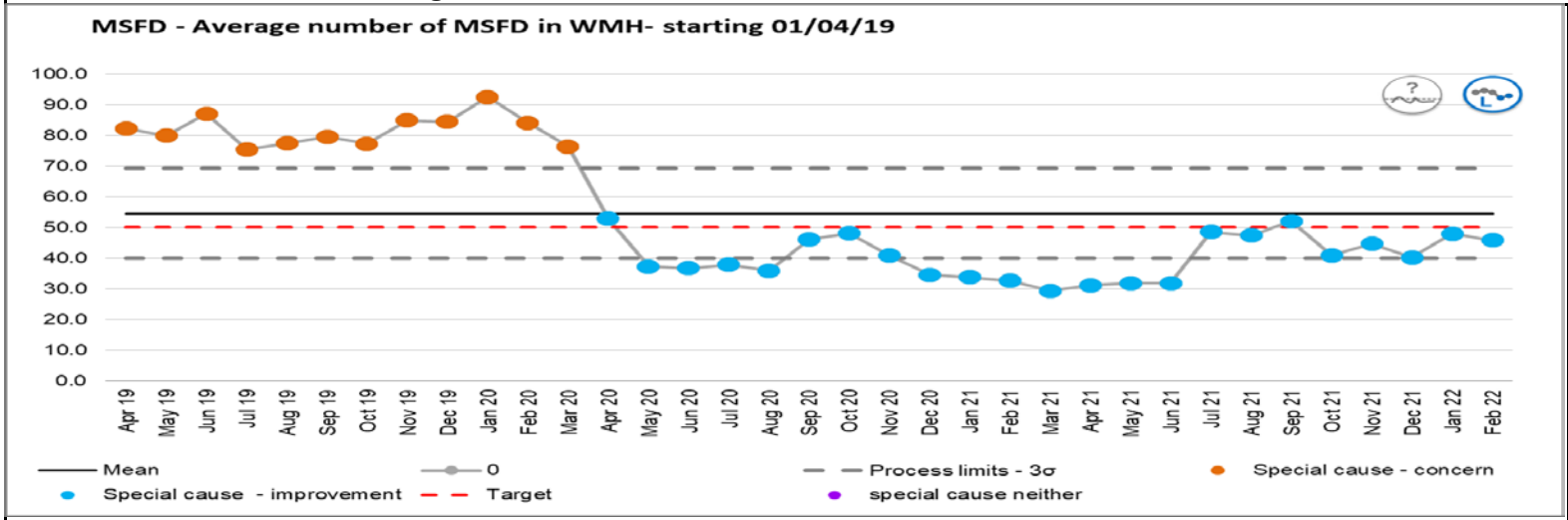
Metric Name: 18 weeks Referral to Treatment - % within 18 weeks - Incomplete



Month
Feb-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
92.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Performance remains statically special cause concern. In February 2022, the 18 week RTT incomplete is 63.25%, which is in line with the trajectory of 63%. The number of patients waiting greater than 18 weeks increased during February by circa 260 patients (10,665 vs 10,403).	Performance impacted due to the requirement to cancel some cases to accommodate trauma. There were two 104 week incomplete breaches for February, due to the surgeon being unavailable (covid issue) and no other appropriate surgeon available The patients have since been dated for March.	Recovery plans are in place for DOS and MLTC. Weekend clinics continue in March, including a super clinic in Orthopaedics focusing on the spinal patients, supported by Physiotherapy to create some one stop pathways. Additional sessions for Neurology have been arranged during March.	Elective cases have been assessed (in line with Federation of Surgical Specialty Associations guidance), to ensure that patients are placed in order of priority for the available theatre lists. The Trust has introduced an Artificial Intelligence (AI) Tool to support decisions made by clinicians.

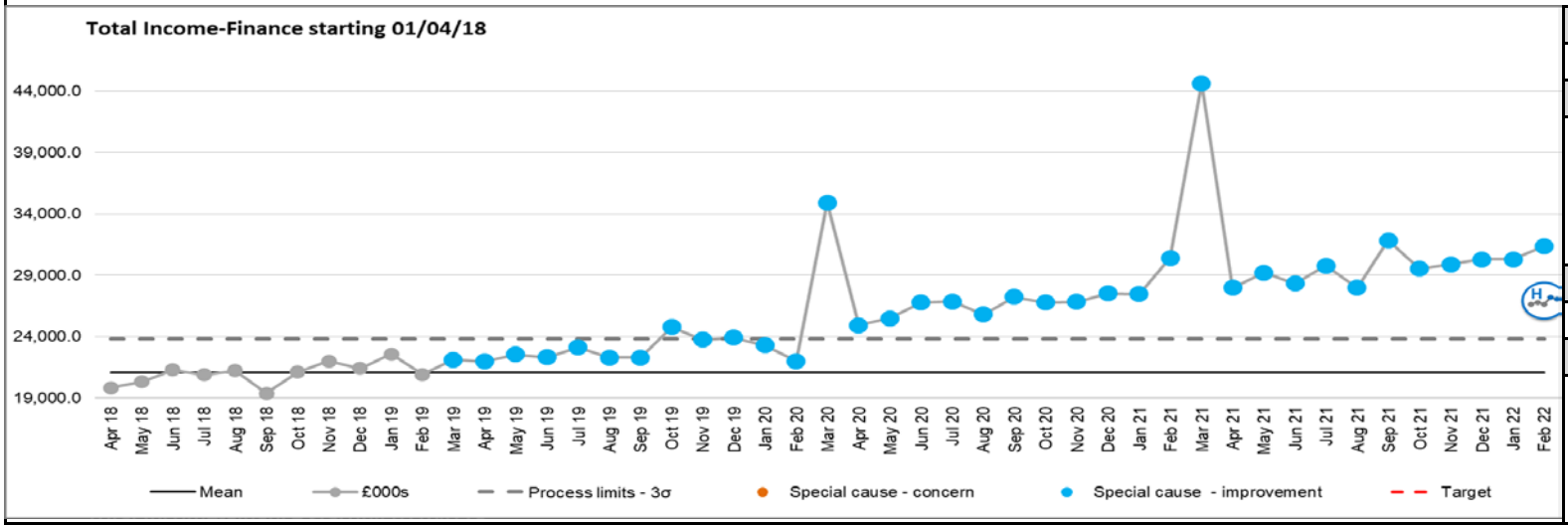
Metric Name: MSFD - Average number of MSFD in WMH



Month
Feb-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
50
Target Achievement
Variation Indicates Consistently Passing the Target

Background	What the chart tells us	Issues	Actions	Mitigations
The number of medically stable for discharge patients (average). These are patients who do not need hospital bed for their acute management	Special cause of improving nature. The Intermediate Care Service delivered a strong performance in February with the number of MSFD patients being maintained below an average of 50 with the length of stay below 4 days	Demand in terms of the Intermediate Care Service remains high.	Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients. Further work is being completed on enabling service to ensure resilience . Number of MSFD patients were maintained below the average of 50 with the length of stay decreasing.	Actions have been taken by the Community Division, ICS and partners in response to the difficulties being experienced in commissioning and providing packages of care.

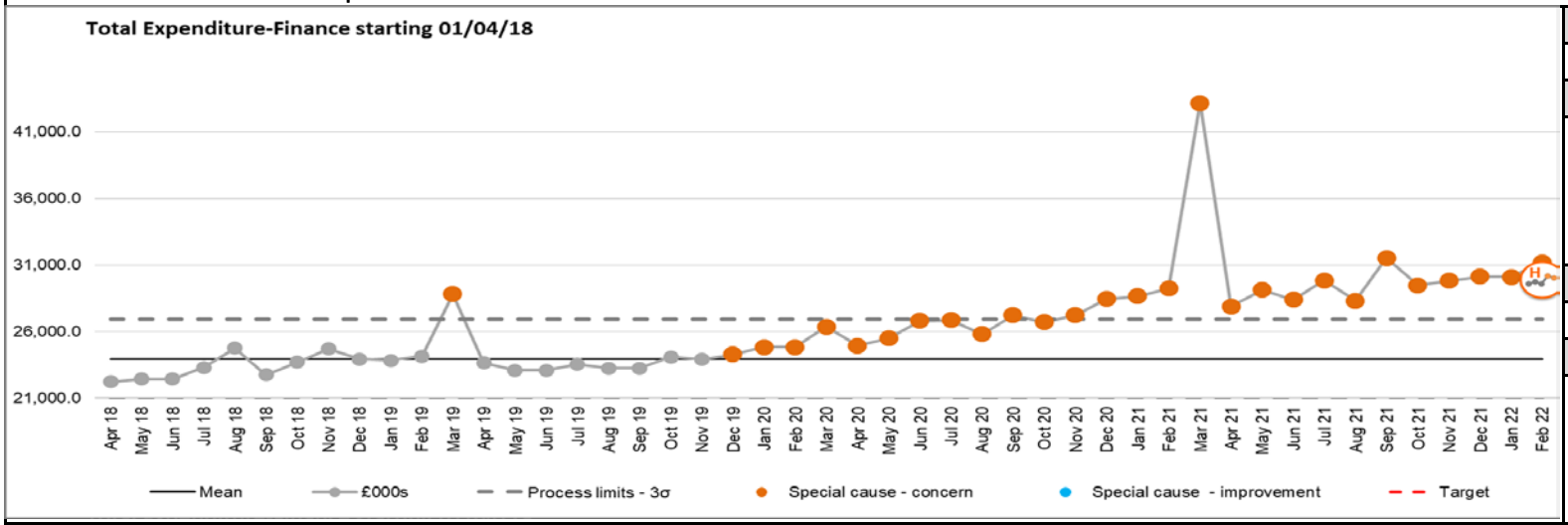
Metric Name: Total Income



Month
Feb-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Total income for the Trust	Statistically increase over time, maintaining above upper limit.	It is likely income will decline as the pandemic impact reduces	The Trust needs to seek appropriate sources of income and cost efficiency to live within the funding envelope	Variable funding sources including risk share and elective recovery fund

Metric Name: Total Expenditure

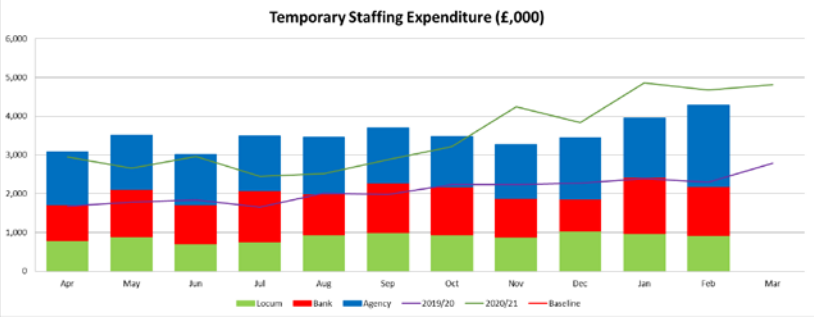


Month
Feb-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Total expenditure for the Trust	Statistically increase over time	Expenditure will need to decrease from historically high levels post pandemic	Cost efficiency must be targeted, £2.2m in H2, £5.3m in 22/23	H2 efficiency delivery targetted at £2.2m. Overseas recruitment through the Clinical Fellowship programme for Medical and Nursing staff to reduce reliance on temporary staffing

Financial Performance to February 2022 (Month 11)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Income			
Healthcare Income (Inc. Vaccs)	300,510	309,996	**9,486**
Other Income (Education&Training)	7,778	8,181	**403**
Other Income (Other)	5,598	8,357	**2,760**
Subtotal Income	**313,885**	**326,534**	**12,649**
Pay Expenditure			
Substantive Salaries	(164,117)	(168,034)	**(3,917)**
Temporary Nursing	(15,170)	(18,413)	**(3,243)**
Temporary Medical	(15,050)	(13,056)	**1,993**
Temporary Other	(4,704)	(4,657)	**47**
Vaccination Programme	(5,871)	(3,276)	**2,595**
Subtotal Pay Expenditure	**(204,911)**	**(207,437)**	**(2,526)**
Non Pay Expenditure			
Drugs	(16,327)	(18,293)	**(1,966)**
Clinical Supplies and Services	(15,572)	(17,471)	**(1,900)**
Non-Clinical Supplies and Services	(14,577)	(16,690)	**(2,113)**
Other Non Pay	(45,919)	(48,571)	**(2,652)**
Vaccination Programme	(265)	(592)	**(327)**
Depreciation	(7,778)	(7,764)	**14**
Subtotal Non Pay Expenditure	**(100,438)**	**(109,382)**	**(8,944)**
Interest Payable	(8,687)	(8,793)	**(106)**
Subtotal Finance Costs	**(8,687)**	**(8,793)**	**(106)**
Total Surplus / (Deficit)	**(151)**	**922**	**1,073**
Donated Asset Adjustment	212	(305)	**(518)**
Adjusted Surplus / (Deficit)	**62**	**617**	**555**



Financial Performance

- The Trust has determined an operational plan for the period October to March of 2022 (Horizon 2 of the 2021/22 financial year) that has enabled the Board to endorse a financial plan for this period.
- The Trust has a surplus at the end of February 2022 of £0.617m, an improvement to plan of £0.555m (planned surplus £0.062m) largely due to underspends in the Winter Plan.
- The Trust continues to see high levels of temporary staffing spend particularly in areas of increased activity, the main driver being temporary nurse staffing as a result of increased activity in ED, ICU and Maternity. However, overall temporary workforce costs remain below the level seen in the same period last year.
- The Trust is forecasting to attain plan for the year. However, the Sustainability and Transformation Partnership (STP) has an improved forecast outturn following a number of 'other' partners increasing their forecast surplus (to c£23m). The endorsed risk share agreement results in the Trust therefore increasing its surplus through distribution of this resource to c£3m (this benefits the Trust in cash holdings as the surplus is cash backed).
- Excluding ERF, Non Pay was above forecast due to High Cost Drugs and Devices usage and purchase of healthcare which has been offset by increased income.

Capital

- The approved programme for the year includes the Emergency Department, ward refurbishment and theatres 5 & 6 upgrades. The capital schemes are progressing well, with the New Emergency Department construction on plan, ward environment works and two theatres refurbishments now complete.
- Capital expenditure totals £19.5m to February 2022 and the Trust is expecting to spend up to the programme at close of the financial year. The Trust is continuing negotiations on securing resources to finance the 2022/23 capital plan.

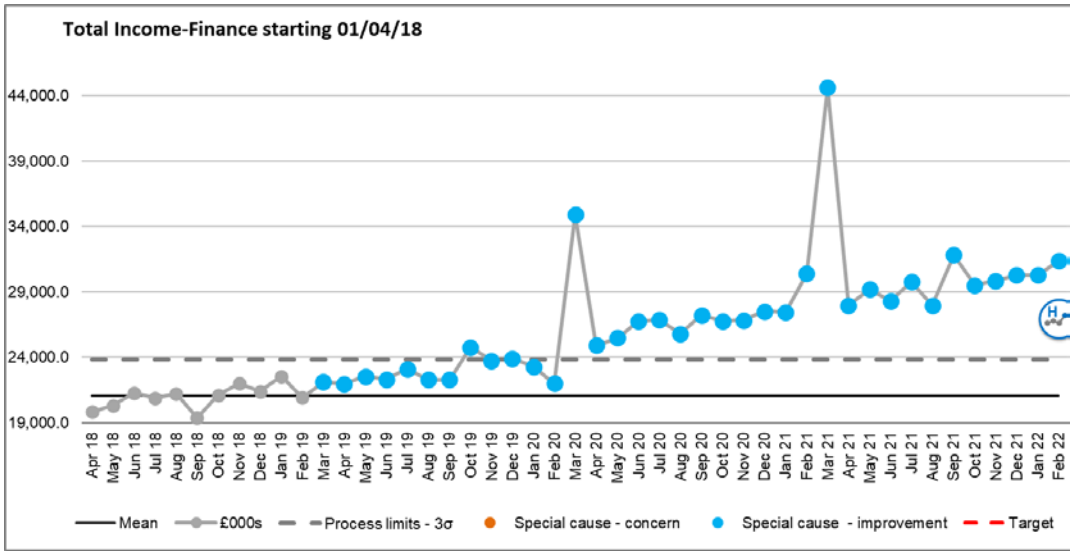
Cash

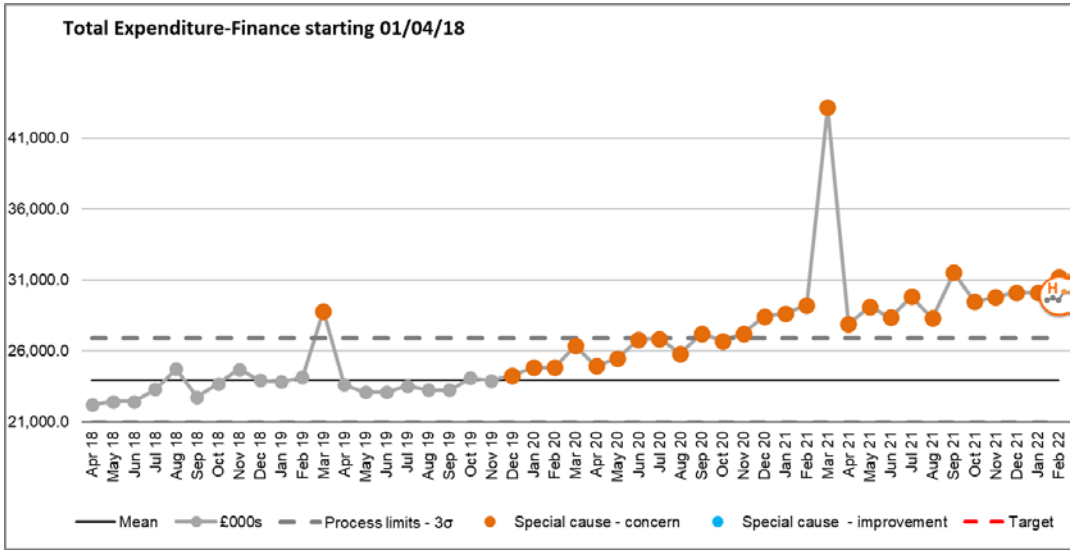
- The Trust has a positive cash holding of £42.2m as at 28th February.

Efficiency attainment

- The emergency budget planning letter and guidance states there was no efficiency requirement for Months 1-6. However, development of Improvement Programme initiatives is key to ensuring financial sustainability moving forwards, with the outputs of this program to be reviewed by Performance, Finance and Investment Committee.
- The financial sustainability for the second half of the year requires attainment of a 1.6% efficiency and moving into 2022/23 it is envisaged further savings will be required to maintain financial sustainability of services with the Trust targeting 2% efficiency on Operational Budgets. Delivery of this savings ask is a key risk to the Trust.

Income and expenditure run rate charts





Income additional information

- Income has continued to increase year on year, this reflects a level of tariff inflation and growth serviced through the Trust over this period.
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).
- From October there will no longer be retrospective top up funding received, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.
- The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears.

Expenditure additional information

- March 2019 the Trust accounted for the ICCU Impairment of £6.2m
- 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

Cash Flow Statement & Statement of Financial Position

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending February 2022	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	9,707
Depreciation and Amortisation	7,764
Donated Assets Received credited to revenue but non-cash	(608)
(Increase)/Decrease in Trade and Other Receivables	(1,681)
Increase/(Decrease) in Trade and Other Payables	18,014
Increase/(Decrease) in Stock	(262)
Increase/(Decrease) in Provisions	0
Interest Paid	(7,553)
Dividend Paid	(282)
Net Cash Inflow/(Outflow) from Operating Activities	**25,099**
Cash Flows from Investing Activities	
Interest received	**8**
(Payments) for Property, Plant and Equipment	**(22,680)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(22,672)**
Net Cash Inflow/(Outflow) before Financing	**2,427**
Cash Flows from Financing Activities	(3,720)
Net Increase/(Decrease) in Cash	**(1,293)**
Cash at the Beginning of the Year 2021/22	43,532
Cash at the End of the February	**42,239**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending February 2022	Balance as at 31/03/21	Balance as at 28/02/22	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Property, plant & Equipment	161,995	175,489	13,494
Intangible Fixed Assets	6,417	5,366	(1,051)
Receivables greater than one year	561	326	(235)
Total Non-Current Assets	**168,973**	**181,181**	**12,208**
Current Assets			
Receivables & pre-payments less than one Year	11,075	12,991	1,916
Cash (Citi and Other)	43,532	42,239	(1,293)
Inventories	2,951	3,214	263
Total Current Assets	**57,558**	**58,444**	**886**
Current Liabilities			
NHS & Trade Payables less than one year	(35,179)	(46,778)	(11,599)
Other Liabilities	(284)	(4,577)	(4,293)
Borrowings less than one year	(4,058)	(4,058)	-
Provisions less than one year	(96)	(96)	-
Total Current Liabilities	**(39,617)**	**(55,509)**	**(15,892)**
Net Current Assets less Liabilities	**17,941**	**2,935**	**(15,006)**
Non-current liabilities			
Borrowings greater than one year	(111,956)	(108,236)	3,720
Total Assets less Total Liabilities	**74,958**	**75,880**	**922**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	215,632	215,632	-
Revaluation	24,307	24,307	-
Income and Expenditure	(164,981)	(164,981)	-
In Year Income & Expenditure	-	922	922
Total TAXPAYERS' EQUITY	**74,958**	**75,880**	**922**

Trust Board Meeting
Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	People and Organisation Development Committee
Date of Committee/Group	28th March 2022
Chair of Committee/Group:	Junior Hemans
Date of Report:	6th April 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The NHS Staff Survey results 2021 show improvement across the NHS People Promise domains with the exception of 'compassionate and inclusive leadership' which is not consistently experienced across the Trust, this is results in higher levels of bullying and harassment and discrimination which is out of line with the Trust Board Pledge. The committee received a full analysis and report on the NHS Staff Survey results 2021 and resolved to receive a monthly assurance report on the actions taken by the Staff Survey and Experience Oversight Group. • The NHS Staff Survey results 2021 show a decline in staff advocacy indicators of 'recommend the trust as a place to work' and 'recommend the trust as a place to be treated' – although the decline is reflected in national results, it means that the trust remains well below the national average for these important indicators. The monthly assurance report from the Staff Survey and Experience Oversight Group will report on the targeted action taken to improve the consistency of staff experience across the trust to improve these indicators. • The committee reviewed actions taken to improve long term sickness absence and noted the impact this had, however also heard how short term sickness absence is contributing to underlying absence rates that are significantly above target. The trust wide 12 month rolling sickness absence average for 2020/21 was 5.3%, for 2021/2022 it was 5.93% excluding Covid related absence. In month absence at February 2022 was 6.47% excluding Covid related absence (+1%), the committee will receive an analysis of cause along with an improvement trajectory and time to meet target at its April meeting, the committee considered the target of 4.5% appropriate.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The committee received an update on the WRES, WDES and Gender Pay Gap reporting in advance of its publication. It noted the improvement with the WRES report indicators however noted further work required on culture and staff experience noted above in order to achieve the Trust Board Pledge on staff experience. • The Race Code Accreditation provides a framework for assurance on the element of the Trust Board Pledge relating to being an anti-racist organisation.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• There has been significant improvement in the representation of Black, Asian and Minority Ethnic colleagues at senior level within the trust (8a and above) during 2021-2022. • The committee took significant assurance from the Education and Training Update report which is presented for assurance to the Board, the committee noted the improvements made and resolved to receive regular updates on education, development and training and agreed to focus on leadership and management development for the next report. • The Trust is in an improved position relating to the National Staff Survey 2021, it falls within 40%-60% of trusts on the indicators, with improvements made across the NHS People Promise, the infrastructure is in place to ensure further improvement for the 2022 national survey. There are regular Pulse Surveys planned to provide Board with regular updates on progress.
Recommendation(s) to the Board/Committee	• To note the reports and assurance, note the action on areas for concern and agree to receive an assurance report on meeting the attendance target.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• The BAF and Corporate Risk Register both highlight culture and staff experience and discrimination as a risk and have shown where improvement has been made and the risk has been controlled. Consequently the committee approved reducing the risk rating on staffing and culture to amber rating. The committee closed the risk on VCOD (Vaccine as a Condition of Deployment) since the provision has been withdrawn.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Assurance from the Staff Experience and Oversight Group on action plans to achieve consistent staff experience across the Trust, meeting the Trust Board Pledge and improving staff advocacy for Walsall as a place to work and a place to be treated. • Assurance on the improvement trajectory to meet trust target for attendance, and reducing sickness absence to 4.5% in year. • Further update on leadership and management development activity and outcomes.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Trust analysis of NHS staff survey results 2021 approved.
ACTIVITY SUMMARY **Major agenda items discussed including**	• NHS Staff Survey 2021/Trust Board Pledge – action planning approved. • Education and Training update – reporting cycle approved. • Workforce Metrics and Performance – noted
Matters presented for information or noting	• The action logs for supporting groups were reviewed at committee as follows: Health and Wellbeing Strategy Group, Equality, Diversity and Inclusion Group, Education and Training Steering Group, JNCC, LNC, Flu and Covid vaccination status.
Self-evaluation/ Terms of Reference/ Future Work Plan	• Future work plan will be approved at April Committee meeting for 2022-23.

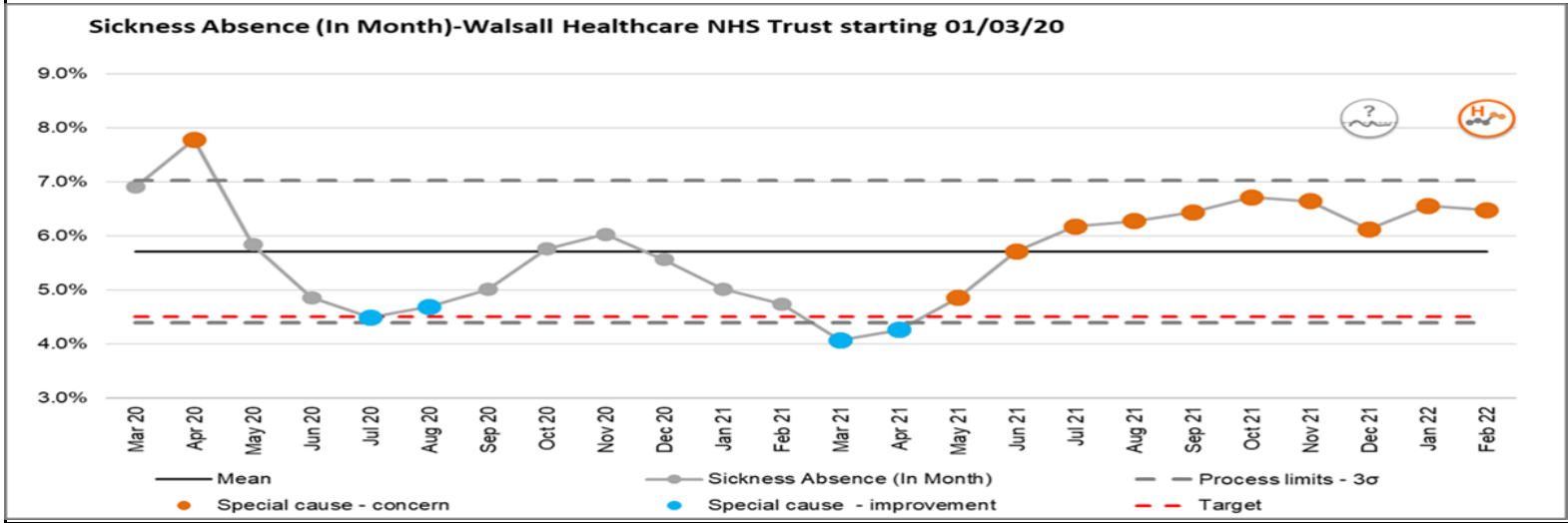
Items for Reference Pack	• Trust analysis of NHS staff survey results 2021 approved.

Walsall Healthcare NHS
NHS Trust

POD

		Reporting Period	Actual	Trajectory	2021/22 Target	SPC Assurance	SPC Variation
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE							
%	Sickness Absence	Feb-22	6.47%		4.50%	?	H
%	PDRs	Feb-22	82.96%		90.00%	F	
%	Mandatory Training Compliance	Feb-22	89.61%		90.00%	?	H
%	% of RN staffing Vacancies	Jan-22	0.56%				L
%	Turnover (Normalised)	Feb-22	11.53%		10.00%	?	H
%	Retention Rates (24 Months)	Feb-22	78.50%		85.00%	F	L
%	Bank & Locum expenditure as % of Paybill	Jan-22	12.64%		6.30%	F	
%	Agency expenditure as % of Paybill	Jan-22	7.24%		2.75%	F	

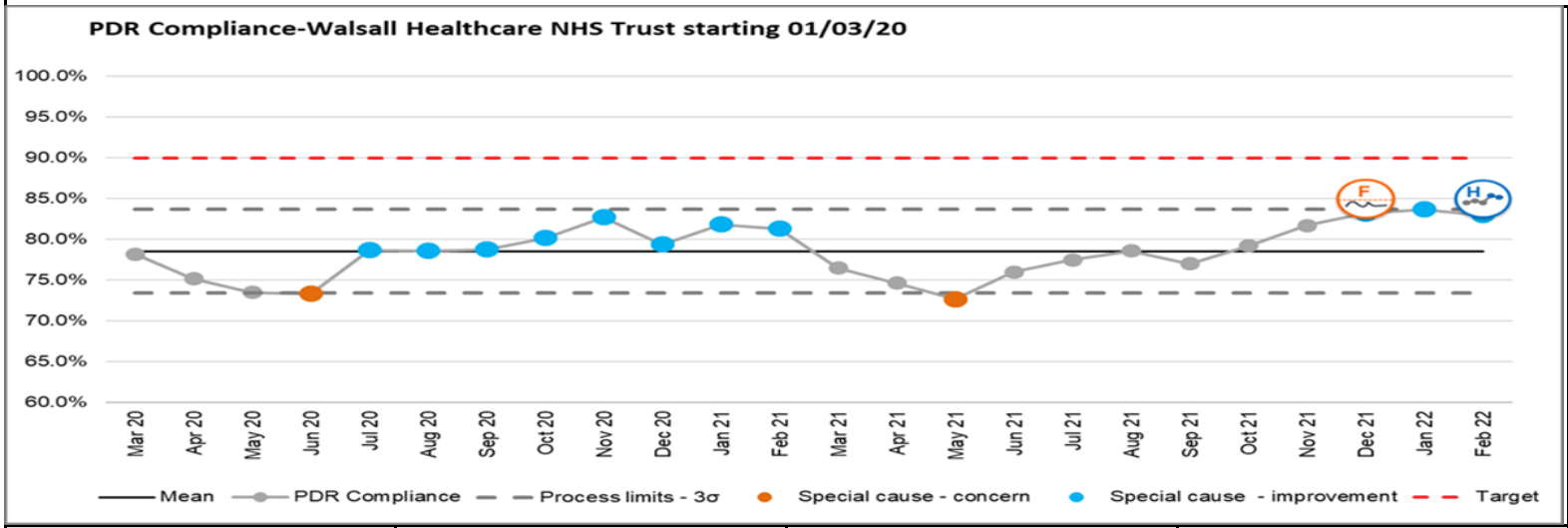
Metric Name: Sickness Absence



Month
Feb-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
4.50%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.	Special cause of concern, 8th month being above the mean average; sustaining an increase in absence which begin during May 2021.	Cold, Cough, Flu – Influenza related illnesses increased by 84% during 21/22 vs 20/21; contributing to short-term absence rises.	Monthly case conferences taking place between HR/OH ensuring that appropriate support is being offered and cases are being progressed where necessary. People & Culture colleages have re-established regular meetings with ward managers/matrons to support the process of managing attendance.	Monitoring of sickness absence includes Executive oversight at the monthly Divisional review meetings. Fast track referrals by the Occupational Health Team to Physiotherapy Services will ensure that injured colleagues receive early recovery interventions.

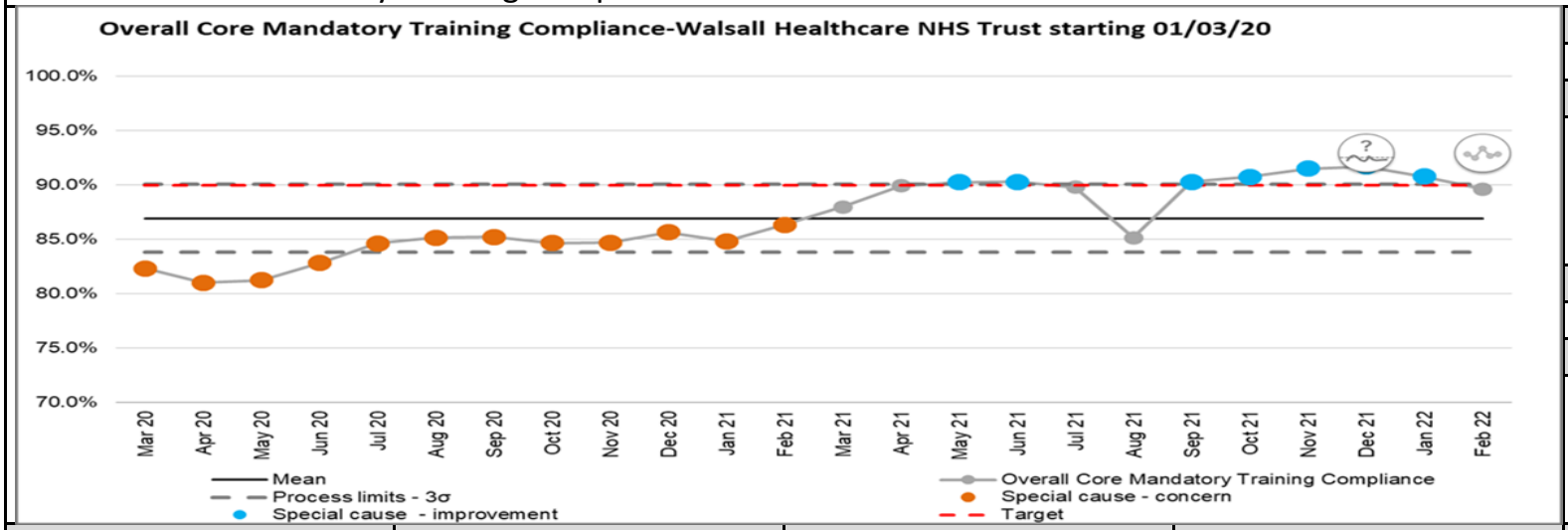
Metric Name: PDRs



Month
Feb-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
90.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Appraisal compliance is calculated using exclusion lists.	Performance remains within an improved trend, with a 3rd month of noted special cause improvement; aligned to interventions implemented by the Learning & Development team.	There has been a surge in PDR completion amongst clinical support & AHP colleagues. Admin colleague appraisal rates remain low (72%).	Revised PDR processes and paperwork are being published on the intranet. Targeted emails will be sent out to people with outstanding PDRs in Mar-21. Training for manager coming out..	Monitoring of PDR compliance is reviewed at the monthly executive led Divisional review meetings.

Metric Name: Mandatory Training Compliance



Month
Feb-22
Variance Type
Common Cause - No Significant Change
Target
90.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Training compliance is calculated using exclusion lists.	Compliance remains within an improved trend, but has fallen back into the 24 month performance range, and missed the 90% target for the first time since summer 2021.	A fall in training completion amongst medical colleagues, specifically amongst level 3 Safeguarding competencies, have disproportionately contributed to a short-term decline in compliance rates.	Collobration with RWT colleagues to align requirements and delivery models for mandatory training. Procurement of the Totora LMS system is in the final stages.	It is expected that the Totara LMS implement planning phase will begin in April 2022.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE Public Trust Board 6th April 2022			
Director of Nursing Report			
Report Author and Job Title:	Lisa Carroll Director of Nursing Caroline Whyte Deputy Director of Nursing	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• Registered Nurse (RN) /Midwife vacancy rate for January 2022 is less than 1% (data for February 2022 not available at time of writing report) • 189 overseas nurses have arrived in the Trust. A further 20 arrive before the end of April 2022. • The prevalence of timely observations is 87.89% and is consistently remaining above trust target. Twenty clinical areas achieved more than 85% trust target, an increase from 17 in January 2022.		
Advise	• There were nine 104-day breaches in December 2021 and four in January 2022 (last available data). Three have been identified as not causing harm and the remainder are under review. • VTE compliance for February 2022 was 93.22% (compared to 91.58% in January 2022) compliance rates remain steady but below the 95% target for compliance. • Falls per 1000 bed days has reduced to 3.79% during February 2022 (5.87% in January 2022). The number of incidents increased significantly in January and a themed review has taken place.		
Alert	• Off framework agency use has decreased during February 2022 to 4385.42 hours compared to the 5902.5 hours used in January 2022. • Safeguarding level 3 adults and children's training remains consistently below trust target despite divisional recovery plans reported into safeguarding committee. • Mental Capacity Act (MCA) audit for February 2022 shows that 45.71% of patients who lacked capacity had a stage 2 assessment undertaken (52.38% in January 2022). Discussion with patient's relatives or attorney has also decreased to 47.44% (70.31% December 2021)		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF IPC BAF Corporate risk 2066; Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels Corporate risk 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'	
Resource implications	None	
Legal and/or Equality and Diversity implications	No negative impact	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

Walsall Healthcare NHS Trust

Director of Nursing Report – April 2022

Introduction

The following report details the Trust positon regarding key nurse indicators and the progress towards the strategic objectives detailed in the Trusts Safe, High Quality Care Board Assurance Framework which can be found in Appendix 1. The Trust continues to have a low-risk appetite for compromising quality and safety of patient care.

Current Position

CQC action plan update

The CQC report following the unannounced inspection of maternity services was published on the 1st October 2021. The division have developed an action plan and progress is being made against the actions. An oversight group is in place to monitor progress against the actions and improvement made.

A corporate action plan is in place to ensure that those actions outside of divisions control and requiring a Trust wide approach to change are led by an Executive Director. Progress against these actions is through TMC to board.

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Falls

The number of falls inpatient falls recorded for February 2022 is reported as 61 a decrease from the 87 reported in January 2022. No severe harm falls were reported in February 2022

The Royal College of Physicians average performance of 6.63 falls per 1000 occupied bed days has been achieved continuously for the past rolling 19 months, and February 2022 has seen a return to previous reported levels.

Falls per 1000 bed days was 3.79% during February 2022 (5.87% in January 2021). The number of incidents increased significantly in relation to repeat falls in month. A themed review has taken place and the lessons learnt shared with the divisional teams.

A Falls Accountability meeting is currently being set up with a plan to run fortnightly and will commence in April 2022. This will enable a summary of outcomes on avoidability, level of harm and lessons learnt sent to correlated trust wide to drive future falls prevention strategies

Tissue Viability

The total number of Trust acquired pressure ulcers in February 2022 is 29. There has been a slight increase in pressure ulcers reported from January 2022, but this remains within normal variation.

Collaboration across Walsall Healthcare NHS Trust and Royal Wolverhampton NHS Trust continues in relation to the tissue viability work stream. The CCG have agreed that all pressure ulcers will be reviewed using a rapid review process within five days of reporting to ensure prompt action and learning.

Venous Thromboembolism (VTE)

VTE compliance for February 2022 was 93.22% (compared to 91.58% in January 2022), compliance rates remain steady but below the Trust target of 95%.

Sepsis

The Trust is aware of issues relating to the accuracy of sepsis reporting where results from manual audits differ from system generated results. Work with System C has shown user issues with de-escalation of patients which are exacerbated by non-friendly user interfaces on E-Sepsis. System C and the digital team are addressing these. Manual audits continue to provide assurance.

A Trust wide deteriorating patient group commenced in March 2022.

Clostridium difficile (C. diff)

The Trust internal target for 2021/22 has been agreed at 29 cases; the national target has been set at 33 cases. The Trust has reported 27 cases to the end of February 2022 for the financial year 2021/22.

There was one reported case in February 2022. A review has identified that the case was an unavoidable incidental finding. There were multiple risk factors and no recent antibiotic use.

Surgical Site Infections

Two cases of deep surgical site infection within trauma and orthopaedics were reviewed in February 2022. Both cases were deemed avoidable due to a lack of assurance as a result of the absence of documentation.

The findings have been shared with the division and SSI Group for action and monitoring.

Outbreak management

The Trust continues to screen all patients admitted to the Trust for COVID-19 and has a programme for repeat screening during a patients stay.

There have been 28 bay closures during February 2022 due to unexpected COVID-19 cases being identified as part of the Trusts routine screening.

Norovirus

At the beginning of March 2022 Norovirus outbreaks were reported within areas of the local community and the Trust closed two full wards and bays on a further two wards due to Norovirus.

Outbreaks have been managed in accordance with the Trusts Outbreak Policy and the CCG and UKHSA have reported that they are assured that the Trust is taking all the required actions to manage the outbreaks.

Percentage of observations undertaken within timeframe

The prevalence of timely observations has increased slightly to 87.89% in February 2022 from 86.28% in January 2022 and remains above the Trust target of 85% for the eleventh month running.

Mental Capacity Assessment (MCA)

Audit for February 2022 shows that 45.71% of patients who lacked capacity had a stage 2 assessment undertaken: this is a decrease from 52.38% in January 2022. Discussion with patient's relatives or attorney has also decreased to 47.44%. Compliance and actions taken to improve compliance are monitored through the safeguarding committee.

The FORCE team have undertaken focussed training sessions as part of their teaching Friday events to support staff in undertaking assessments of capacity, documentation and ReSPECT.

Safeguarding, Prevent, DoLs, MCA and Dementia Awareness Training

Safeguarding Adult and Childrens levels 1 and 2 training remain above trust target. Level 3 training remains under target for both adults and children. Despite improvement plans being pesented to the safeguarding committee level 3 training for adults and children remains below target. Divisions have confirmed that staff are booked onto training over the coming weeks and the safeguarding team are undertaking a review of the content of training

Safe Staffing

Vacancy position

The RN and Midwifery vacancy rate for January 2022 was reported as less than 1%. February data is not available at the time of writing the report.

The Trust is currently experiencing significant vacancies in the Health Visiting team and there is significant focus on how the Trust can attract individuals to apply for these posts, how we recruit RNs and provide training opportunities, the use of the Clinical Fellows programme and international recruitment.

Recruitment

189 overseas Nurses have commenced working within the Trust as of the end of February 2022. 121 have completed their OSCE and are now registered with the NMC. A further 18 are due to arrive during March 2022 and a further 2 are expected in April 2022.
Pastoral care is being delivered by the CFP team and FORCE. Ten Practice Educator Facilitators and a Matron for International Nurses are established in post and are providing support and education in practice.

By the end of February 2022 there were 28 Clinical Support Workers interviewed for substantive positions and 49 successfully interviewed for bank positions. Inductions are taking place in March 2022 with further inductions planned throughout the year.

Eight Trainee Nursing Associates (TNAs) are expected to qualify in June 2022. A further six are expected to complete in September 2022. Nine TNA's commenced the programme in September 2021 and are expected to qualify in November 2023.

Fifteen Student Nurses have been allocated positions to commence in the Trust as Newly Qualified Nurses in January/February 2022.

Temporary staffing

There has been a slight decrease in off framework agency use during February 2022 with a total of 4385.42 hours compared to 4882.5 hours reported in January 2022. The highest use areas for off framework agency staff are ED using 1062.75 hours and ICU using 2239.75 hours.

An ED business case is currently being finalised which if approved will replace this temporary staffing use with substantive staff in line with national standards and the evidence base gained from data collected using the BEST tool. A business case to substantively establish the ICU in accordance with the current and ongoing demand for ICU capacity has been supported by the ICS and recruitment is now underway. Once these posts are recruited to, the use of temporary staff will cease.

The Head of Workforce is working with the Divisional Directors of Nursing to ensure a clear plan is in place for ceasing agency use across the Trust.

Staffing hub

The Virtual Staffing meetings have returned after the closure of the Staffing Hub at the end of February 2022. Matrons are asked to review the 72 hour forecast as part of that staffing review. The virtual meeting provides oversight of staffing levels across the Trust and supports and facilitates the speedy escalation of issues in relation to staffing, acuity and outstanding shift demand. The staffing meetings occur twice daily and are Matron-led; staffing meeting documentation is being collated after the meeting by Corporate Nursing staff. These meetings provide a forum for re-deploying staff across clinical units and divisions, management of red flags, assurance regarding safe staffing levels across the Trust and escalation if risks cannot be mitigated.

Through the safe staffing meetings 1069 hours of RN and 427.5 hours of CSW were re-deployed across the Trust in February 2022.

Red Flags

The SafeCare system is in place across the Trust to record staffing numbers, patient acuity and red flags aligned to NICE guidelines. Red Flags are recorded, reviewed and where possible mitigated, within the safe staffing meeting. Matrons oversee the accuracy of the Red Flags recorded and their appropriateness.

In February 2022 there were 154 Red Flags that were raised and 33 of those were resolved and mitigated during the safe staffing meeting. For the 121 Red Flags that could not be immediately mitigated this is escalated to the appropriate Divisional Director of Nursing for oversight, support and decisions regarding next steps via the Nursing and Midwifery Advisory Forum.

Nursing Strategy

The Trusts Nursing Strategy was approved by the board in 2019. Due to the pandemic the strategy was not embedded across the organisation. There is now an opportunity, with the collaboration with RWT, to review and build on the strategy. An away day with the senior nursing, midwifery and AHPs team took place on the 24th March 2022 to focus on the Trust developing a multi-disciplinary strategy for the non-medical clinical workforce aligned to work previously done internationally and at RWT with the Clinical Systems Framework.

Over the coming month's further work will done to engage with staff across the Trust in developing the framework with clear quarterly goals and measurable outcomes. The framework will be launched later in the year with wider engagement commencing on the 12th May 2022, International Nurses Day.

T34 Syringe Drivers

The Trust purchased T34 syringe drivers in 2021 and delayed roll out due to the pandemic. On the 25th April 2022 these will be rolled out across the Trust. There is a training need prior to roll out and this will take place in the month preceding implementation.

The palliative care team will provide on-site support to wards during and post implementation and all other types of syringe driver will be removed from clinical practice.

AMU improvement plan

The AMU Board had their third meeting on 10 March, many of the business as usual actions were transferred to the Task & Finish groups to progress, and the remaining actions are assurance actions specific to the board.

Progress captured from this groups last meeting are:

- Data currently being gathered for the Health Education England (HEE) response and good progress has been made so far.
- The agreed Key Performance Indicator (KPI) dashboard amendments have been made and forwarded to the data team to populate.
- General Internal Medicine rota provided and to be amended.
- Vacancies added to the dashboard
- Audits confirmed and included in the dashboard.

MEETING OF THE PUBLIC TRUST BOARD Wednesday 6th April 2022			
Patient Voice Report Bi-monthly - January-February 2022			
Report Author and Job Title:	Garry Perry Associate Director Patient Relations and Experience	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	The Trust average compliance rate for complaints (response timeframes) for January and February 2022 was 95%. This is an increase of 2% when compared to the previous quarter, which was 93%.		
Advise	Response rates for the Friends and Family Test have increased significantly 2817 in the two month's Jan-Feb more than the whole of quarter 3 (Oct-Dec 21)		
Alert	No issue of risk/concern this quarter		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☐		

1. PURPOSE OF REPORT

To provide summary data for the Patient Relations and Experience Team including Complaints, Concerns, Compliments and the Friends and Family Test (FFT) for the months of January and February 2022. The report also provides detail on learning taken and a summary of enhanced activity to support a positive Patient Experience.

2. BACKGROUND

A report on patient and carer experiences has traditionally been presented to the Quality Patient Experience and Safety Sub-Committee on a quarterly basis and the Board of Directors as part of the series of quality reports. The timing of this report has now moved to bi-monthly in line with the new Trust board meeting schedule. This report focuses on patient and carer experiences and how people are involved in shaping service developments. Feedback identifies themes for improvement and learning arising from outcomes.

3. DETAILS

3.1 Feedback data

The Trust received a total of 9450 feedback contacts in January and February 2022.

Complaints	55
Concerns	484
Compliments	74
Friends and Family Test	8580
Mystery Shopping (QR code)	257

Table 1. Patient Feedback by contact type

3.2 Theme type

The top 3 trends for **complaints and concerns** relate to clinical care, assessment and treatment, appointments and communication which also featured in the mystery patient feedback albeit there were more favourable ratings than negative. Negative themes for friends and family feedback (poor to fair) relate to respect and dignity, environment, and facilities however positive feedback good to excellent rated for courtesy of staff, environment, dignity, and respect.

3.3 Friends and Family

Area	% January	% February	Change
In-patients	83	86	↑ 3%
Outpatients	92	93	↑ 1%
Emergency	76	81	↑ 5%
Community	96	97	↑ 1%
Antenatal	94	71	↓ 23%
Birth	79	79	− No change
Post-natal ward	90	80	↓ 10%
Post-natal community	70	80	↑ 10%

Table 2. Friends and Family

% changes reflect positive recommendation score increases for in-patients, outpatients, the emergency department, community services and the post-natal community. There were no changes to the scores for birth, with reductions in antenatal, post-natal ward.

3.4 Mystery Patient feedback

The mystery patient feedback is collected via a bedside/departmental poster which also includes a link to provide friends and family feedback via a QR code linked to the area.

257 patients provided feedback via this route during January and February. 217 comments were positive with treatment/care and customer service the most commented on.

40 patients provided less positive feedback with communication, customer service and systems/processes commented upon.

Near time action: food temperature, access to refreshments in the Emergency Department and signposting to carers support are examples of response outcomes.

4.0 Complaint response times

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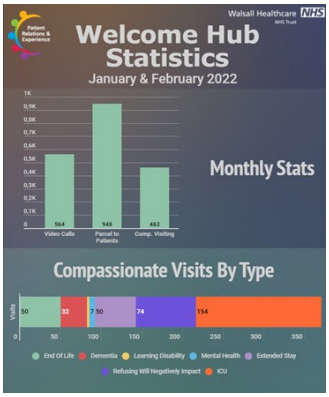
The Trust average compliance rate (response timeframes) for January and February was 95%. This is an increase of 2% when compared to quarter 3 data.

5.0 Enhancing the Patient Experience

5.1 Visiting

The Welcome Hub continues to provide invaluable support for patients – in January and February:



- 463 compassionate visits were arranged
- 564 video calls undertaken
- 948 Parcels to Patients took place

Compassionate visits were arranged for ICU, where refusing would negatively impact the patient, for end-of-life patients, those with dementia, learning disability, mental health and where a patient had been in hospital for over a week.

5.2 The Manor Lounge

In November 2021 we were successful in being awarded £25,000 from the NHSE/I Voluntary Services Fund. We partnered with Manor Farm Community Association who have provided involvement and support in developing new volunteer roles and overseeing the transfer of the former Wingman Lounge to the new Manor Staff Well-being Lounge now open next to Ward 29. The funding was granted on the basis that we support staff well-being through volunteer roles and involvement.

The NHSE/I team have reviewed the range of projects and have selected the volunteering projects at Walsall Healthcare NHS Trust as an area to celebrate and highlight.

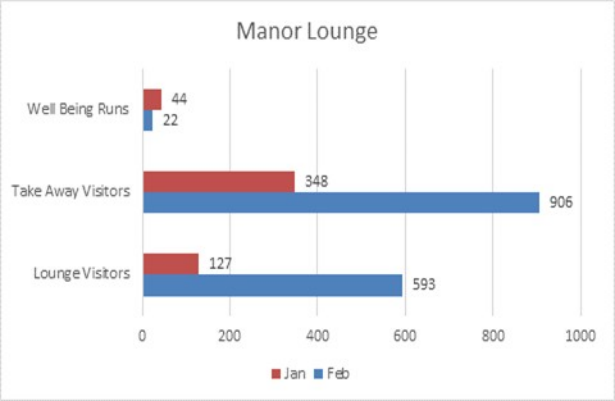
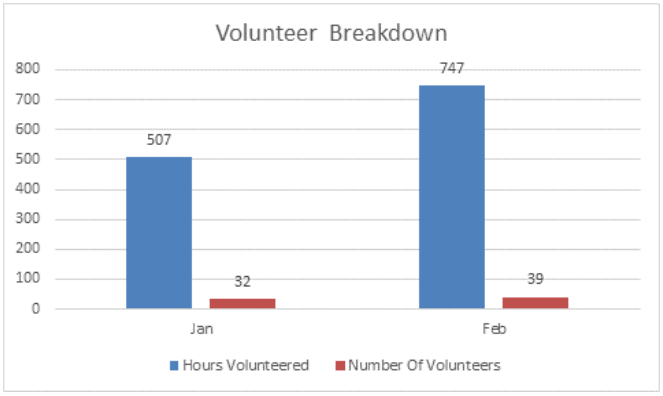


Table 3. Manor Lounge usage data

- 66 well-being runs undertaken (hydration/snacks taken to staff/wards/departments)
- 1254 staff took refreshments away from the Manor Lounge
- 720 staff visited the lounge for a 'break'
- 106 staff completed an experience survey with 4.98 out of 5 the average rating

5.3 Volunteers



- Table 4. Manor Lounge usage data

71 volunteers committed an average of 18 hours per week during January and February. Working in a variety of settings – welcome hub navigators, PPE distributors, refreshment rounds (during omicron impact). Our Enhancing Ward Experience (EWE) volunteers continues to growth in strength, partnered with Juniper Training we have EWE's supporting ward and clinicals areas with new EWE roles now in place in the Emergency Department and Maternity.

5.4 Patient involvement Partners (PiP's)

The Patient Partner programme continues to evolve. Workstreams where partners have expressed an interest in involvement include Patient Information Boards, End of Life Steering Group, Little Voices/Young listeners, the AMU Improvement plan, the Oncology Nurse Specialist out of hours survey and the Patient Experience Group.

4. RECOMMENDATIONS

Note the contents of the report and progress

APPENDICES

1. Summary data reports

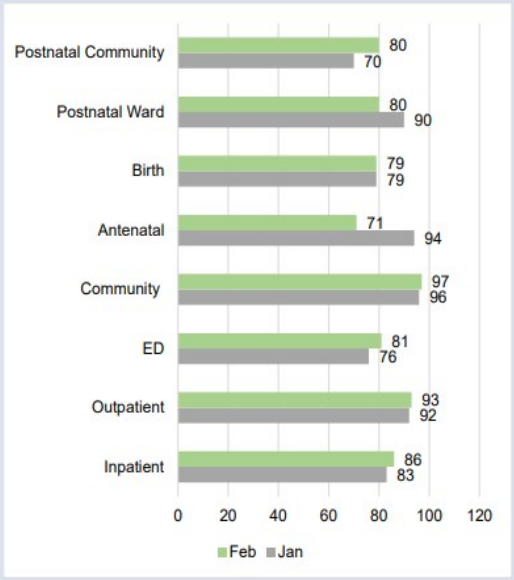
Patient Voice Report

Walsall Healthcare NHS Trust

This Reports Edition: Mar-22

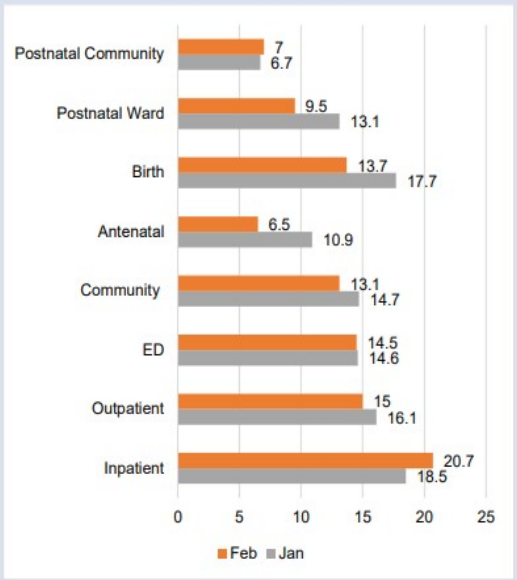
Trust Level Data

FFT Recommenations (%)

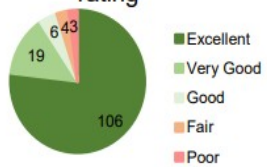


Friends & Family Test (FFT)

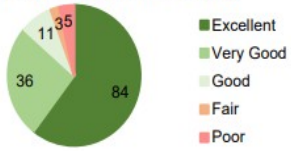
Response Rates (%)



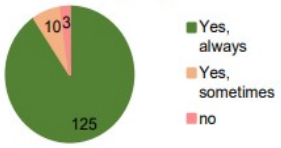
Courtesy of the staff rating



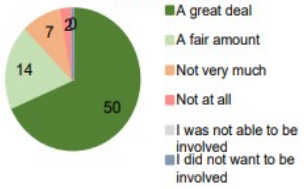
Environment and hospital facilities rating



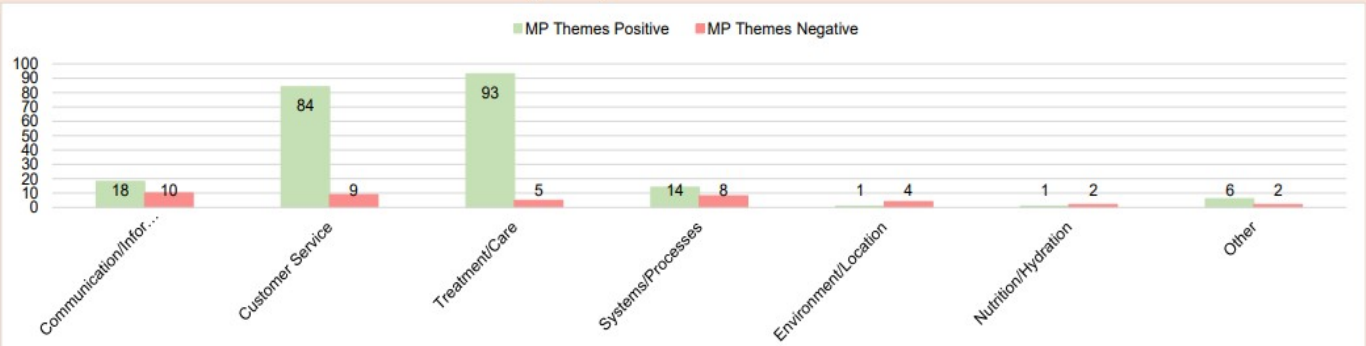
Treated with respect and dignity



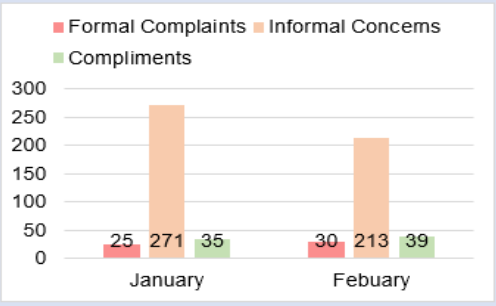
Involvement in care and treatment?



Mystery Patient Feedback



Patient Relations - Complaints, Concerns and Compliments



Informal Concerns/Formal Complaint Themes

	Informal Concerns
1	Clinical Care/Assessment
2	Appontments
3	Communication
4	Access
5	Information

	Formal Complaint
1	Clinical Care/Assessment
2	Attitude
3	Communication
4	Discharge
5	Medication Error

Compliments

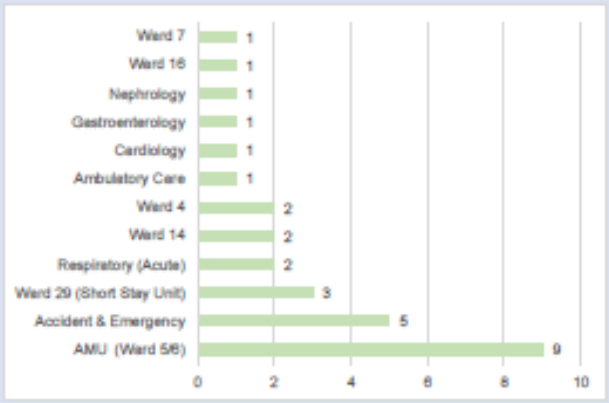
1	Patient explained the staff were fantastic and that the staff treated him with a lot of compassion. Patient wanted to thank all staff for their help.
2	Patient explained the staff were fantastic and that the staff treated him with a lot of compassion. Patient wanted to thank all staff for their help.
3	Compliment has been received for Chaplaincy thanking them for such a wonderful service.

Bi Monthly Report- Patient Relations

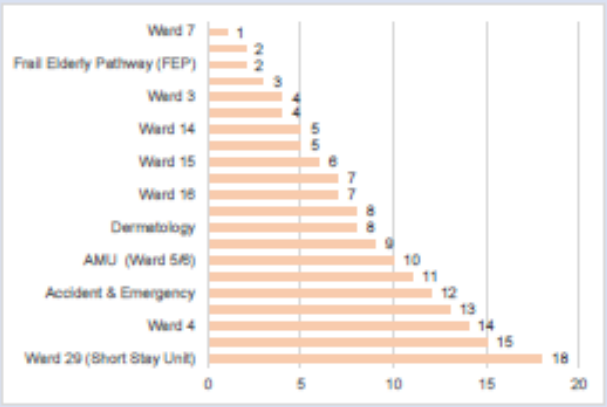
Walsall Healthcare NHS Trust

Medicine & Long Term Conditions

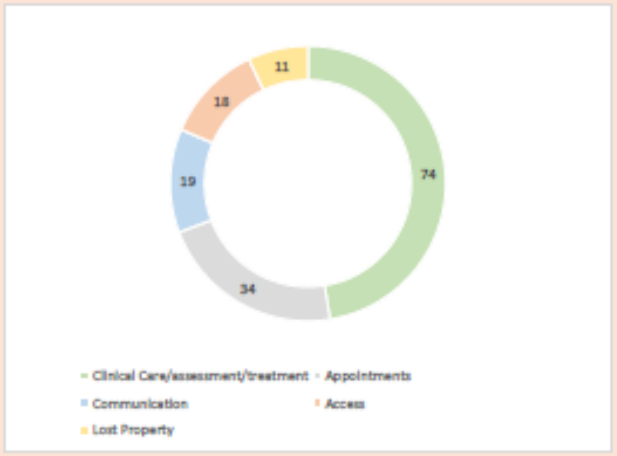
Formal Complaints By Department



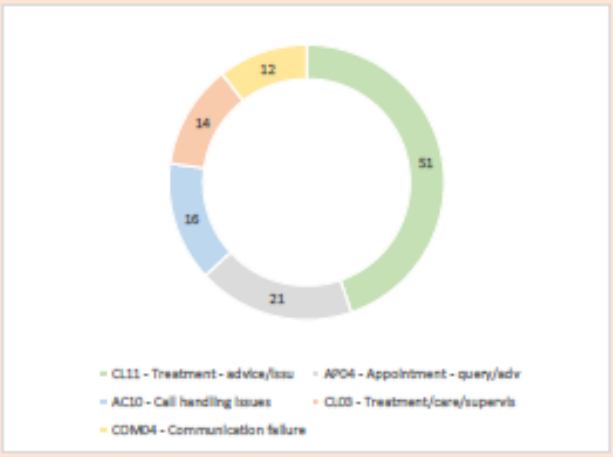
Informal / Queries By Department



Top 5 Category Type



Top 5 Category (further breakdown of category type)



Compliance	
January/Febuary 12/12 -	100%

Learning From Complaints

Case 34368 was a concern raised regarding the level of nursing care the patient received on with nursing care on AMU. Concerns were raised regarding a delay in pain medication being provided and poor communication between staff.

During the investigation it was identified that the communication surrounding the patients discharge could have been better, and it was clear that the patient felt nursing staff were abrupt when they did communicate with her. It was agreed that complaint handler will complete a behaviour and culture review of the acute medical unit working with the medical and nursing teams and will be implementing any necessary actions to ensure improvements.

Contact Us

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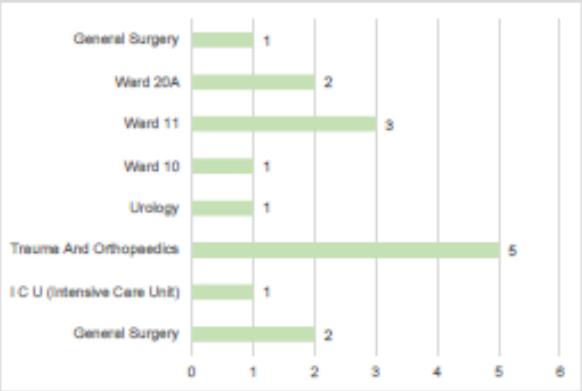
Bi Monthly Report- Patient Relations

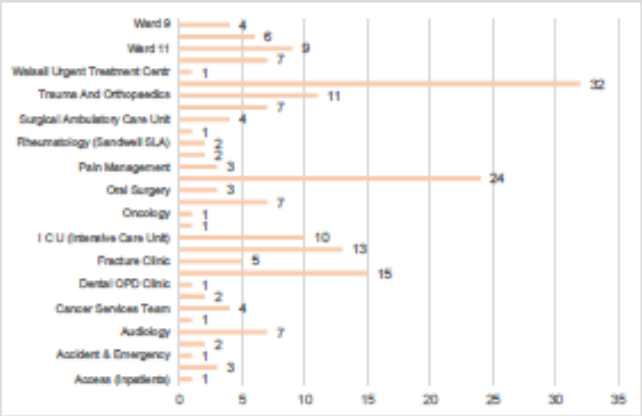
Walsall Healthcare NHS Trust

Surgery

Formal Complaints By Department



Informal / Queries By Department



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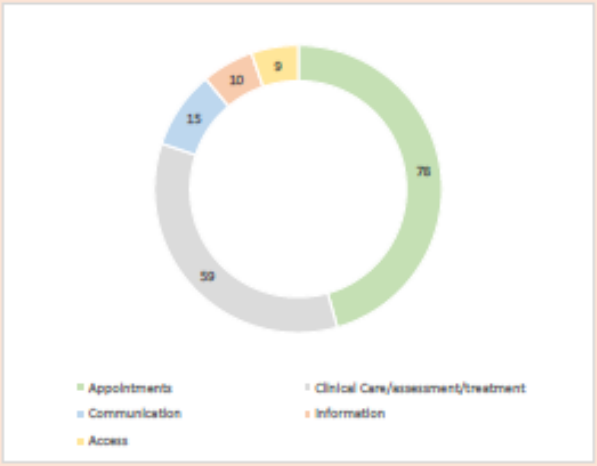

Top 5 Category (further breakdown of category type)

Compliance	
January/Febuary 17/20 -	85%

Learning From Complaints

Case 34647 - Patient had wrote in to raise her concerns about her Trauma & Orthopaedic procedure had been cancelled twice and how this was having an effect on her.
Action - We are operating additional theatre sessions to try and manage the elective referrals and backlog.

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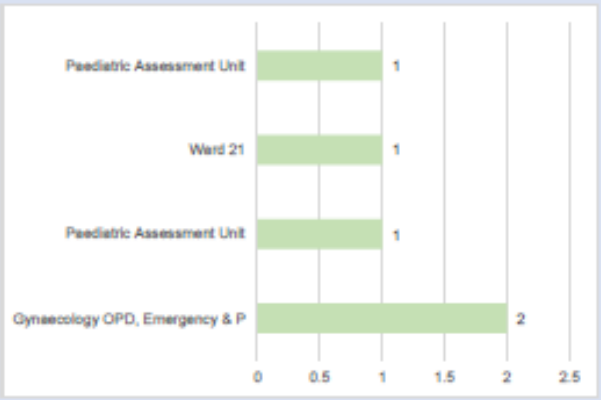
Bi Monthly Report- Patient Relations

Womens, Childrens & Clinical Support Services

Formal Complaints By Department



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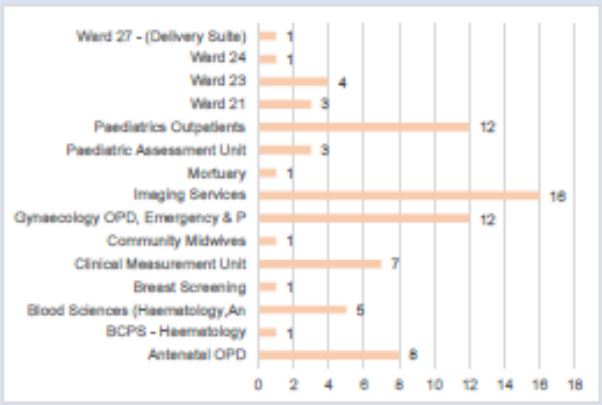

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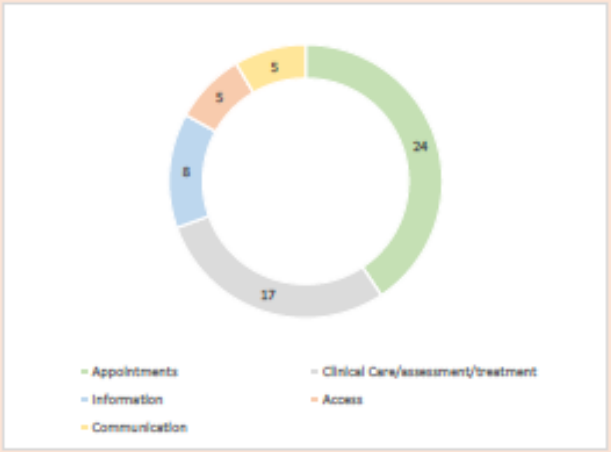

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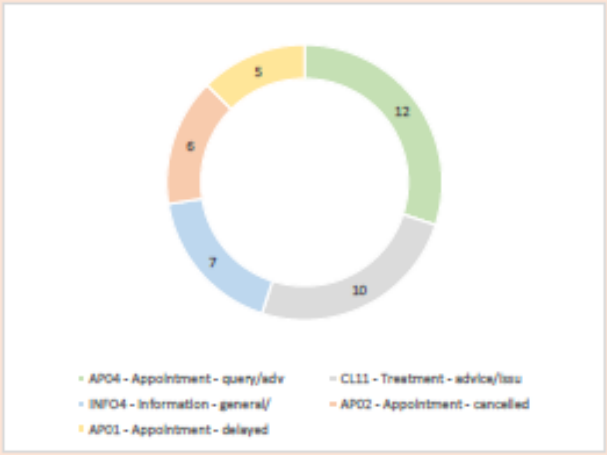

Compliance	
January/Febuary 13/13 -	100%

Learning From Complaints

Case 34493 - Son has a condition called sagittal suture and mother feels this was missed.

Actions/learning

It was agreed that the concerns the family raised will be discussed at the delivery suite and ward meetings. This will ensure that all staff have increased awareness about sagittal craniosynostosis as this is a very uncommon condition. This will also ensure staff can have an understanding of how their words and actions can be perceived differently to that which was intended.

The team also agreed to ensure that written information published by Great Ormond Street Hospital is available on the wards for staff to read and refer to.

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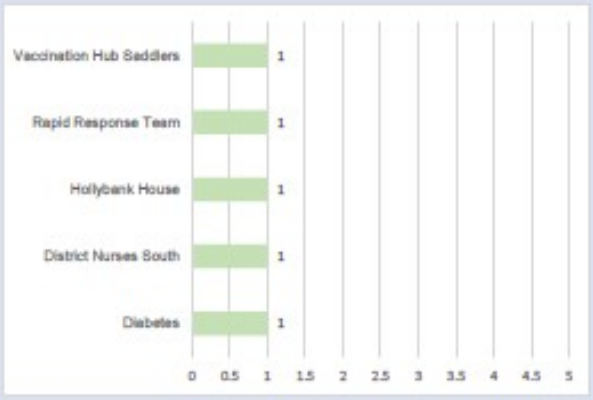
Bi Monthly Report- Patient Relations

Walsall Healthcare NHS Trust

Community

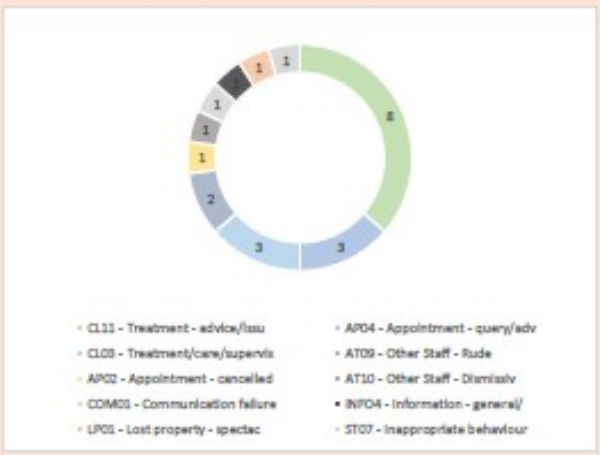
Formal Complaints By Department



Informal / Queries By Department

Top 5 Category Type

Top 5 Category (further breakdown of category type)



Compliance

January/Febuary – No complaint responses due out

Learning From Complaints

Case 34469 was a concern received regarding a family being unhappy with the decision to transfer their relative from community to hospital for catheter insertion. It was felt this could have been avoided if the day team were on duty. The family asked that learning was identified to prevent this happening to another family.

Following investigation it was agreed that there would be a review of the current process undertaken within Palliative & End of Life Care services when a patient is transferred from one CNS team to another CNS to ensure communication is undertaken with patient and significant other.

The team also agreed to undertake a review of the catheterisation policy in order to ensure that it reflects potential risk assessment for patients at end of life - requiring catheterisation at home. The team will ensure decisions and risk assessments undertaken will be fully communicated with patient and significant other to minimise any confusion caused.

A review will be undertaken regarding the bereavement follow up protocol undertaken by Palliative Care teams will be undertaken. It is important that the teams recognise that carer's may benefit from a call from the healthcare professional that may have had a greater volume of contact with patient and family. Higher urgency being recognised for families that experienced traumatic events as loved ones died.

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MEETING OF THE PUBLIC TRUST BOARD Wednesday 6th April 2022			
Black Country Ockenden and Kirkup Bay Update			
Report Author and Job Title:	Carla Jones-Charles – Director of Midwifery, Gynaecology and Sexual Health	**Responsible Director:**	Lisa Carroll – Director Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Assure	• Compliance against the 7 Immediate and Essential Actions as recommended by Ockenden • Compliance against Kirkup recommendations		
Advise	• Internal Maternal Network Pathways in place. • Regional Maternal Network Pathways in its infancy. • Gap analysis completed by Maternity Voices Partnership (MVP), action plan in place to address gaps.		
Alert	• Ongoing support required by Communications and IT to ensure Maternity Website is updated, provides full information to patients and is able to be updated regularly.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022.		
Resource implications	Communications and IT Support		
Legal and/or Equality and Diversity implications	This supports the national agenda in reducing maternal and fetal morbidity in minority groups.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Black County Ockenden and Kirkup Bay recommendations

1. PURPOSE OF REPORT

The purpose of the report is to provide the board with assurance against the 7 essential and immediate actions (EIAs) recommended in the Ockenden Report and against the Kirkup report (2015).

2. BACKGROUND

On 10 December 2020 The Ockenden Report into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust was published.

The Report includes seven essential and immediate actions (EIAs) to be implemented by Trusts:

- Enhanced safety
- Listening to women and families
- Staff training and working together
- Managing complex pregnancies
- Risk assessment throughout pregnancy
- Monitor fetal wellbeing
- Informed consent

An action plan was developed to provide assurance that the Maternity Services is committed to being fully compliant with all IEAs.

The Trust received a letter from the National Chief Nurse Office dated 25th January 2022 regarding: Ockenden Review of Maternity Service – one year on, advising of the regional oversight process for Trusts and Systems in the Midlands.

As per the letter, we are providing progress on the following:

- Implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance
- Maternity services workforce plans
- Compliance against the Kirkup reports

This report is to provide an update on the actions identified to achieve full compliance against all seven IEAs, Maternity services workforce plans and the Kirkup report which forms part of NHSEI's mandatory assurance processes

Previous assurance has been bought to the board regarding submission of evidence to the NHSEI portal last July 2021. This highlights the progress against all actions not previously completed.

3. DETAILS

Overall the Trust are fully compliant with the Ockenden and Kirkup recommendations (see appendix 1 for Black Country Ockenden Kirkup return with embedded evidence). Action plans are in place and ongoing for two elements as highlighted below. The Regional Chief Midwife has confirmed that having these action plans in place makes the Trust compliant with the recommendations.

- **Ockenden Assurance:**

7 Ockenden IEAs (including 12 Clinical Priorities): Trust Walsall Healthcare NHS Trust Exec Sign off _____	**Compliant**	**Partially Compliant**	**Non-Compliant**
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	✓		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	✓		
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	✓		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	✓		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	✓		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	✓		
Confirmation that funding allocated for maternity staff training is ring fenced	✓		
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	✓		
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	✓ **internal maternal networks are in place. Lead consultant collaborating with the regional networks to support specialist centres.**		
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	✓		
6) Monitoring Fetal Wellbeing			
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	✓		
7) Informed Consent			
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	✓ **Gap analysis completed by MVP and action plan in place to update the maternity website.**		

- **Kirkup Actions:**

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Action Met Y/N
5	**R2**	Review the current preceptorship programme	Y
6	**R2**	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Y
7	**R2, R3**	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Y
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Y
9	**R2**	Review the current induction programme for locum doctors	Y
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.	Y
11	**R2**	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Y

12	**R2**	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Y
13	**R2**	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Y
14	**R2**	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	Y
15	**R3**	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.	Y
17	**R3**	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations	Y
20	**R8**	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	Y
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention	Y
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	Y
26	**R11, R12**	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.	Y
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	Y

36	**R26**	Ensure that all staff are aware of how to raise concerns	Y
37	**R31**	Provide evidence of how we deal with complaints	Y
38	**R31**	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Y
41	**R39**	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	Y

4. RECOMMENDATIONS

For the committee to review and approve.

APPENDICES

Appendix 1 – Black Country Ockenden and Kirkup return

Appendix 1 - 20220125 Black Coun

Completion Guidance:

1. Overview tab – please complete in full
2. Ockenden return tab – this mirrors earlier returns and requires updating on progress to 31/1
3. Kirkup return tab – please note some recommendations have been greyed out – these do n Ockenden recommendations. (There is a 4th tab which details the Kirkup recommendations as

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update
	Yes/No	please insert date
Walsall Healthcare	Yes	06/04/2022
Insert Trust Name		
Insert Trust Name		
Insert Trust Name		

LMNS sign off of the combined trust returns

LMNS Name	Executive	
	Date	Name
Black Country LMNS		

2/2021
ot require completion as they are superseded by information in the a helpful reminder – this doesn't require any completion)

Executive sign off of this return		
Date	**Name**	**Role**
22/03/2022	Lisa Carroll	Director of Nursing

sign off
Role

Ockenden Inital report reccomendations

Results of Regional Update January 22

IEA	Question	Action	Evidence Required
	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.
			Submission of minutes and organogram, that shows how this takes place.
		Maternity Dashboard to LMS every 3 months Total	
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.

			Policy or SOP which is in place for involving external clinical specialists in reviews.
	Q2		
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total	
		Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed
	Q3		
			Submit SOP
		Maternity SI's to Trust Board & LMS every 3 months Total	
IEA1		Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q4		Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total	
		Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.
	Q5	**Submitting data to the Maternity Services Dataset to the required standard Total**	
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.
	Q6	**Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total**	
		Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.
	Q7		Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total	
IEA1 Total			
		Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:
			Evidence of link in to MVP; any other mechanisms
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed
	Q11		Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions
			Name of NED and date of appointment
			NED JD
		Non-executive director who has oversight of maternity services Total	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)
	Q13		Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total	
		Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.
			Log of attendees and core membership.
	Q14		Minutes of the meeting and minutes of the LMS meeting where this is discussed.

Q14		SOP that includes role descriptors for all key members who attend by-monthly safety meetings.
	Trust safety champions meeting bimonthly with Board level champions Total	
Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total	
Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken
		Name of ED and date of appointment

IEA2

	Q16		Role descriptors
		Non-executive director support the Board maternity safety champion Total	
IEA2 Total			
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total	
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)
			SOP created for consultant led ward rounds.
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total	
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance
			Evidence from Budget statements.
			Evidence of funding received and spent.
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.
			MTP spend reports to LMS
		External funding allocated for the training of maternity staff, is ring- fenced and used for this purpose only Total	

IEA3

	Q21	90% of each maternity unit staff group have attended an 'in-house' multi- professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
			Attendance records - summarised
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.
		90% of each maternity unit staff group have attended an 'in-house' multi- professional maternity emergencies training session Total	
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total	
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total	
IEA3 Total			
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total	
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.
		Women with complex pregnancies must have a named consultant lead Total	
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.
		Complex pregnancies have early specialist involvement and management plans agreed Total	
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.
			Guidelines with evidence for each pathway
			SOP's
IEA4		**Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total**	

	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.
			Submission of an audit plan to regularly audit compliance
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total	
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways
			Criteria for referrals to MMC
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total	
IEA4 Total			
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.
			Review and discussed and documented intended place of birth at every visit.
			SOP that includes definition of antenatal risk assessment as per NICE guidance.
			What is being risk assessed.
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics
			Out with guidance pathway.
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.
			SOP that includes review of intended place of birth.
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total	
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)
			How this is achieved in the organisation
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.
			Review and discussed and documented intended place of birth at every visit.
			SOP to describe risk assessment being undertaken at every contact.
			What is being risk assessed.
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total	
IEA5 Total			
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.

		monitoring	Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.
			Incident investigations and reviews
	Q34		Name of dedicated Lead Midwife and Lead Obstetrician
	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		
Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	
		Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	
		Improving the practice & raising the profile of fetal wellbeing monitoring	
		Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	
		Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	
		Keeping abreast of developments in the field	
		Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	
		Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	
	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		
Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	
		Guidelines with evidence for each pathway	
		SOP's	
	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		
	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	
		Attendance records - summarised	

IEA6

	Q37		Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total	
IEA6 Total			
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total	

IEA7	**Q41**	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.
			CQC survey and associated action plans
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.
		Women must be enabled to participate equally in all decision-making processes Total	
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.
		Women's choices following a shared and informed decision-making process must be respected Total	
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total	
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified
			Gap analysis of website against Chelsea & Westminster conducted by the MVP
			Information on maternal choice including choice for caesarean delivery.
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total	
IEA7 Total			
		Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan
Q45			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.
			Most recent BR+ report and board minutes agreeing to fund.
	Demonstrate an effective system of clinical workforce planning to the required standard Total		
Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?		Most recent BR+ report and board minutes agreeing to fund.
	Demonstrate an effective system of midwifery workforce planning to the required standard? Total		
Q47	Director/Head of Midwifery is responsible and accountable to an executive director		HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director
	Director/Head of Midwifery is responsible and accountable to an executive director Total		

Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met
		Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care
	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total	
Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.
		Evidence of risk assessment where guidance is not implemented.
		SOP in place for all guidelines with a demonstrable process for ongoing review.

WF

		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total	
WF Total			

Key to evidence	
Evidence completed and submited	
Updated March 2022	
WALSALL	Evidence
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100%	Review of maternity Leadership Requirements Action plan completed (Enc 39)
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Kirkup report recommendations Regional Update 31st December 2021
Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further	Action	Suggested documents that may support Trust assurance.	WAS/ALL	
1	R1, R13, R24	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's)		NA
			Women and their families are kept informed of the progress of the investigation		
			Women and their families are invited to contribute to the investigation process		
			Offering an apology		
2	R1, R13	Review the current processes for obtaining feedback from the public to increase the information received	Ensure that all nurses and midwives are aware of their responsibilities in relation to the duty of Candour and their NMC Code		
			Offering women and their families the opportunity to make suggestions e.g. "You said …we did…"		
			Ensuring that national/ local awareness opportunities are utilised effectively e.g. International day of the midwife/ nurse.		
			Continue to support the LSA in the feedback mechanism to staff from service users regarding our service		
			Share patient stories		
3	R2	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered		
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working		
5	R2	Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team.	31/4/21	Band 5 midwives all have preceptorship document booklet to rotate to all areas. For each area they will meet their preceptor/buddy for that area and identify them in the document. They have regular meetings with the practice development midwife and ward managers thoughout the process.
			The buddy midwife is allocated time to support the preceptee		
			Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is struggling to attain certain clinical skills		MaternityPerceptorship New Starter Process (Enclosure 3) & Competency Document (Enclosure 4) and Maternity Induction and Orientation package (Enclosure 8)
			Midwives are confident and competent to go through the gateway within the agreed timeframe		Midwifery Clinical Update (Enclosure 5) , Maternity Perceptorship Competency Document (Enclosure 4), Skills Drills for New Starters (Enclosure 6), Maternity Induction and Orientation package,(Enclosure 8)
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	31/4/21	Feedback received and working through with Practice Development Midwife. (Enclosure 7).

7	R2, R3	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green	Maternity Perceptorship Competency Document (Enclosure 3) used as basis to assess and support new band 6 midwives and Maternity Induction and Orientation package (Enclosure 8)
			Completion of the Mentoring module		The term and role mentor has been updated in line with the new Future Nurse Standards. Practice Supervisor & Assessor is now used instead of mentor and teaching around this is on the MCU training (Enclosure 9)
			Suturing competency		Competency document Perineal Suturing (Enclosure 10)
			IV therapy competency		Competency Document IV canulation (Enclosure 11)
			Care of women choosing epidural anaesthesia.		Study pack for epidural anaesthesia (Enclosure 40)
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green	MaternityPerceptorship New Starter Process (Enclosure 3) & Competency Document (Enclosure 4) and Maternity Induction and Orientation package (Enclosure 8)
9	R2	Review the current induction programme for locum doctors	Locum policies	Green	Please note WHT has had no external locums for past 3 years. Locum pack (Enclosure 12) Clinical passport (Evidence 13)
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.		Green	
11	R2	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green	The AIMS course is not completed by maternity staff. The midwives and obstetricians complete PROMPT training (Enclosure 14). PROMPT training shares the principles of AIMS training that of recognition of the deteorating patient, escalation and treatment of concerns and deviations. Enhanced maternity care document (Enc 15)
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green	Re-certification of competence for Transitional Care (Enclosure 16). Transitional care training document (Enclosure 17)
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news		Green	Flow chart detailing how learning is shared (Enclosure 18)
15	R3	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.		Green	Communication from Inpatient matrons detailing rotation process and plan to implement full change list for rotation in July 2022. Rotation list 2021 (Enclosure 19)
16	R2, R3, R8	Review and update the Education Strategy			NA
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green	Both documents detail support to staff (Enclosure 3) , the Personal Oerientation pack details supernumery status (Enclosure 8)
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status			NA
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate			
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate		green	Recruitment and retention strategy from both Obstetrics (Enclosure 20) and Midwifery (Enclosure 21).
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas		NA	
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green	Guidance on Completing Leavers discussions for Manages (Enclosure 23).
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns		Green	Examples of Junir doctors forum minutes (Enclosure 24) , Inpatient (Enclosure 25) and Outpatient forum minutes (Enclosure 26)
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.		NA	NA
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.			
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green	Cascading learning from incidents (Enclosure 18) and Personal Induction and Orentation Document (Enclosure 27) taught on mandatory training.
27	R11, R12	Including a review of the processes for disseminating and learning from incidents			NA
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	green	List of all trained staff Enclosure 22)
			Identified midwives to have completed RCA training		List of all trained staff Enclosure 22)
			Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills		Since 2019 most maternity cases fitting a specific criteria are investigaed by HSIB. (Enclosure 28) - Cases not fitting the criteria are investigaeed by individuals who have had investigative training (Enclosure 29)
			Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)		List of all trained staff Enclosure 22)
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents			NA
30	R12	Ensure that all Serious Incidents (SI's)are feelback to the staff			
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions			
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports		
33	R14	Review the current obstetric clinical lead structure			
34	R15	Review past SI's and map common themes	Thematic reviews		
35	R23	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports		
36	R26	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green	Midwifery Clinical Update Agenda (Enclosure 30) Raising concerns flowchart is available for staff (Enclosure 31) and how to report an incident and raising concerns on Safeguard (Enclosure 32)
37	R31	Provide evidence of how we deal with complaints		Green	Trust Formal investigation of complaints process and policy detailing guidance regarding local resolution (Enclosure 33).
38	R31	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green	The Trust policy on complaints includes support for local resolution (Enclosure 34) and the Trust has developed a new training programme which includes local resolution (Enclosure 35).
39	R32	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model		NA
40	R38	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager		
41	R39	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Green	A GAP analysis has been completed by the Bereavement Midwife and Consultant. Presentations (Evidence 36 & 37) have been presented a gap analysis actio plan (Evidence 38).

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.

5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non- executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.

32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow- up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

MEETING OF THE PUBLIC TRUST BOARD Wednesday 6th April 2022			
WHT Safeguarding Update Report Q3 (Oct-Dec 2021)			
Report Author and Job Title:	Fiona Pickford Head of Safeguarding	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	• Safeguarding Training compliance overall is in line with WHT and CCG expectations • Substantial work has been completed in regard to the Safeguarding Development Plan and subsequent work. • Improvement has been noted in the completion of most outstanding actions in respect of WHT Safeguarding Case work (as a result of the newly formed internal practice review group which oversees the partnership DHR, SAR and CSPR work). • WHT participated in Walsall Partnership assurance audits in respect of Section 11 (Children Act 2004) and Care Act 2004 during Q3. The feedback from the partnership was that WHT had good governance arrangements overall.		
Advise	• Significant staff shortages (safeguarding children and maternity team) during Q3 have had an impact on contributing to Walsall Partnership work. This has been included on the risk register. To note this is now resolving in Q4. • The outcome of 'the expansion to the safeguarding team' (as progressed as part a business case is expected in early Q4. • DBS reporting to the CCG has been suspended until Q4, due to concerns around the accuracy of the data supplied by WHT workforce. This has been escalated for resolution. • Children's MASH and Domestic Violence activity remains consistently challenging throughout this quarter due to the complexity of cases being discussed. During Q4, the CCG are reviewing the funding framework around the working model.		
Alert	• Safeguarding Training Level 3 (adults and children) compliance has shown a slight variation during this period, as a result there will be an overall review of the delivery of this programme during 2022.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risks implicated in this report		
Resource implications	There are costs associated with the expansion of the safeguarding service, as highlighted in the business case.		

Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.”	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☒
	Resources ☒	

Safeguarding Update Report Q3 (Oct – Dec 2021]

1. PURPOSE OF REPORT

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

2. DETAILS

The key points from the report include:

- The Safeguarding DASHBOARD has been submitted on a monthly basis to the CCG (at CQRM) following scrutiny at the Trust Safeguarding Committee.
- The Safeguarding Midwife post has been successfully recruited to. The new post holder will join the team in April 2022.
- It is noted that from October to December 2021, compliance in all mandatory safeguarding training has been maintained with a small deviation in Level 3. Ongoing work with the divisions is in place, but a further review of the safeguarding training programme is expected during 2022 to consider alternative forms of training programme delivery. The WHT Board have received their annual training during Q3.
- WHT have attended all CCG and LA partnership meetings.
- Progress has been noted in completion of actions aligned to the Safeguarding Development Plan. There is further work to be progressed in regard to audit (in particular oversight of the Child Protection Information System known as CP-IS in ED). This work will conclude by April 2022.
- WHT internal CSPR/SAR/DHR/LeDeR Group formed in December 2021 continues to meet on a bi-monthly basis to review and update all actions aligned to the organisation
- The number of MASH checks completed by the safeguarding children team has remained consistently high and complex in nature. For domestic violence activity, it is noted that there has been a 25% increase in activity overall.
- The number of DoLS applications submitted has been monitored during Q3. It is noted that there was a reduction in December from 36 (in November) to 26 (in December). This has been attributed to staff shortages.
- Safeguarding supervision compliance for Health Visitors, School Nurses and Community Midwives has been static. (89-95%).
- During Q3, WHT participated in Walsall Partnership assurance audits in respect of Section 11 (Children Act 2004) and Care Act 2004. The feedback from the partnership was that WHT had good governance arrangements overall.

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

This Q3 2021/2022 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 Wolverhampton Safeguarding Together 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**
Data to be provided in the Safeguarding Department Annual Report (November 22)
d. All health providers are required to have effective arrangements in place to safeguard Children and Adults at risk of abuse or neglect; are compliant with the Counter-Terrorism and Security Act 2015, and to assure themselves, regulators and their commissioner that these are working. These arrangements include: • Safe recruitment practices (to include safe recruitment standards – DBS) and arrangements for dealing with allegations against people who work with adults, children or vulnerable children as appropriate.

- Safeguarding responsibilities are included in all staff job descriptions.
- A suite of safeguarding policies.
- Effective arrangements for engaging and working in partnership with other agencies.
- Demonstrate that the organisation is managing allegations against staff in line with Safeguarding Partnerships and Safeguarding Adult Boards (this must include reference to risk assessments and clear process when protection thresholds in the local authority are not met). This includes referrals to the Local Authority Designated Officer for concerns around children's safeguarding and referrals relating to persons in position of trust in relation to adults. This must also include review of Prevent concerns around staff.
- Identification of a Named Doctor and Named Nurse (and a Named Midwife if the organisation provides maternity services) for safeguarding children and adults. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professionals from any relevant health or social care background.
- Evidence that there is a safeguarding team in place in accordance with specifications set out in the Intercollegiate Documents for Adults (2018), Children (2019) and Working Together (2018).
- Named professionals for Children and Young People in Care.
- Identification of a Named Lead for Adult Safeguarding.
- MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.
- Prevent Lead.
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- Information sharing (including Duty of Candour) in line with local, regional and national requirements.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the MCA 2005 and Children Acts 1989/2004.
- Demonstrate that safer recruitment standards are monitored by the Executive Director and action taken where they fall short of expectations (i.e., charity

visitors, volunteers, celebrities and agencies are monitored by the Executive Director and are consistent with their own HR internal policies).

- Demonstrate how the organisation manages requests for access from volunteers, paid/unpaid charity fundraisers, celebrities and 'friends' of the organisation and has a policy in place to reflect this.
- Demonstrate that there are systems in place to report unsafe practice to external professional bodies (i.e., Police, DBS, NMC, GMC).
- Demonstrate that the organisation has a policy regarding internet and social media use which addresses safeguarding.

Annual Submission

Full data to be provided in the Safeguarding Department Annual Report (November 22).

To note, a business case was submitted at the end of Q3 to request funding for additional safeguarding posts. This was approved in February 2022.

During Q3, there has been a request for WHT to provide assurance against the DBS recording process (evidence of compliance required for the monthly safeguarding dashboard). This has been escalated to the Director of Nursing and HR. Further work in Q4 has subsequently taken place (between HR and Workforce) to ensure that this will be reported on imminently.

NHSI Learning Disability and Autism improvement standards

WHT has enrolled on the annual submission

- Organisational processes
- Service user feedback
- Staff feedback

The Risk and compliance team are supporting with the co-ordination of data collection, from Performance, complaints, governance, and safeguarding. The access to the staff survey has been distributed directly to the teams and promoted more widely through trust communications. The Learning Disabilities acute liaison nurses are supporting the service user feedback surveys.

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.
WHT Safeguarding Training Compliance is reported on a monthly basis at the Trust Safeguarding Committee (for each Division) and via the Safeguarding Dashboard (attached ***SG Dashboard***). It is noted that from October to December 2021, compliance in all mandatory safeguarding training has been maintained with a slight deviation. All compliance is now at, or in line with CCG and WHT requirements. Poor compliance for Adult Level 3 training (<85%) during Q3 was discussed on a monthly basis with the Divisions for their attention and support. Staff shortages were cited as a key reason for this deviation. During Q3 Safeguarding Children Level 3 training was maintained at over 88% predominantly. To note that the safeguarding team are able to provide bespoke training to teams and ensure that through supervision and regular contact via ward/community team contact that key messages are disseminated appropriately. WHT Board members received their annual training on 6.10.21 by the Safeguarding Team. This was well received and will be repeated during Q3 2022. During Q4/Q1 there will be a review of the safeguarding children and adult training programme to ensure it continues to reflect local/national guidance and will be benchmarked across other local health provider services too. Staff training in relation to 'Learning Disabilities is in line with the level 3 safeguarding adults compliance as it forms part of level 3 training. An e learning autism package has been developed for all staff to have a basic awareness of autism. It is expected that formal reporting can commence during Q1.
3. a. Safeguarding Named Doctor/Nurse/Midwife/Named Professionals/Safeguarding Specialists should have access to advice and support and a minimum of quarterly safeguarding supervision with Designated Professionals. b. Professionals supervising staff or working on a day to day basis with adults, children and families should have child and adult safeguarding supervision available to them, appropriate to their role and responsibility in order to promote good standards of practice.

During Q3, the Safeguarding Team specialists, including Named Doctors have been offered or have had access to safeguarding supervision except for the Named Midwife (as this post was vacant). It is noted that for most safeguarding professionals this supervision is provided externally by the CCG or other experts.

Total number of children community Staff/midwives identified to receive supervision within Q3	**Total number of staff who received supervision within Q3 period**	**Q3 Compliance**
Health Visitors: 37 School Nurses: 19 Community Midwives 51	Health Visitors: 35 School Nurses: 17 Community Midwives 49	**95%** **89%** **93%**

Health Visitor and School Nurse supervision compliance has remained static during Q3. Staff sickness and reduced capacity within these services have been cited as the cause of the 6 staff members who did not complete their supervision within timescale. All outstanding supervision will be automatically provided the following month.

The Safeguarding Supervision Policy was completed in December 2021 and is now awaiting oversight from the newly formed policy group at WHT. Safeguarding supervision is recommended for front line staff as and when required (Adult Safeguarding Roles and Competencies for Healthcare Staff 2018). Nominated WHT Safeguarding champions will receive and deliver supervision on a 3 monthly basis. This will be formally reviewed and Compliance will be collated from Q1 2022-2023. This will be monitored as part of the Dashboard which is presented to the Trust Safeguarding Committee each month.

General support has also been provided to all key areas within the Trust including ED, Children Ward, Sexual Health and community services allowing for ad hoc support on demand.

Safeguarding Supervision training has been completed during Q3 by WHT staff as part of a commissioned training event by Richard Swann (National Safeguarding Supervision Expert)

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.
During Q3, WHT have attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR). WHT internal CSPR/SAR/DHR/LeDeR Group formed in December 2021 continues to meet on a bi-monthly basis to review and update all actions aligned to the organisation. During this period, 1 case was submitted to the practice review group to be considered for a serious adult review. It was acknowledged that the case did not meet the SAR criteria. Members felt it was important to have a multiagency discussion about the case to establish whether there were any concerns or learning in relation to the self-neglect elements. Three new serious adult review referrals were submitted to Walsall 'Practice Review Group' during Q3.All have progressed through to a SAR process (SAR 6, 7, 8) .One review (SAR 5) has now concluded. A CSPR referral was made to Walsall Practice Review Group during Q3, however after an in-depth review it was recommended that this be submitted as a SAR, due to the potential learning being adult focused. It is proposed that this will be a joint SAR with Walsall and Wolverhampton; this will be agreed at One Panel (Wolverhampton) and PRG (Walsall) in Q4. The Learning Disability Team have continued to participate in the 'Learning from

Lives and Deaths' programme. During Q3, WHT have made 7 notifications of LD patients who have died in the care of WHT. Future work is planned to assess if patient notes reflect robust detail around the contact with LD nurses and sufficient documentation is recorded.

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.

During Q3 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

Recommendations are also embedded within mandatory and bespoke safeguarding training.

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

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

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

The recently formed WHT internal practice review group have completed most of the actions that were outstanding. This group meets on a bi-monthly basis (attached **WHT internal practice review group action plan).**

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.

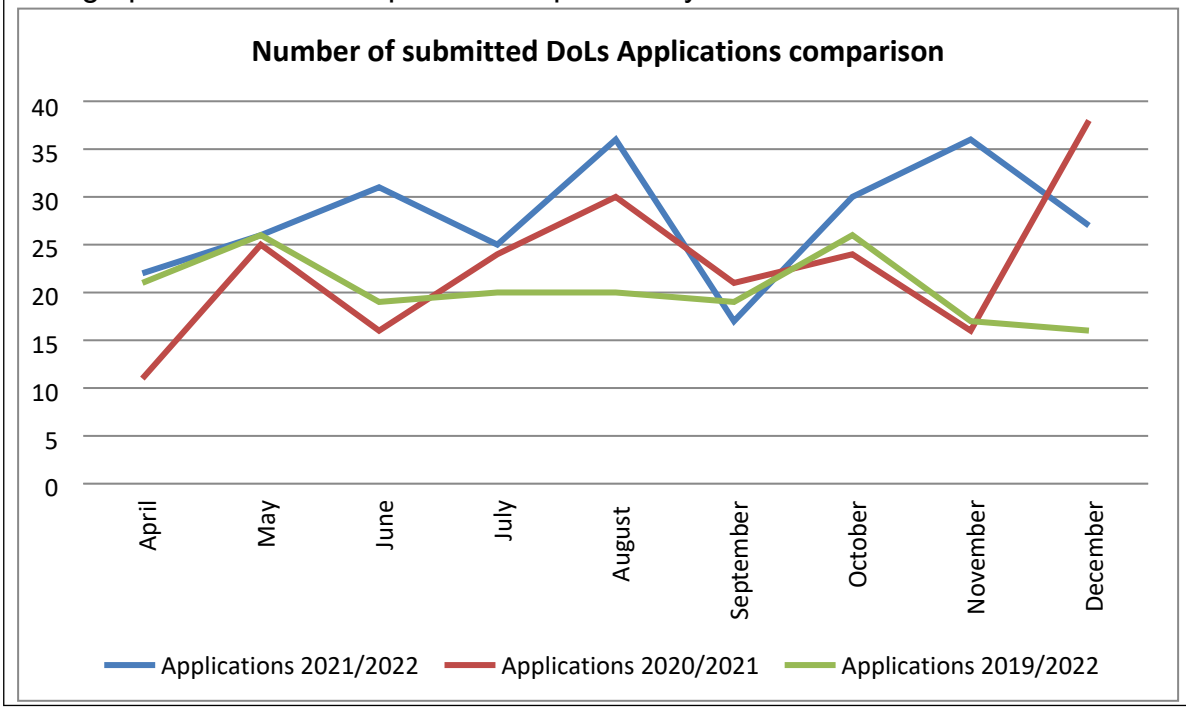
Annual Submission

Data to be provided in the Safeguarding Department Annual Report (November 22)

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.

Safeguarding Adults Activity

The number of DoLS applications submitted in Q3 has varied overall, a trend seen in recent years.
The graph details the comparisons to previous years.



- No Prevent referrals have been made during Q3. This is not unexpected, as Walsall has a low level of activity.
- All Prevent returns have been completed in required reporting timeframe.
- 29 Section 42 enquiries were instigated during Q3, compared to 33 during Q2. Concerns relating to neglect, acts of omission and poor discharge account for the majority of the concerns raised.
- During Q3, WHT were asked to look at the impact of the forthcoming implementation of Liberty Protection Safeguards (LPS). As part of this work, WHT will be looking at scoping a range of opportunities to contribute to this work stream which Walsall CCG will lead on across the Black Country
- The safeguarding team continue to offer support, training, and guidance on the Mental Capacity Act, assessing mental capacity, and completing DoLS applications.

Safeguarding Children Activity

- During Q3, it was noted that there was significant staffing shortages due to sickness, maternity leave and vacancy factors. This prompted the service to be placed on the Trust Risk Register. To note subsequently that during Q4, this has resolved significantly with the return of staff, and the temporary placement of 2 staff from 0-19 service to assist with safeguarding supervision.
- Regular drop-ins to targeted areas of the Trust continued. This included frequent attendance to support Ward 21, ED, Maternity, Sexual Health and the community teams.
- Safeguarding Children Supervision has been delivered to the Health Visiting, Maternity and School Nursing Teams by a mixture of remote and face to face sessions. This has remained a key priority.
- Group Supervision has been offered to Ward 21, ED and Sexual health, minimal engagement noted. This is being addressed via, in-service training days, in house meetings and closer working relationships between services.
- ICON training sessions (coping with crying babies) has been offered to non-compliant staff.
- During Q3 WHT have participated in the daily MASH and Domestic Violence referral activity (this involves information sharing and safeguarding checks being completed). The activity has remained high, particularly regarding domestic violence activity oversight. During Q2 996 checks were completed for DV cases overall. During Q3 1246 checks were completed (25% increase in activity). The safeguarding children team are in the process of reviewing the service specification with Walsall CCG for this work. To note that there will be wider consideration from the CCG in response to health partners in MASH (including the plans to expand the work to include exploitation too).

- The Safeguarding Children advice line calls have reduced slightly during Q3. 84 advice calls taken during this period compared with 109 during Q2. (attached **Safeguarding Children Activity**)

Learning Disability Team Activity

Learning for WHT in relation to the LeDeR reviews has been transposed into an action plan to ensure that there is an on-going review and monitoring process in place monitored via the Trust internal practice review group. The latest learning revolves around

- Discharge planning / process
- Access to LD nurse/ Learning disability nurse input
- Reasonable adjustments / hospital flagging system
- OPD appointments
- Standard of documentation / record keeping

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.

During Q3, WHT participated in Walsall Partnership assurance audits in respect of Section 11 of the Children Act 2004, and Care Act 2004. The feedback from the Walsall Partnership was that WHT had good governance arrangements overall. Positive feedback (during Q4) referred to effective governance, training, service engagement and working within the 'Think Family' model.

Throughout Q3, WHT, Walsall Local Authority and Walsall CCG met to conclude the actions that were highlighted in the Safeguarding Development Plan, the work has progressed significantly in relation to the concerns raised during 2021 and most of the outstanding actions have now been completed. (*attached* ***Safeguarding Development Plan)***

The following audits are planned for WHT during Q4:

- An audit to assess if practice is in keeping with the Protocol for Injuries in Non-Mobile Children Presenting in the Emergency Department. This is outstanding and will be progressed during Q4.

- An audit of compliance with the Child Protection Information Sharing System (CPIS) in ED is planned for Q4.

8. Health providers are required to provide evidence and assurance that they are responding to National Reports and Inquiries.
During Q3 WHT Safeguarding Team has not participated in any specific inquiries. No outstanding CQC actions. During Q4, there is an expected SEND and JTAI inspection in Walsall which WHT will be supporting and contributing to.

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)
During Q3 the Safeguarding team have attended all requested partnership and safeguarding meetings with Walsall Local Authority (LA), CCG and all care planning operational meetings. This includes MARAC and Practice Review Group (PRG) WHT have submitted the completed monthly CCG dashboard. *(attached **Safeguarding Dashboard**)*

3. RECOMMENDATIONS

The committee is asked to receive the report for assurance.

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 6th April 2022			
Walsall Together Partnership Board Highlight Report			
Report Author and Job Title:	Michelle McManus, Acting Programme Director	**Responsible Director:**	Mike Sharon, Strategic Advisor
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☐		
Assure	• A new Chair for the Partnership, Mr Patrick Vernon, has been appointed and will commence in post in April 22 • There are no significant risks or delays to report in the transformation programme		
Advise	• The Walsall Together Partnership Board met in full on Wednesday 16th March 22; the first meeting since 15th December 21. • Following the departure of John Dunn at the end of February, Mike Sharon was agreed by partners to Chair the meeting • The Board approved the establishment of a Place Development Programme through 2022/23 and will look at governance and accountability arrangements for the partnership • A Children & Young People's Strategic Alliance has been formed in Walsall; Walsall Together is represented		
Alert	• All partner organisations and services continue to experience significant pressures from demand and note high levels of staff exhaustion. Despite this, a good level of service delivery remains in place. Partners have noted the focus on supporting staff across individual partner organisations and at system level.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk - Failure to deliver care closer to home and reduce health inequalities		
Resource implications	None		
Legal and/or Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence locally and nationally. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare. The current operational pressures have further impacted on delivery of routine and non-urgent care services; the extent to which this will impact the longer-term health outcomes and inequalities within our local population is being assessed.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Walsall Together Partnership Board
Highlight Report
March 2022

1. PURPOSE OF REPORT

This report provides an overview of the key items discussed at the Walsall Together Partnership Board at its meeting on Wednesday 16th March 2022.

The Chair of the meeting was Mr Mike Sharon, on agreement of partners.

2. BACKGROUND

Under the Care at Home strategic objective, WHT is the Host Provider for the integration of Walsall Together partners, addressing health inequalities and delivering care closer to home. The Walsall Together Partnership Board is a sub-committee of the Walsall Healthcare Trust Board.

3. BOARD HIGHLIGHTS

The following sections provide a summary of the key agenda items discussed.

3.1. **Chair Appointment**: The Board welcomed Mr Patrick Vernon, newly appointed Chair of the Partnership, in advance of his formal commencement in post in April. Mr Vernon joined the meeting for the first hour.

3.2. **Staff Story: Integrated Assessment Hub:** The board received an overview of a patient story from Mrs Kirsty Donaldson, Lead Nurse for the Integrated Assessment Hub (IAH). Partners commended the work of the team, particularly during the recent period of high system pressures. An opportunity was identified to work with Council colleagues to further support vulnerable individuals that come through the service. Assurances were provided that the service is operating according to levels of demand and appropriate services for interpretation and other support are aligned.

The Board resolved to note the update and the positive impact the services is having on patients in Walsall.

3.3. **Operational Update:** The Board received an overview of operational performance for the services in scope across all Tiers of the Walsall Together model. The Board noted the increase in COVID cases being seen nationally and took assurance that the Walsall Together model had demonstrated its effectiveness in responding to increased demand over recent months.

Members reported continued pressure across all services and noted increased levels of staff exhaustion. Fuel prices are also impacting several staff groups. In primary care, it is becoming increasingly challenging to deliver both recovery and vaccination targets.

The Board took assurance that there remains a good level of excellent work being delivered by teams across partnership services. Yet there remains a considerable amount of work to be undertaken to develop and support a resilient workforce that can deliver high quality services.

Several statutory partners confirmed their organisations' respective commitments to paying the real living wage. However, a partnership position on such issues, and the role of Anchor Institutions and Anchor Networks, is being explored by the Workforce & OD Steering Group, aligned to the wider work of the Black Country system.

3.4. **Transformation Update**: the board took assurance that there were no new or significant risks to delivery of the transformation programme. Whilst several areas have been impacted by system pressures, work has continued, and live projects will be taken forward into the 2022/23 transformation programme. The central resources will be fully utilised to support next year's programme, with non-recurrent monies also being utilised to support resource across both transformation and place development, including the workforce and OD workstream.

The Board resolved to accept the transformation report.

3.5. **Communications Brief**: The Board approved the monthly Communications Brief, which has since been disseminated across all partner organisations.

3.6. **Central Budgets**: The central budget for the partnership was reported to be forecasting a small surplus for the 2021/22 financial year. This is a result of having additional non-recurrent funding available as well as vacant posts and there are some cost pressures against the budget into 2022/23. Funding partners have resolved to retain the current contributions for 2022/23 on the basis that some additional non-recurrent money has been allocated from the ICS and on the basis that the place development programme includes a review of the future recurrent resourcing requirements for the partnership.

3.7. **Place Development**: Partners received a summary of the outputs of the Partnership Board development session, held on 16th February. This reaffirmed commitment to the partnership and the strategic aims.

A proposal was made to establish a Place Development Programme, which will support the work required to define the future governance and accountability frameworks, establish an outcomes-focussed environment, and ensure the citizen voice is embedded throughout the partnership. The Board resolved to approve the establishment of the programme and to seek to identify Board-level sponsors for each of the workstreams.

In addition to the workstreams identified, the Board resolved to consider development requirements relating to system leadership. This will form part of the existing Workforce & OD workstream.

Children's Alliance: The Board received an overview of the role and purpose of a recently established Children and Young People Strategic Alliance. In January 2021 there was a review of strategic partnership working around the agenda of children,

young people and families. This review was undertaken in collaboration with the CCG, Walsall Health Trust, the Safeguarding Partnership and the Safer Walsall Partnership and raised some critical issues around the effectiveness of the partnership as well as some drivers for change, opportunities and solutions. As a result, all partners collectively agreed to a series of externally facilitated strategic partnership workshops to explore more effective strategic collaboration and decision making across the partnership in relation to children, young people and family business. The work of the Alliance is continuing to form and has representation from Walsall Together partners.

3.8. **Workforce & OD**: The Board received a detailed discussion paper on the challenges faced across the partnership from a workforce and organisational development (OD) perspective. The paper presented some questions designed to encourage debate and to provide an overall steer to the future work of this workstream.

The main areas of focus are a) supporting the care provider market with recruitment and retention, and b) providing structured development to the integrated health and social care teams. In line with the partnership's priorities, a focus on reducing health inequalities is a golden thread within this work, ensuring we can support individuals from our most vulnerable and deprived communities into work.

An outcomes framework for the workstream is in development and partners will start to see workforce data being reported through the operational report in coming months. Early thoughts on providing support to the partnership around systems leadership were introduced and supported in principle, with further detail to be explored in the coming months.

Partners referenced the challenges with recruitment and retention across several partner organisations and services. Part of the work will be to create developmental support and pathways across organisational boundaries and support all staff to feel valued and engaged in the work they undertake.

Further discussions took place in support of ensuring the work includes: the role of apprenticeships; and the importance of cultural competence in the OD strand.

4. RECOMMENDATIONS

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

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 6th April 2022			
Care at Home Report			
Report Author and Job Title:	Michelle McManus, Acting Programme Director	**Responsible Director:**	Matthew Dodd, Director of Transformation
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☒		
Assure	• This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain during February 2022. • It includes operational performance for Community Services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1), the latest Board Assurance Framework (BAF) for Care at Home, and an update on place-based partnership arrangements. • Access for Walsall residents to domiciliary care and care homes improved during February		
Advise	• The Partnership continued to implement responses outlined in the systems pressure plan, in order to address underlying drivers of demand within the system. • Recruitment & retention for staff in all partner organisations needs to be made more resilient and the Workforce Group is developing plans around this		
Alert	• There will be reduced funding available to support many of the initiatives that have been implemented this winter by the Partnership		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk - Failure to deliver care closer to home and reduce health inequalities, and links to Corporate Risk Register: • Risk 2624 - Risk of suboptimal levels of care due to capacity not being able to respond quickly enough to fluctuating demand within all areas of the system (level 16)		
Resource implications	There has been significant non-recurrent investment to support the work of the partnership over winter / during Covid which will be reduced during the next financial year. Partners are seeking to map the extent of this, assess the potential impacts and identify mitigation strategies		
Legal and/or Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence locally and nationally. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare. The current operational pressures have further impacted on delivery of routine and non-urgent care services; the extent to which this will impact the longer-term health outcomes and inequalities within our local population is being assessed.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Care at Home Executive Summary
March 2022

1. PURPOSE OF REPORT

This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain during February 2022.

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

This report covers:

- Operational performance for community services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1);
- Board Assurance Framework (BAF) for Care at Home;
- An update on the place-based partnership arrangements in Walsall and across the Black Country Integrated Care System (Appendix 2).

2. BACKGROUND

Under the Care at Home strategic objective, WHT is the Host Provider for the integration of Walsall Together partners, addressing health inequalities and delivering care closer to home.

3. PERFORMANCE, ASSURANCE AND RISK – COMMUNITY SERVICES

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

3.1 Demand: Demand for Community Locality Services reduced in February 2022 while the Care Navigation Centre saw a sustained level of high demand. Colleagues within PCNs reported continued demand on primary care services during February.

3.2 Capacity:

Locality Services: At 15%, the cancellation rate for Community Locality Services was better than experienced last summer. This was against a background of reduced demand however, and Community Services are working on staff recruitment including overseas recruitment drives.

Discharge & Step Up Pathways: In previous months the Trust Board has been informed about the impact that the shortage of staff in care agencies created, the effect of care home closures on the place-based system and the mitigations enacted by partners. In February there was more capacity provided by Care Agencies for domiciliary care while the Care Homes reported less infection control outbreaks and reduced business continuity pressures. This resulted in fewer delays for Walsall

residents with complex needs being discharged from hospital at both the Manor and surrounding hospitals.

Systems Pressure Plan: Additional schemes funded through winter pressures money were able to support admission avoidance activity and reduced attendance at the Emergency Department at Walsall Manor Hospital. These schemes included the Falls Service (designed to relieve pressure on WMAS crews and the Emergency Department), triage of ED patients by the Integrated Front Door team and extension of the criteria for the Care Navigation Centre to include GP calls to acute medical teams. These schemes are being reviewed to identify what needs to be maintained and how others will be tapered down during Q1 of 2022/23.

Covid Vaccination Centre: Walsall Together has been asked to extend the Covid vaccination service and from 1st April this will be provided by Community Services in a new location within Walsall town centre.

4. BOARD ASSURANCE FRAMEWORK

The overall risk score on the Care at Home Board Assurance Framework (BAF) remains at level 16. As predicted and reported over previous months, several partnership risks have been adversely impacted by the COVID outbreak.

There following risks remain on the Corporate Risk Register with mitigations through the Systems Pressures Plan and partnership governance arrangements:

- Risk 2370 – Delays in presentations for other, non-COVID, conditions may further exacerbate health inequalities and increase the risk of premature mortality.
- 2372 – The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.
- Risk 2624 - Risk of suboptimal levels of care due to capacity not being able to respond quickly enough to fluctuating demand within all areas of the system

The following risk was de-escalated in February following continued capacity to discharge patients and maintain acceptable levels of medically stable patients. It will continue to be monitored at divisional level and across the Walsall Together partnership:

- Risk 2641 – Delayed discharges at Manor Hospital and other settings for medically stable patients as a result of low availability of packages of care

5. PLACE BASED PARTNERSHIP ARRANGEMENTS

A new Chair, Patrick Vernon was appointed for Walsall Together partnership early in March. It is anticipated that he commences this role in April 2022.

The Walsall Together Partnership Board (WTPB) development session was held on 16th February. This reaffirmed commitment to the partnership and agreed a formal place development programme for the partnership (Appendix 2). This will support the

work required in response to the recent integration White Paper which seeks to define the governance and accountability relationships between place (Walsall Together) and system (the Black Country Integrated Care System).

6. RECOMMENDATIONS

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

APPENDICES

1. Operational Performance Report for March 2021: Walsall Together
2. Report to Walsall Together Partnership Board: Place Development

Walsall Together

Walsall Together Partnership Operational Update: March 2022

Matthew Dodd
Director of Transformation

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

Tier	Activity	Thresholds					2020-2021	Feb-22
Tier 0: Resilient Communities								
Social Prescribing	whg - No. referrrals received							47
	Primary Care - % referrrals received East 1	<0.4%		>= 0.4%			0.55%	
	Primary Care - % referrrals received East 2	<0.4%		>= 0.4%			0.50%	
	Primary Care - % referrrals received North	<0.4%		>= 0.4%			1.30%	
	Primary Care - % referrrals received South 1	<0.4%		>= 0.4%			0.71%	
	Primary Care - % referrrals received South 2	<0.4%		>= 0.4%			1.30%	
	Primary Care - % referrrals received West 1	<0.4%		>= 0.4%			0.80%	
	Primary Care - % referrrals received West 2	<0.4%		>= 0.4%			1.78%	

	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Workforce: Anchor institutions	No. staff employed by whg via scheme												68	No data receieved	75	79
	% whg customer's												38%	No data receieved	37%	37%

[Emergent] Score Card for WT Tiers – Tiers 1

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services																
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	10905.5	10347	9450.25	5576	6574.25	5945.25	5769.75	6038	6127	7015.75	6228.5	5210.5
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	473	305	623	1020	1453	1546	1557	1255	1271	1093	861	920
	% of hours demand unmet	>23%	20%-23%	<20%	4.2%	2.9%	6.2%	15.5%	18.1%	20.6%	21.2%	17.2%	17.2%	13.5%	12.1%	15.0%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	29	19	19	27	25	26	26	22	26	24	26	23
	No. referrrals received	<100	100-200	>200	29	27	35	37	26	26	34	26	30	27	25	24
	No. cases reviewed	<100	100-200	>200	29	27	32	40	90	96	92	88	120	103	108	89
Adult Social Care	1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	<100%		100%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).					2.8%	2.8%	2.9%	2.9%	3.1%	3.1%	3.2%	3.4%	3.3%	3.3%	3.3%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).					84.8%	85.5%	84.5%	84.9%	84.4%	84.6%	84.4%	84.4%	84.7%	84.9%	84.9%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	<9.1		>= 9.1		1.2	2.4	3.0	3.0	3.0	3.6	4.8	6.6	7.2	7.8	9.0
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8		69.3	142.6	186.1	229.7	257.4	306.9	344.6	405.9	437.6	479.2	510.9
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%		79.0%	83.8%	77.6%	82.8%	85.6%	84.4%	81.7%	85.2%	74.8%	81.8%	80.4%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				449	478	494	550	553	617	661	695	738	724	831	718
	Care and Support Assessments and 3 Conversations Completed - Total				351	324	302	343	346	341	346	287	313	292	296	429
	Monthly Adult contacts completed by Team				1,122	1,030	1,010	1,094	1,025	1,061	1,131	1,071	1,235	1,019	1,228	1,207
	Total Initial & Subsequent Reviews Completed				451	295	323	334	327	268	290	290	268	249	288	304

[Emergent] Score Card for WT Tiers – Tier 2

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Tier 2: Specialist Community Services																
ASC Safeguarding Concerns	Concerns received				297	253	292	307	315	258	286	316	297	265	291	336
	Concerns progressing to s42 eqnuiry				72	79	84	83	88	66	81	87	79	83	73	91
	% of concerns progressing to s42 enquiry				24%	31%	29%	27%	28%	26%	28%	28%	27%	31%	25%	27%
	Safeguarding cases in progress				39	25	48	15	36	20	17	35	31	7	34	86
Care Homes	Care Home residents	1,503<	1,503-1,650	>1,650	1,258	1,267	1,259	1,285	1,294	1,330	1,329	1,353	1,325	1,297	1,269	1,276
	Vacancies	>291	144-291	144<	436	430	441	416	408	368	370	357	412	416	494	432
	% vacant beds	>15%	8-15%	8%<	25.7%	25.3%	25.9%	24.5%	24.0%	21.7%	21.8%	20.9%	23.7%	24.3%	28.0%	25.3%
	Total No of Care Homes	53<	53-56	>56	57	58	58	58	58	58	58	58	59	59	60	60
	Closed to admissions	>8	3-8	3<	14	7	8	8	2	10	12	5	6	28	20	13
	% of available homes closed to admissions	>10%	5-10%	5%<	19.7%	10.8%	12.1%	12.1%	3.3%	14.7%	17.1%	7.9%	9.2%	32.2%	25.0%	17.8%

Supporting the Covid Vaccination Programme: *Saddlers (and Manor Walk In Centre)*
As of 11/10/21 combined they have delivered 162,761 vaccinations.

[Emergent] Score Card for WT Tiers – Tiers 3 (& 4)

Walsall Together

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Tier 3: Intermediate Care, Unplanned Care & Crisis Services																
Care Navigation Centre	Calls received	<435	435-512	>512	550	580	691	747	821	840	869	925	861	1094	1225	1170
Rapid Response Team	Referrals received	<160	160-247	>247	232	210	216	304	301	334	227	230	264	268	260	254
	% admission avoidance	<73%	73%-87%	>87%	77.2%	79.2%	79.6%	78.4%	84.7%	86.8%	79.7%	87.4%	91.7%	90.7%	90.4%	91.3%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50- 57.5	<50	29.33	31.13	31.86	31.89	48.56	47.38	52.11	41.00	44.67	40.25	48.00	45.88
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	2.7	2.7	3.6	3.9	4.2	5.1	4.5	4.5	4.6	3.6	3.4	3.5
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	30	27	29	N/A	N/A	N/A	N/A	N/A	35	34	32	26
	Domiciliary Pathways - Average service users				188	181	180	N/A	N/A	N/A	N/A	N/A	196.5	207.75	200.2	181.5
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	29	46	49	N/A	N/A	N/A	N/A	N/A	33	50	43	38
	Bed-based Pathways - Average beds in use				83	67	61	N/A	N/A	N/A	N/A	N/A	86.5	68.5	74	82.5
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	44	56	90	90	80	72	113	84	94	85	158	168
	Early Supported Discharge	40<	40-54	>54	52	51	106	43	48	47	26	35	29	65	35	44
	Assisted Discharge	35<	35-50	>50	75	62	71	63	103	61	42	54	42	75	54	40
	Prevent Readmission	35<	35-50	>50				63	60	62	20	43	33	32	41	37

Tier 0: whg Resilient Communities Social Prescribing programme

H Factor

During February the team have continued to use Social Prescribing as a model to reduce risk and vulnerability and provide a non clinical response to people who may otherwise seek support from Primary Care or other clinical services .

As part of the Governments COVID recovery support local Councils have been given access to a grant called the Household Support Fund . The overall fund available is £500m . Walsall Council were awarded £2.8 million and from this allocated whg £300k to directly support our vulnerable customers .

The purpose of the grant is to assist vulnerable households to manage during the winter months in particular to help them keep well and warm , reduce food poverty and ensure families have essential items . People who are in receipt of certain means tested benefits were eligible for assistance . whg will provide a detailed report in April for the full £300k however £60k was ringfenced specifically for the Social Prescribing Team to use to ensure peoples health was not impacted due to the cold .

The team **supported 173** individuals and families awarding overall grants worth **£45k** . The grants provided items such as energy vouchers , beds for children , warm winter coats and shoes for children , food vouchers and white goods such as cookers and washing machines . The fund has brought into focus the really difficult circumstances that people are living in day to day . If a child doesn't have a bed how can they then be rested for school . A lack of this basic item will directly lead to inequalities caused by the wider determinants of health . We will use the data from our full report as a platform to discuss Child Poverty via the Resilient Communities workstream .

Last updated on Mar 2022

TIER 0 why Resilient Communities

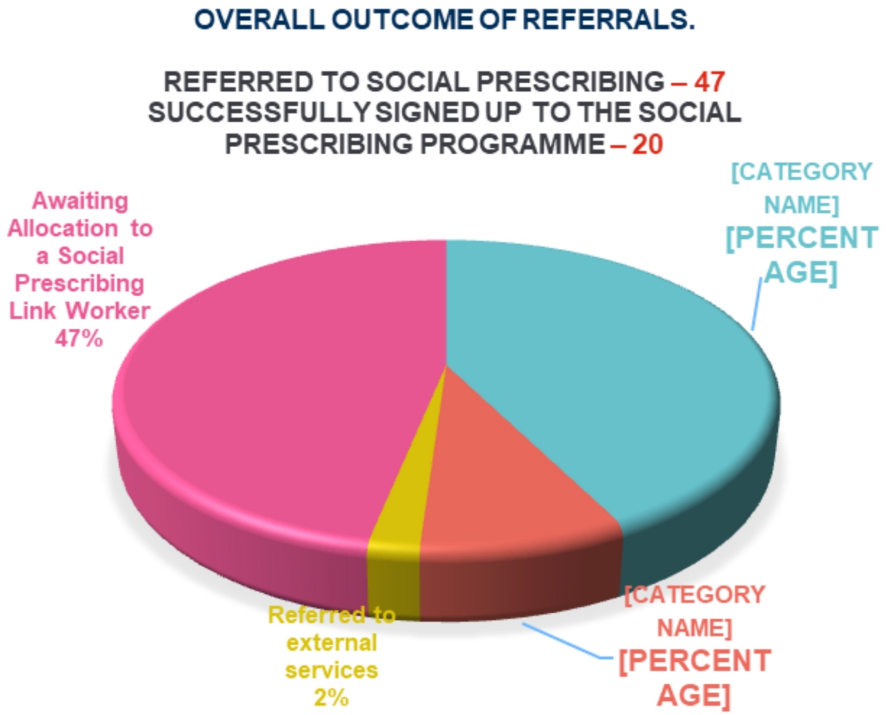
Kindness Counts : Reducing Loneliness and Isolation Our team of Kindness Champions have been out and about this month carrying out random acts of kindness . Kindness protects and improves health by reducing blood pressure and inflammation levels , reducing anxiety and increasing confidence and self esteem . It also brings people together with one act of kindness sending out ripples of kindness to 6 other people . This month the team recognised and thanked why customers who operate in front line key worker roles to thank them for their contribution to their communities . One recipient was the local school crossing person who works at Butts Primary School . Alongside keeping children safe every day she is also a carer and a local volunteer .She was overwhelmed at the recognition saying it had made her realise how value she is These citizens are the very people who increase health hope and happiness within communities .

During February the team have undertaken

- ✓ **77** Random Acts of Kindness
- ✓ Completed **99** Clever Conversations with people who are lonely or isolated
- ✓ Completed **22** Home Visits Face to Face
- ✓ Completed **10** Loneliness and Isolation Assessments (**ONS4**)
- ✓ Coproduced **5** PERMA Wellbeing Plans with people who are lonely and isolated (PERMA Wellbeing model) The plan should be Positive , Engaging , Relationship focussed , Meaningful and lead to Achievement
- ✓ Worked alongside **1** Community Organisation supporting **10** people aged 65 and over
- ✓ Referred **5** people for Aids and Adaptations support to maintain their independence at home

Last updated on Mar 2022

whg H Factor Social Prescribing Referrals 2022

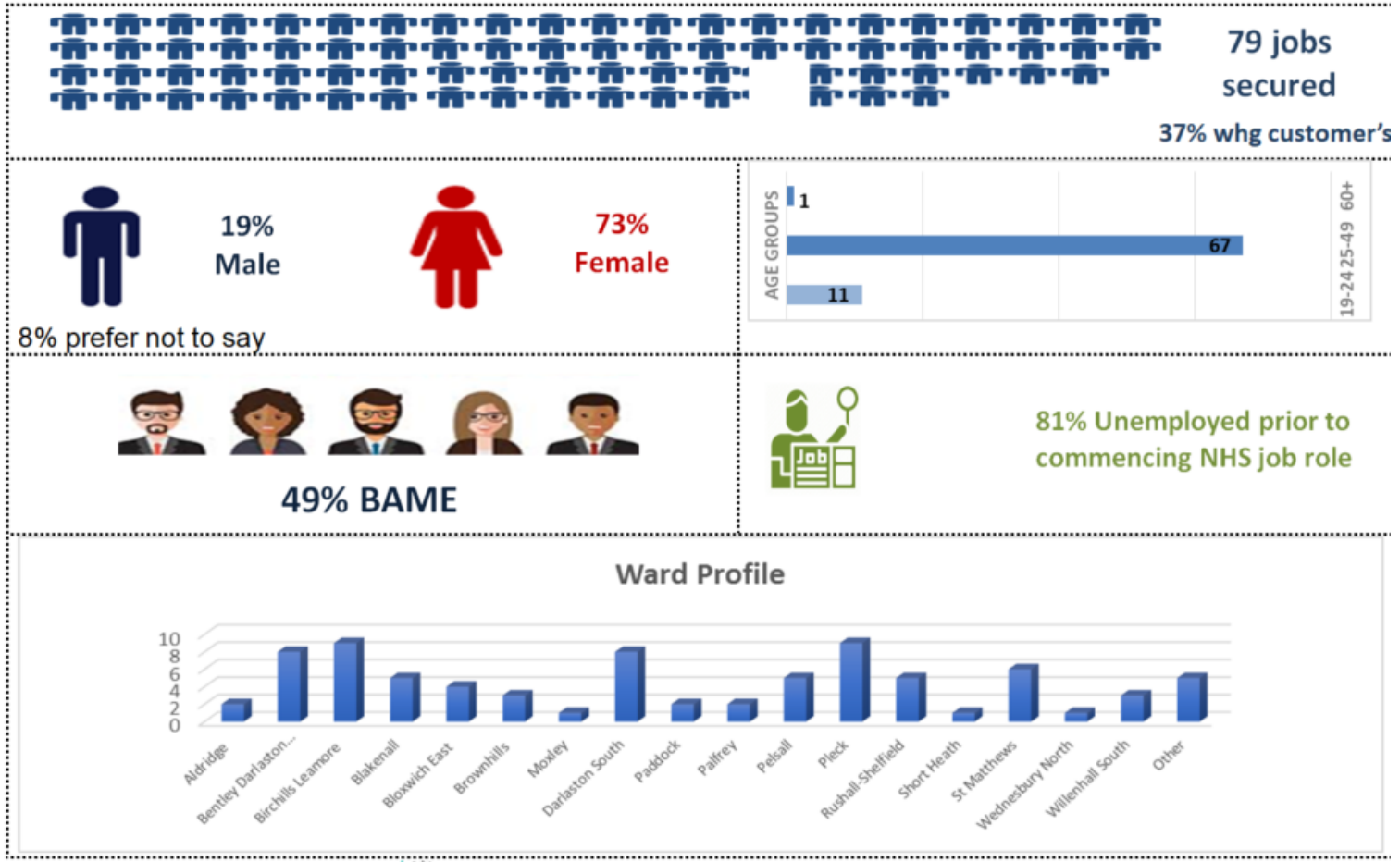


Last updated on Mar 2022

Walsall Together

whg/Walsall NHS Trust's Recruitment Programme

whg Work 4 Health programme – Total into employment (February 2022)



NHS

Department for Work &

Walsall College

whg

Last updated on Mar 2022

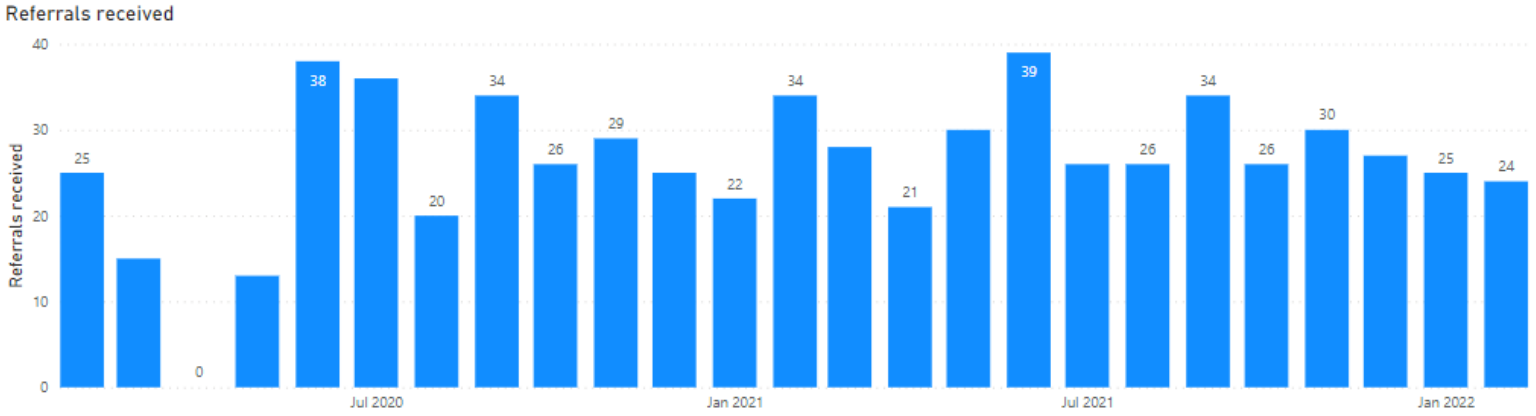
Tier 0: Walsall's Voluntary & Community Sector – One Walsall

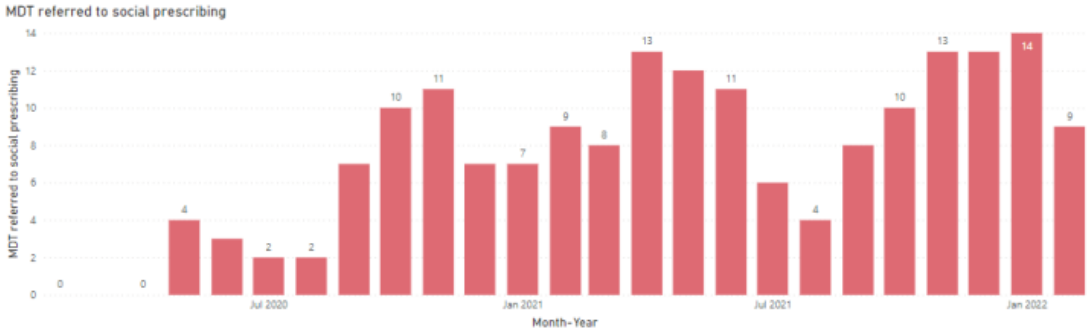
- The demand for mental health services from professionals in the sector continues to increase; BC CCG has now commissioned £140,000 a collaborative piece of work with six mental health providers from the VCSE to deliver additional capacity for referrals, which will take place until June/July 2022. One Walsall will be monitoring this with a view to utilising feedback commissioners about working with the VCSE on an ongoing basis.
- NHS colleagues are donating laptops to community groups and individuals without digital access, alongside providing training in basic use of IT. These will be disseminated across the borough as part of a Black Country scheme via the four CVS areas.
- An event being planned for May looks to enhance the corporate responsibility offer to the VCSE by hosting a business breakfast, bringing together local businesses and VCSEs. The intention is to explore employee supported volunteering projects, but also to look at creating funding opportunities, which will enhance the capacity of the sector to deliver services to patients.

Last updated on Mar 2022

Tier 0: Multidisciplinary Team (MDT)

Demand is significantly below capacity for GP-led Multidisciplinary Team





The service is established for 7 x MDTs with up to 50 cases to be reviewed per week

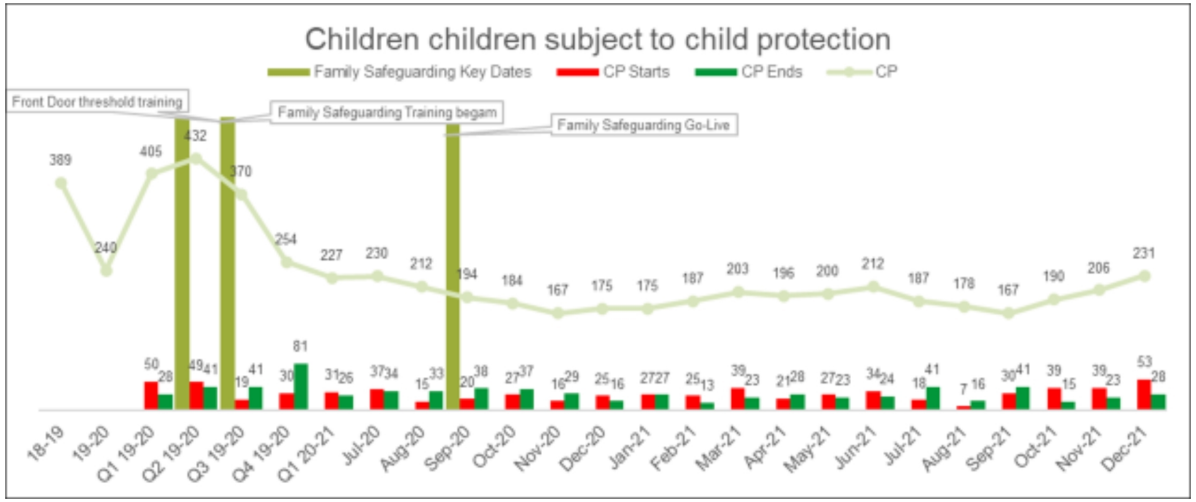
It has been agreed with PCNs that the risk stratification will change [eg case finding by the MDT Coordinators to focus on people who have had four admissions in the last year]

Further review meeting planned with PCN MDT lead to look at how to increase referrals from other teams

Last updated on Feb 2022

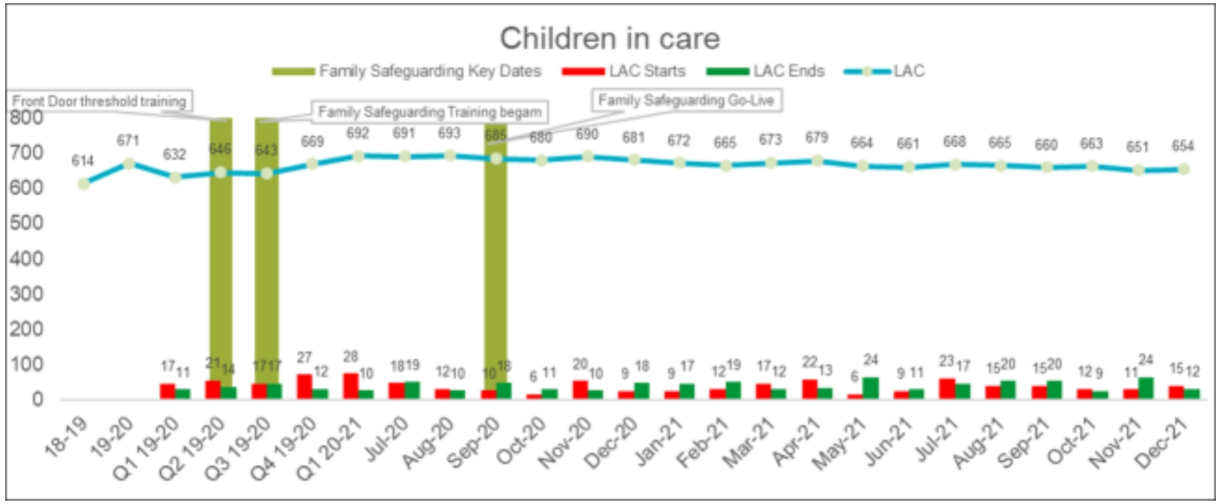
Tier 1: Family Safeguarding

Children subject of a child protection plan



- The number of children who are subject of a child protection plan has reduced from 370 in December 2019 to 227 at the end of December 2021, a reduction of 38.6%.
- For children aged 12 and under, the number of children subject of a plan have reduced from 318 to 181, a reduction of 43.1%.
- The proportion of children who are subject of a plan who are aged under 12 has reduced from 85.9% to 79.7%.

Children entering care

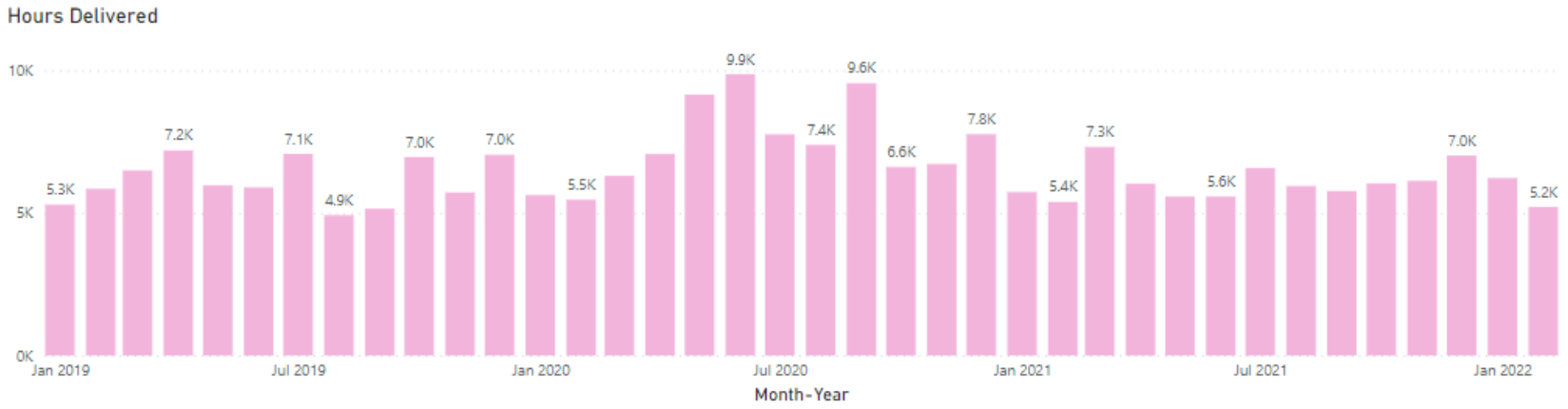


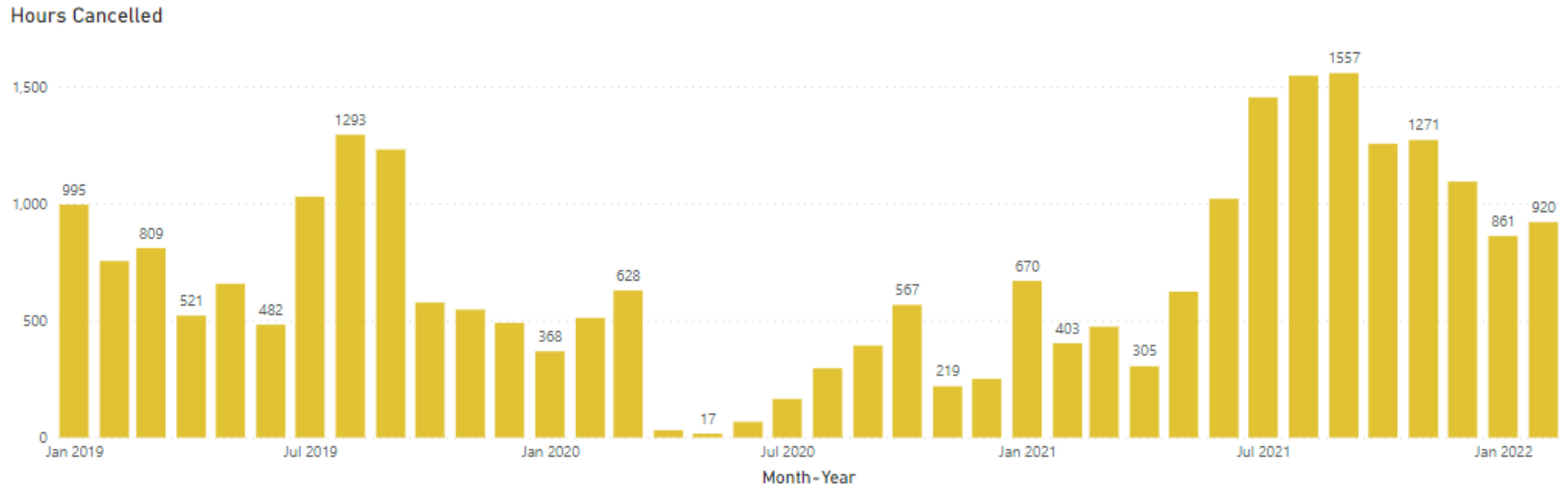
- Between April 2019 and March 2020, 242 children entered care, of which 177 (73%) were age 12 and under.
- Between March 2021 and February 2022, 166 children have entered care, of which 112 (67%) were aged 12 and under.
- Overall the number of children who have entered care has reduced by 31%, but for children aged 12 and under the reduction is 37%.

Last updated on Mar 2022

Tier 1:

Community Nursing Capacity and Demand: In December 2021, Community Services delivered more hours than the previous month and cancelled the fewest hours since June 2021





The Locality Teams delivered less hours than in December. The teams also cancelled less hours than November and December and the least since June 2021.

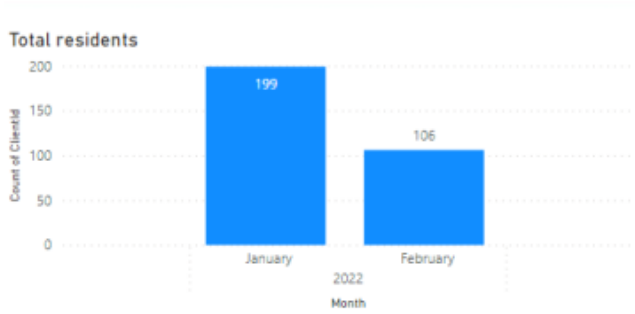
This is as a result of the actions that have been and continue to be taken by the Community Division in response to workforce challenges that the Locality Teams are experiencing.

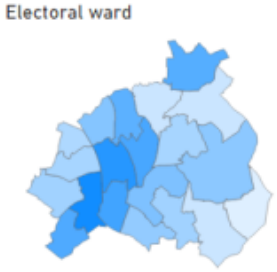
- A review of capacity and demand modelling has enabled increased efficacy of staff and skill mix in meeting caseloads
- The Locality Teams have now merged into one Care Group this has enabled greater cross locality working to ensure priority patients are seen
- Additional resource has been redirected from other Teams (Locality Rapid Response, Diabetes and Podiatry) in order to minimise the number of patient hours being cancelled

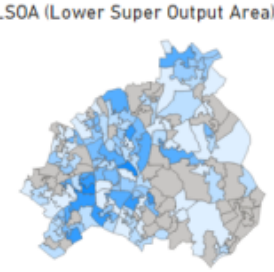
Last updated on Feb 2022

Tier 1: Making Connections Walsall

There were 305 residents referred between Jan & Feb 2022

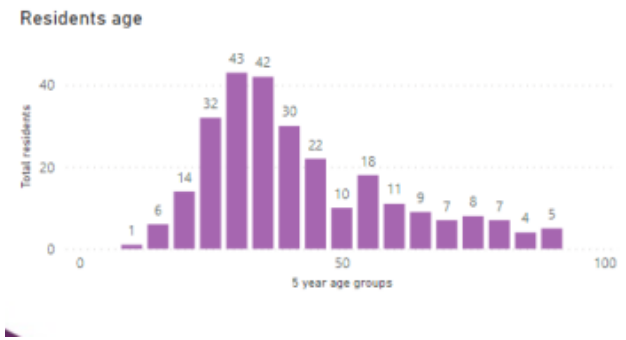






Client type	n	%
COVID_19	245	80%
Making Connections	60	20%
Total	**305**	**100%**

Locality	n	%
West	90	30%
North	79	26%
South	70	23%
East	66	22%
Total	**305**	**100%**



Ethnicity	n	%
A: White _ British	204	66.9%
I: Asian or Asian British _ Pakistani	15	4.9%
Z: Not Stated	14	4.6%
99: Not Known	11	3.6%
C: Other White Background	10	3.3%
H: Asian or Asian British _ Indian	10	3.3%
Declined	8	2.6%
K: Asian / Asian British _ Bangladeshi	8	2.6%
M: Black / Black British _ Caribbean	5	1.6%
N: Black / Black British _ African	5	1.6%
S: Any other ethnic group	5	1.6%
D: Mixed _ White and Black Caribbean	4	1.3%
P: Black / Black British _ Other background	2	0.7%
B: White _ Irish	1	0.3%
G: Mixed _ Any Other Mixed Background	1	0.3%
Total	**305**	**100.0%**

Consider themselves disabled	n	%
	223	73%
Not disabled	52	17%
Disabled	30	10%
Total	**305**	**100%**

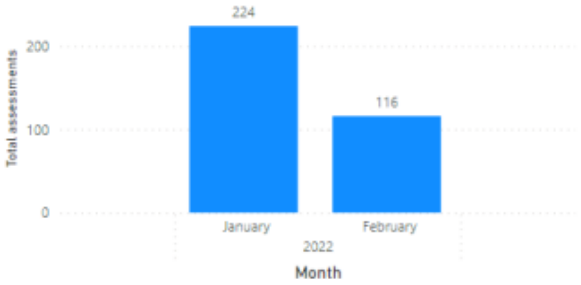
Long Term Physical Health Condition	n	%
	141	46.2%
Yes	59	19.3%
No	55	18.0%
Not stated	45	14.8%
Unknown	5	1.6%
Total	**305**	**100.0%**

Total residents
305
Total contacts
255

Last updated on Mar 2022

Tier 1: Making Connections Walsall

There were 340 new assessments between Jan & Feb 2022



Assessments 340

Locality	n	%
West	96	28.2%
North	88	25.9%
South	81	23.8%
East	75	22.1%
Total	**340**	**100.0%**

LocalIssue	n	%
	310	91.2%
Loneliness & isolation	22	6.5%
Emotional wellbeing	5	1.5%
Financial concerns	3	0.9%
Total	**340**	**100.0%**

Referral Source	n	%
Local authority Services	204	60.0%
Self	70	20.6%
GP or other primary care services	37	10.9%
Community / voluntary services	15	4.4%
Hospital services	4	1.2%
Lifestyle services	4	1.2%
Intermediate care team	3	0.9%
Advice and Guidance	1	0.3%
Community & District Nursing	1	0.3%
Emotional wellbeing services	1	0.3%
Total	**340**	**100.0%**

Employment	n	%
Response declined	102	30.0%
Temporary sick	68	20.0%
Unemployed	51	15.0%
Retired	45	13.2%
Permanently Sick / Disabled	26	7.6%
Employed: routine / manual	24	7.1%
Employed: intermediate occupations	14	4.1%
Employed: managerial / professional	4	1.2%
Looking after home or family full time	4	1.2%
Full time carer	1	0.3%
Student	1	0.3%
Total	**340**	**100.0%**

Sign Off Reason	n	%
Only wanted some information	148	43.5%
Signpost only	102	30.0%
	52	15.3%
Could not contact client	14	4.1%
Other	10	2.9%
Plan completed	5	1.5%
Not ready to make changes	4	1.2%
Not eligible	2	0.6%
Plan part completed	2	0.6%
Client DNAs (Did not attend)	1	0.3%
Total	**340**	**100.0%**

Goals 88

Goal (objective)	n	%
Reduce anxiety/low mood	35	39.8%
Actions to enable goal achievement	24	27.3%
Connect more: Join a group	11	12.5%
Information required	11	12.5%
Be active: Find an enjoyable activity	7	8.0%
Total	**88**	**100.0%**

Referred to	n	%
Community / voluntary services	63	71.6%
Local authority services	6	6.8%
Other (put details in 'Referral_other')	6	6.8%
	3	3.4%
Disability services	3	3.4%
Bereavement Support	2	2.3%
Emotional Wellbeing Services	2	2.3%
Dementia cafe	1	1.1%
Hospital Services	1	1.1%
Leisure activity	1	1.1%
Total	**88**	**100.0%**

Last updated on Mar 2022

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

- We had recruited 4.5 wte of our 7 ARRS workers for year 1 but sadly 1.5 have withdrawn due to physical health reasons

South 2 ARRS worker in post currently rolling out across surgeries

West 2 – 0.4 started 1st March

West 1 – 1wte due to start 1st April

East 1 – 0.6 starting 1st May

Last updated on Mar 2022

PCMH Nurse PCN Alignment

- Due to the issues around recruiting to the ARRS roles we are moving forward to align PCMH nurses back with GP surgeries/PCNs

We are plan to return back to F2F working offering telephone/video conferencing where this is patient preference and where indicated/appropriate

The nurses will be in touch to determine if there is room availability in the surgeries

Where an ARRS workers is appointed the PCMH Nurse will receive referrals direct form the ARRS workers

The PCMH service continues to offer a self-referral system

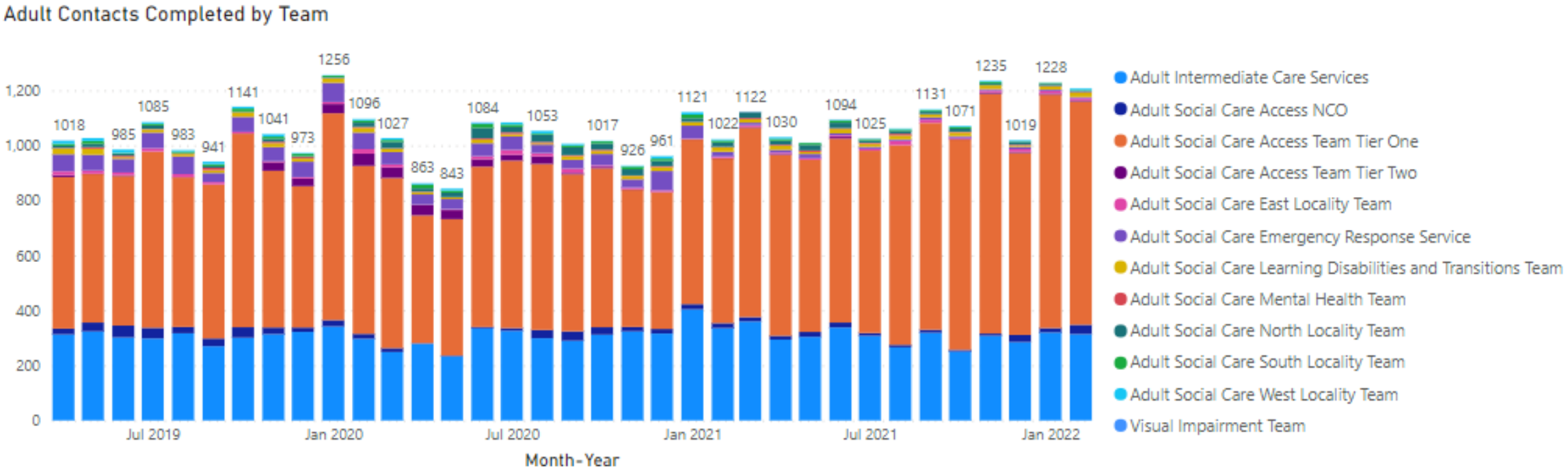
Last updated on Mar 2022

PCMH Activity – February 2022

PCN Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
East 1	39	63	49	52	53	33	35	57	43	44	64	5	537
East 2	47	31	36	38	29	28	37	34	50	50	39		419
North	49	70	62	82	54	85	75	72	59	80	61	14	763
South 1	54	54	66	65	59	52	40	51	54	65	67	7	634
South 2	31	33	38	33	33	42	39	48	35	40	33	3	408
West 1	47	37	37	52	39	58	47	53	40	41	51	4	506
West 2	44	38	63	62	56	78	59	70	49	66	56	6	647
Total	311	326	351	384	323	376	332	385	330	386	371	39	3914

Last updated on Mar 2022

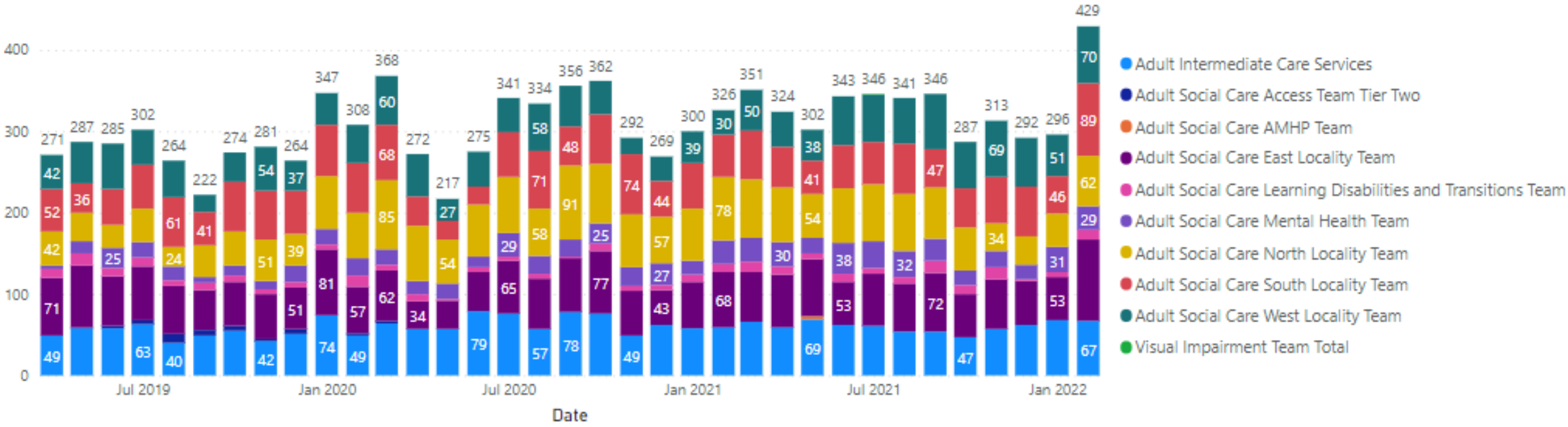
Tier 1:
Adult Social Care



Demand coming into Adult Social Care has roughly remained the same since the beginning of the year. Absence levels have reduced which has shown an increase in assessments and reviews completed in the month of February.

Last updated on Mar 2022

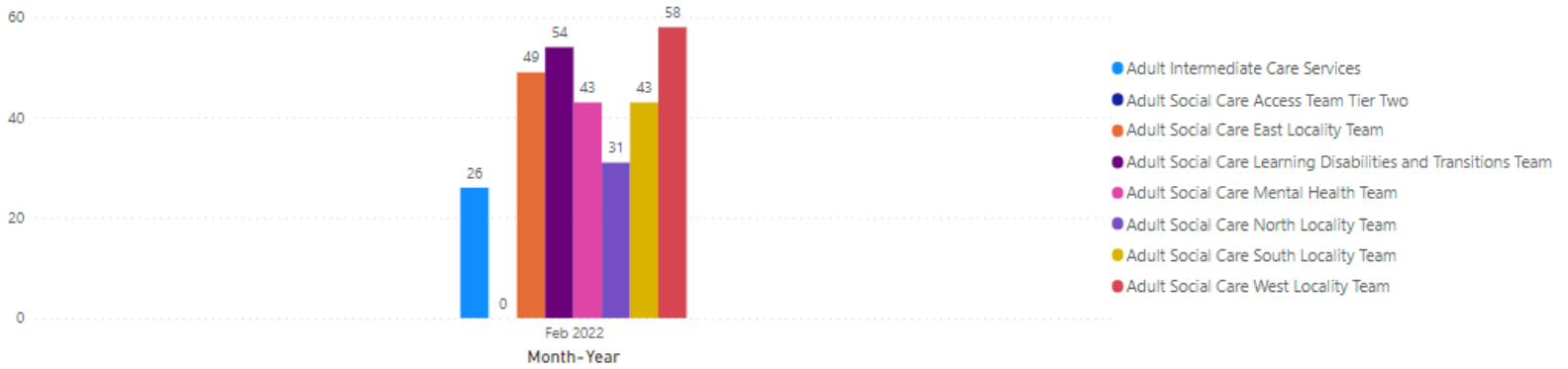
Care and Support Assessments and 3 conversations completed



Last updated on Mar 2022

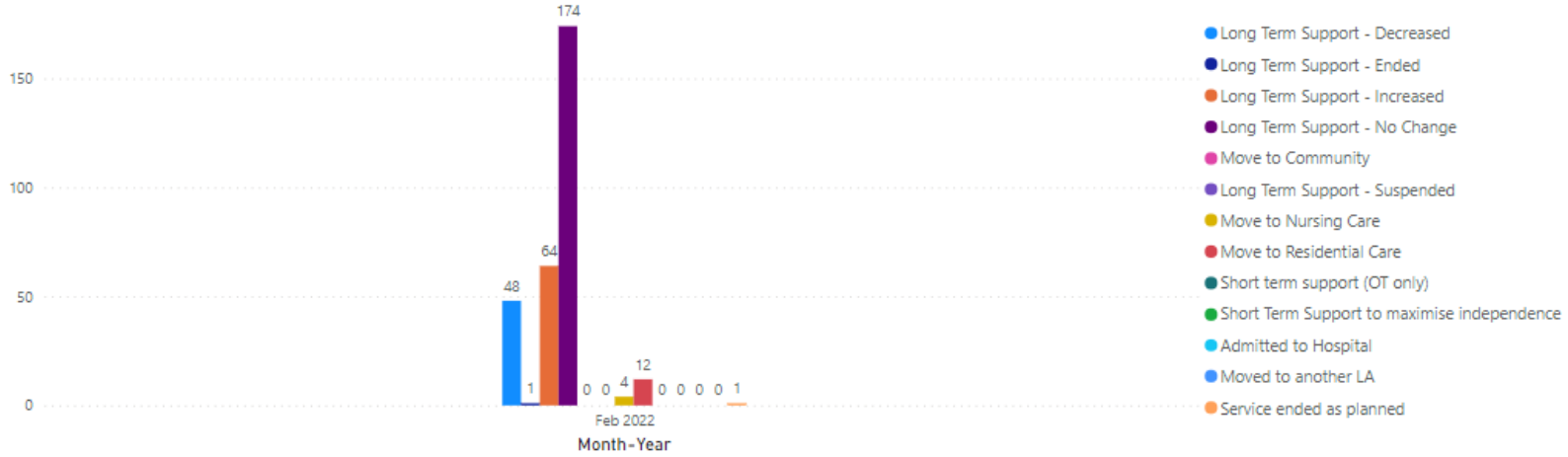
Walsall Together

Initial and Subsequent Reviews Completed by Teams



Date	Sum of Total Initial and Subsequent Reviews Completed
Feb-21	380
Mar-21	451
Apr-21	295
May-21	323
Jun-21	334
Jul-21	327
Aug-21	268
Sep-21	290
Oct-21	290
Nov-21	268
Dec-21	249
Jan-22	288
Feb-22	304

Initial and Subsequent Review Outcomes



Last updated on Mar 2022

Tier 2:
Adult Social Care

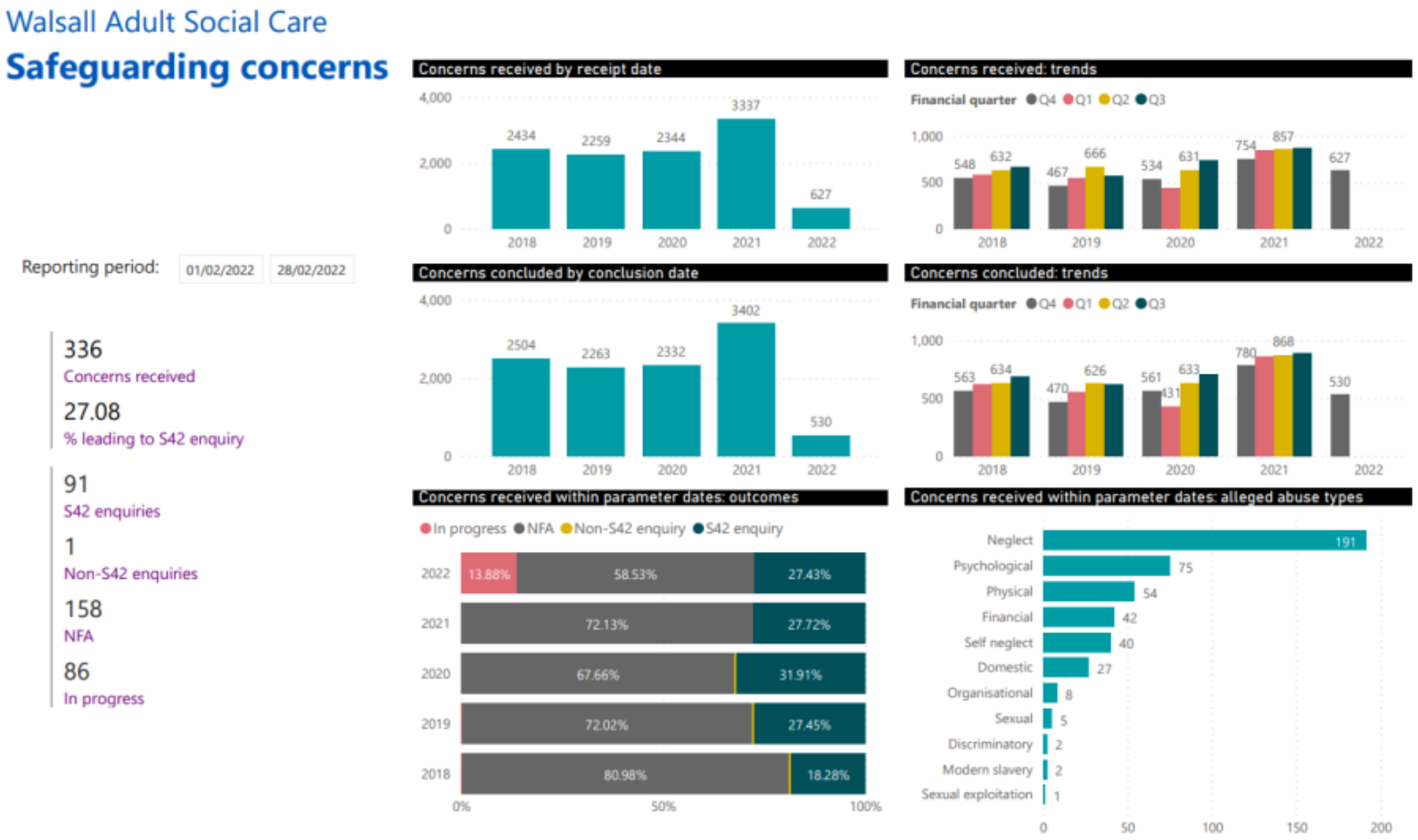
ASC have received 336 concerns which is a significant increase of 45 referrals on the previous month.

The number of cases progressing to a s42 enquiry is a 27.08 received which is a slight increase on the previous period.

There are currently 86 open s42 enquiries. Focussed activity in concluding work and MSP in a timely way is a key priority for practitioners, a number of these enquiries are caused to other parties.

Neglect & Psychological abuse remain the two highest categories of alleged abuse in this period. Adult Self Neglect is a partnership priority and work is currently focussing upon a new pathway (launch April 2022) and strategy for the Borough.

Making safeguarding personal and working with individuals and their advocates to achieve their outcomes remains integral to the safeguarding process.



Last updated on Mar 2022

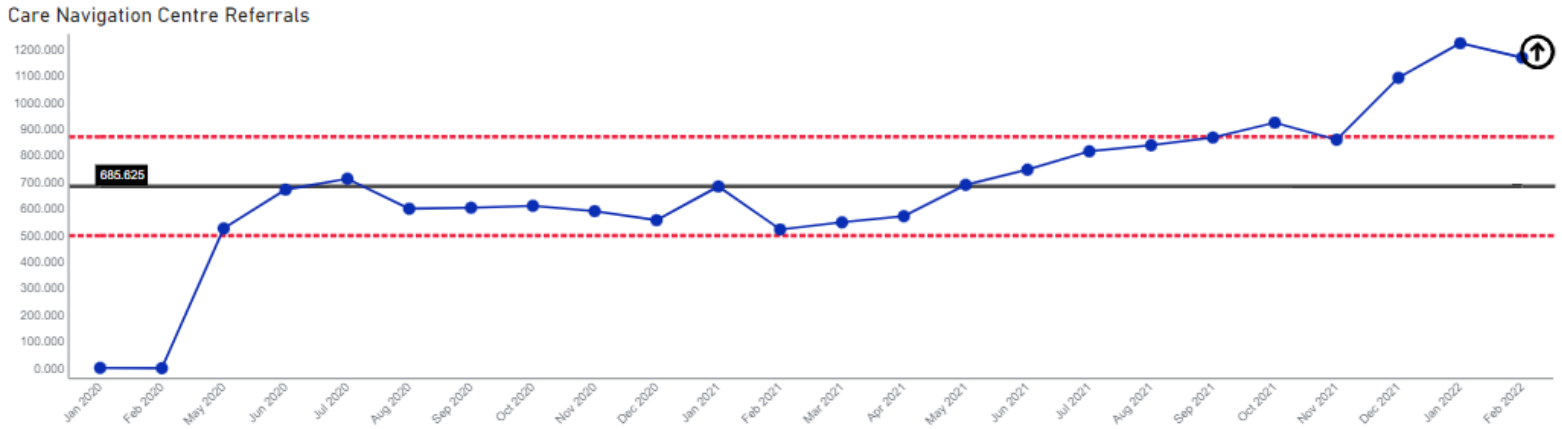
Walsall Together

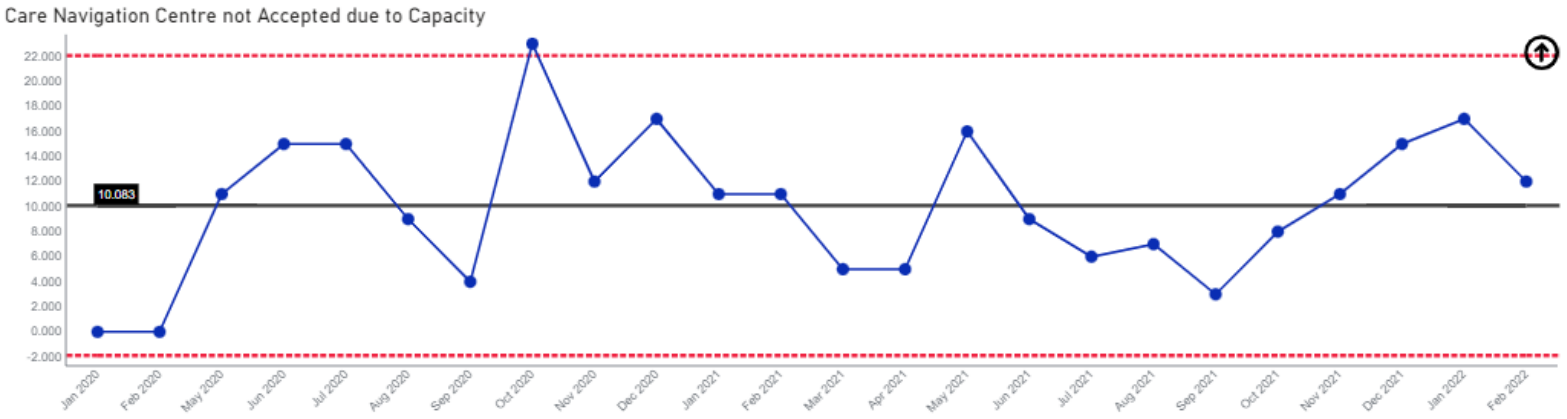
Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2021/22

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	April 21/22 Data	May 21/22 Data	June Q1 Data	July 21/22 Data	Aug 21/22 Data	Sept Q2 Data	Oct 21/22 Data	Nov 21/22 Data	Dec Q3 Data	Jan 21/22 Data	Feb 21/22 Data	Mar 21/22 Data	21/22 Target	Comments
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2211	2245	2203	2193	2180	2167	2153	2159	2151	2152	2191			
	AACM	1895	1951	1954	2045	2100	2188	2211	2245	2203	2193	2180	2167	2153	2159	2151	2152	2191			
	Jennie Pugh	**91.3%**	**97.3%**	**98.4%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		**100.0%**	
1E: Proportion of adults **(aged 18-64)** with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	15	15	16	16	17	17	18	19	19	19	19		12	
	AACM	551	585	587	596	574	573	540	545	548	550	546	553	558	565	568	570	575			
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**2.8%**	**2.8%**	**2.9%**	**2.9%**	**3.1%**	**3.1%**	**3.2%**	**3.4%**	**3.3%**	**3.3%**	**3.3%**			
1G: Proportion of adults **(aged 18-64)** with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	458	466	463	467	461	468	471	477	481	484	488			
	AACM	551	585	587	596	574	573	540	545	548	550	546	553	558	565	568	570	575			
	Jennie Pugh	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**84.8%**	**85.5%**	**84.5%**	**84.9%**	**84.4%**	**84.6%**	**84.4%**	**84.4%**	**84.7%**	**84.9%**	**84.9%**			
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	2	4	5	5	5	6	8	11	12	13	15		15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500			
	Jennie Pugh	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**1.2**	**2.4**	**3.0**	**3.0**	**3.0**	**3.6**	**4.8**	**6.6**	**7.2**	**7.8**	**9.0**		**9.1**	
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	271	309	311	329	301	311	35	72	94	116	130	155	174	205	221	242	258		335	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500			
	Jennie Pugh	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**69.3**	**142.6**	**186.1**	**229.7**	**257.4**	**306.9**	**344.6**	**405.9**	**437.6**	**479.2**	**510.9**		**671.8**	
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	113	95	111	101	107	103	89	69	77	72	86			
	Provider Services	317	130	266	73	91	125	143	113	141	122	125	122	109	81	103	88	107			
	TBC	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**79.0%**	**83.8%**	**77.6%**	**82.8%**	**85.6%**	**84.4%**	**81.7%**	**85.2%**	**74.8%**	**81.8%**	**80.4%**		**85.0%**	

Last updated on Mar 2022

Tier 3:
Care Navigation Centre (CNC): The number of referrals increased significantly during December.





The number of referrals to the CNC increased significantly during January.

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

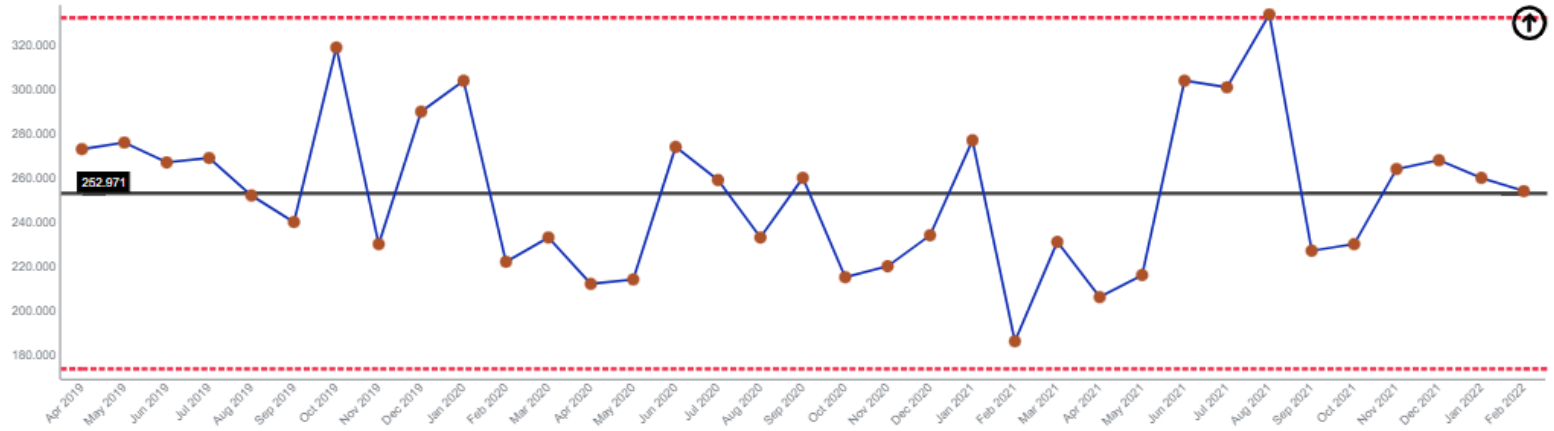
The high volume of calls are a result of the enhanced service that has been implemented. This includes a further expansion of CNC capacity, streaming patients directly from WMAS to Community pathways and services including a further strengthening of disposition pathways into Rapid Response and Integrated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

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

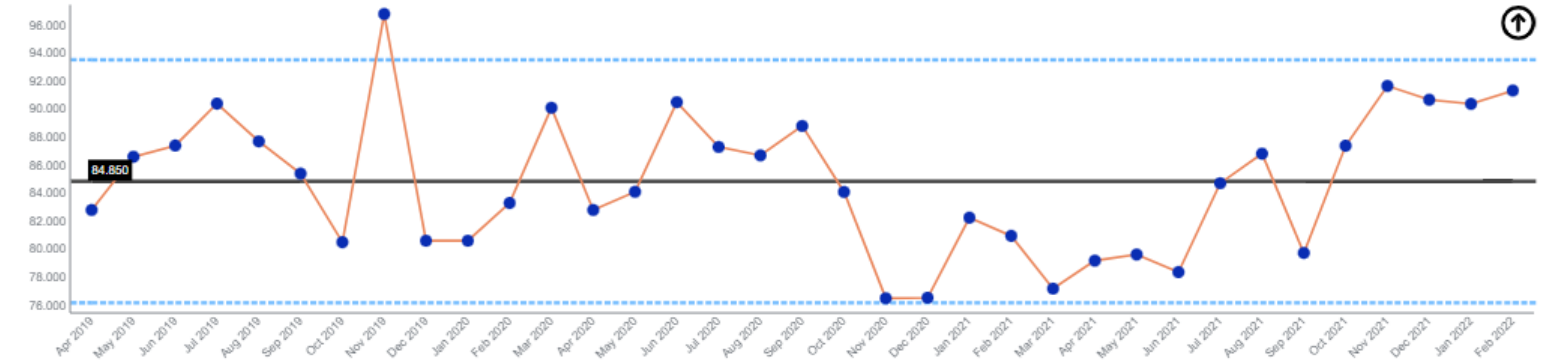
Last updated on Feb 2022

Tier 3: Rapid Response
The pattern of demand is changing [impact of CNC]

Patient Referrals - Rapid Response Team



Percentage Admission Avoidance-Rapid Response

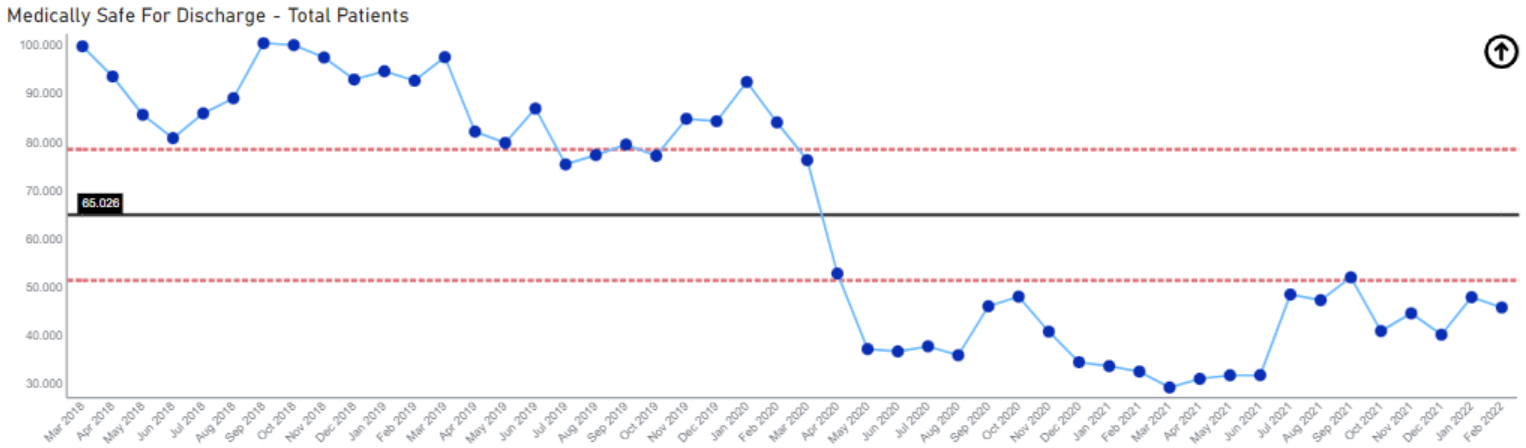


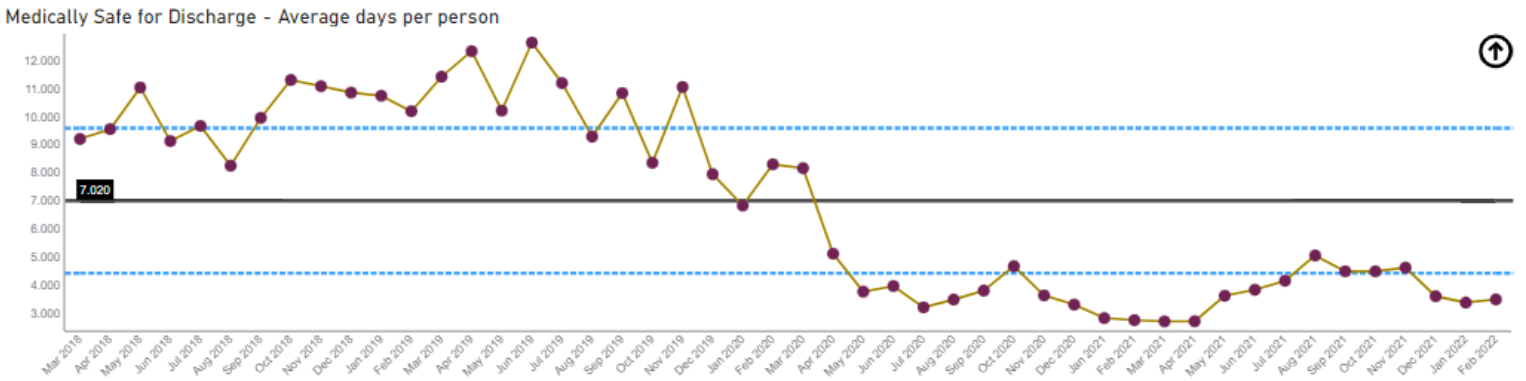
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present capacity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

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

Last updated on Feb 2022

Tier 3: Medically Stable for Discharge (MSFD): numbers remain low

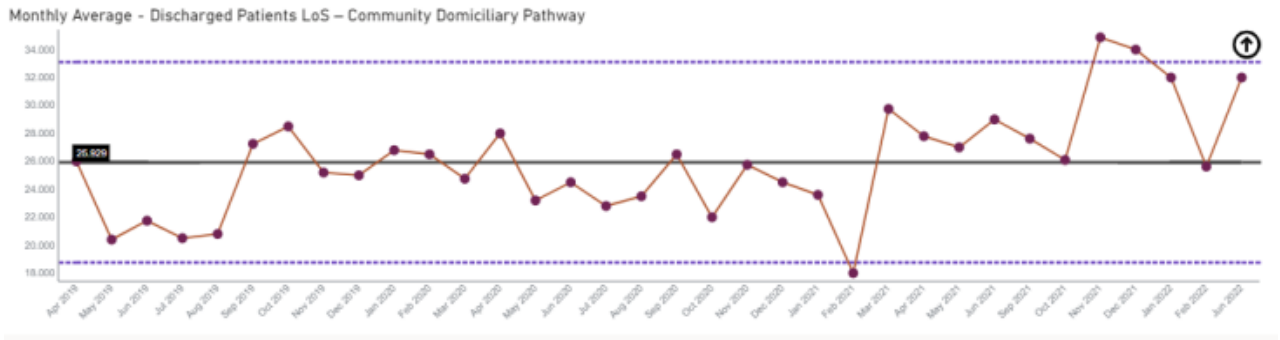




- The number of MSFD patients were maintained below an average of 50 with the length of stay decreasing during January. This is as a result of the actions that have been taken by the Community Division, ICS and partners in response to the difficulties being experienced in commissioning and providing packages of care.
- The response has led to an additional 700 hours of domiciliary care being procured and delivered by the market with a further 200 being procured for Winter from the beginning of December for Fast Track patients.
- Additionally, patients are being placed on an interim basis into care home beds rather than being discharged back home with a care package, while continuing to seek a package of care to enable them to be cared for in their own home. Plans for an expansion of beds are being prepared for the Winter period to provide further resilience
- Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients. Further work is being completed on enabling service to ensure resilience through the Winter period
- 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 on Feb 2022

Tier 3: Domiciliary and Bed-Based Pathways

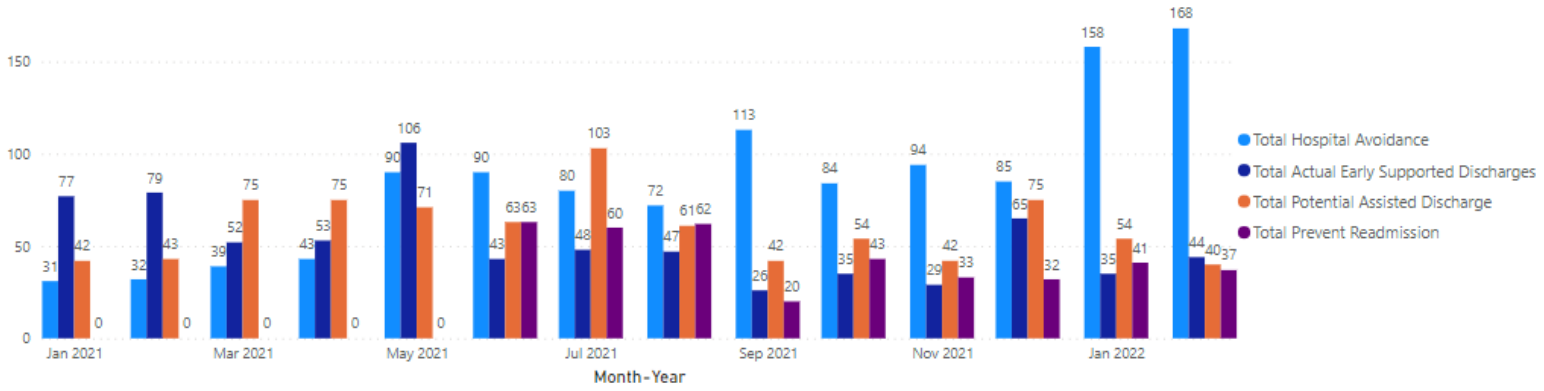


- Therapy demands and the change in national model is having a significant impact on community ICS therapists, unplanned crisis demands and hospital discharges remain key priorities in patient safety.
- Due to Covid, individuals have been more unwell and therefore have needed rehab/Reablement for a longer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

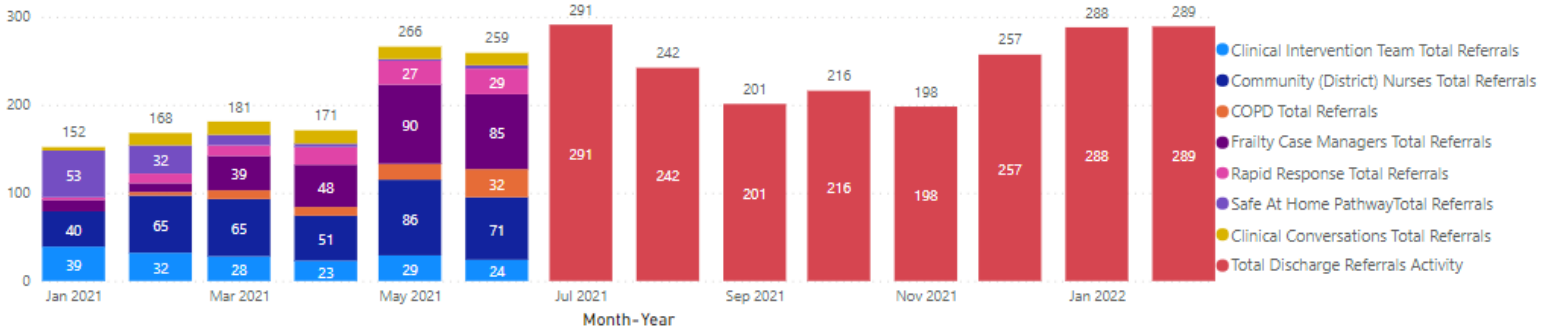
Last updated on Feb 2022

Tier 3/4:
Integrated Assessment Hub:

Total Monthly IAH Activity



IAH Discharge Referrals Activity



Integrated Assessment Hub

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

Last updated on Feb 2022

Place Development
March 2022

1. PURPOSE OF REPORT

This report summarises the outputs from the recent Partnership Board development session and make a series of recommendations for next steps. It proposes the creation of a 'Place Development' programme that will develop the governance and ways of working for the partnership set in the context of all relevant legislation, policy and guidance.

2. BACKGROUND

The Walsall Together Business Case: Moving towards an Integrated Care Partnership (January 2019) describes the ambition and opportunity to deliver more integrated care and improved outcomes for the citizens of Walsall. It describes an operating model that will significantly transform the way in which health and care services are delivered to the Walsall population, increasing focus on prevention and building resilience in communities such that citizens remain independent and require less support from services that don't deliver the best outcomes.

The partnership was formally established in April 2019. The arrangements outlined in the business case were intended to establish the foundations of partnership working, allowing for evolution and further integration as the partnership matures:

- Initial objectives
- Outline operating model
- Outcomes framework
- Host Provider governance arrangements and Alliance Agreement
- Commercial model

Partners agreed to convene a development session to reconfirm the shared aims of the partnership and to review future priorities, set in the following context:

- COVID-19 pandemic has impacted on our ways of working and our future priorities, particularly in respect of the health and social inequalities
- Senior leadership changes across the partnership, including the departure of both the Chair and Executive Director
- Several White Papers, and accompanying policy and guidance, have been released over the past 12 months, with more expected to be published over the course of 2022

The aims of the day were:

- To learn from the experience of current successes
- To agree how best to focus collaborative efforts 2022-25
- To identify improvements in how we do our work

3. OUTPUTS

The following strategic aims were reconfirmed with SMART objectives to be developed in due course:

- Promote equality and reduce inequalities by focussing on the wider determinants of health
- Provide high quality and accessible care for all who need it
- Improve health and wellbeing outcomes for the population of Walsall
- Develop a skilled, motivated and happy workforce
- Make best use of partnership resources

Based on the achievements set against the core components of the business case, the following proposals were agreed:

1. Define the ambition of further integration across Primary Care Networks (PCNs), mental health and services for children
2. Focus on the 'how' rather than the 'what'
    - Develop a robust data & intelligence function that facilitates an outcomes focussed environment and Population Health Management
3. There is a robust structure in the partnership for dealing with the urgent
    - Let the partnership get on with this, with oversight by the Partnership Management Team
4. Increased the focus of the Partnership Board on driving the planned transformation and development agendas
    - Focus on outcomes, mapped back to the Joint Strategic Needs Assessment and aligned to the model of health, care and wellbeing
5. Ensure primacy of place, with outward accountability to citizens
    - Develop an Outcomes Framework based on place priorities and engage in the national consultation for place-based partnerships
    - Develop a governance model that describes the relationship with the Health & Wellbeing Board, Joint Commissioning Committee and the Integrated Care Board (ICB) in respect of decision making, covering contentious issues, managing risk, resolving disagreements, and agreeing shared outcomes
    - Be more explicit in how we look at money and infrastructure arrangements
    - We must include relationships with non-NHS boards e.g. Safeguarding, Safer Walsall Partnership, Children's Alliance
    - Update our digital roadmap to include, for example, how we will use the NHS app, remote monitoring, access to shared records (professionals and citizens)
6. Commercial model
    - Keep under review with services considered on case-by-case basis only if contractual changes would enable integration further or faster than otherwise possible
    - Engage with the ICS/ICB on decisions regarding the scope of services, delegation of functions or pooled funding arrangements at place

Feedback on the priorities for the partnership transformation programme has been collated and is included in the appendix. This will be used alongside the Joint Health & Wellbeing Strategy, to develop the 2022/23 transformation programme, and brought back to the Partnership Board for approval in April. The draft workstreams for the 2022/23 transformation programme are:

- Care Coordination
- Population Health Management
- Resilient Communities

- Workforce & OD
- Community Mental Health
- Services for Children

4. PLACE DEVELOPMENT PROPOSAL

To take forward the proposals agreed in section 3 above, it is recommended to establish a 'Place Development' programme that consists of the following workstreams:

- **Governance** workstream will confirm accountability relationships with ICB, HWB and any other relevant groups. It will refresh Alliance Agreement, strengthening risk management arrangements, dispute resolution and agreeing shared outcomes
- **Finance & Contracting** workstream will confirm the scope of services and functions proposed for delegation, and outline due diligence requirements
- **Digital, Data & Intelligence** workstream will produce an integrated quantitative and qualitative intelligence solution that enables performance management, population health management, and enables an outcomes focussed environment
- **Citizen Voice** workstream will formalise current engagement approach, define how qualitative intelligence about our population will be utilised in decision making, and define how the citizen voice will be incorporated into strategic governance

Each workstream will operate within a framework designed to ensure consistency in approach, exploration of key lines of enquiry aligned to the strategic aims, and creation of a revised integration roadmap for 2022/23 and beyond. Each workstream will require a Senior Responsible Officer, ideally a WT Board member or equivalent senior leader from within the partner organisations, who will establish appropriate working arrangements and provide assurance on progress back to the Partnership Board.

Importantly, Walsall Together is predicated on creating an environment where multiple, sovereign partners can work together to achieve an agreed set of common, desirable outcomes, whilst retaining individual strategic and statutory responsibilities. This will remain the foundations of our future partnership working and all of the place development workstreams will consider the wider operating, policy and governance environments that are pertinent to each of our partners.

In the context of the relationship between Walsall Together and the Black Country Integrated Care System (ICS), there are time pressures associated with defining our governance and accountability relationships. The recent Integration White Paper infers that governance and outcomes frameworks will imposed upon us if they are not defined locally in advance of April 2023. There is also a requirement for a Single Accountable Person to be identified with accountability for health and wellbeing outcomes at place. Due to the potential implications on the statutory roles and responsibilities of Walsall Healthcare, Adult Social Care and the CCG, a senior working group from these partners will be established to confirm the high-level parameters within which we can start to define our partnership response to this specific White Paper. The ambition is to complete this initial work within quarter 1 of 2022/23, to inform, where necessary, the

place development programme and to align the role and responsibilities of the vacant Executive Director post.

Importantly, the core transformation programme needs to continue in parallel. We have resource to progress to our new Model of Health, Care and Wellbeing. This will also ensure our that system plans are built from the priorities at place, with focus across the breadth of the partnership, demonstrating the significant value added by our non-NHS partners.

5. RECOMMENDATIONS

The Board is asked to approve the creation of a Place Development programme and to review and propose options for Senior Responsible Officers (SROs) for each of the identified workstreams.

APPENDIX – collated feedback from Board Development session re future priorities

	2025 Aims/ Themes	2023 Objectives - what would be different? How do we do it?
1	Workforce	a) Develop a more explicit workforce & OD plan over and above the high-level aim b) Relationship between system and place – define roles and responsibilities c) Career progression and development across place/model d) Match demand with capacity e) Use digital platforms to make working lives easier not police them
2	Citizen voice	a) Clearly define engagement approach and coordinate this effort across our partners that already do this well b) Define how our citizens can drive our priorities going forward – coproduction? c) Use knowledge of our population to deliver personalised care, prevention
3	Care coordination/ navigation for social prescribing/ RC/ CVS	a) Better coordination and consistency of the 'offer' at the interface between statutory services and community/CVS (social prescribing, health coaching, wellbeing etc) b) Refresh digital strategy in line with national plans e.g. NHS app and original intentions for SPA/CNC function in this part of the model

4	How we work/ enablers	a) Culture of segmentation, approach to population health management – important to get this right to ensure directing resource and effort in the best way b) OF – alignment of data and intelligence resource, don't over complicate c) Courage to not do what doesn't work d) Difficult decisions to dis-invest and invest in a different organisation
5	Health inequalities	a) Agree the levers that we are able to pull versus areas we might want to influence e.g. economic board b) What do we mean by HI and how is this understood in the population c) Coordination of a single plan, functionality to respond to funding opportunities
6	Practical support for resilient communities We make people better in communities	a) Establish long term funding model to improve capacity and resilience b) Help with bidding but that has limitations c) Need to focus and coordinate bidding opportunities so its less fragmented d) Make sure bidding/funding is outcomes focussed and evidence based e) How much has VS spending reduced since 2011
7	Mental Health – rising tide particularly for children	a) Ensure upstream support b) Link ICS CMH strategy to local physical health strategy. More MH professionals is not the only answer
8	Older people	a) EOL identification b) Better IT help reduce F2F c) Admission avoidance d) LTC management
9	Disinvest to invest	a) Left shift to be built into everything we do

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Charitable Funds Committee
Date(s) of Committee/Group Meetings	14th March 2022
Chair of Committee/Group:	Paul Assinder
Date of Report:	23rd March 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The Charity is, in part, reliant upon its portfolio of investments to generate income. With the recent conflict in Ukraine and subsequent economic sanctions, it is highly likely that the international markets and thus our portfolio, will be subject to volatility in the coming months.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The Charity employs professional Investment Managers to advise upon the ethical investment of surplus funds. The value of the investments held by Brewin Dolphin as at 31st December 2021 was £812,245.83 (including cash held totalling £64,234.38). • The overall movement in the book value of investment during the quarter is an increase of £31,000.

ASSURE
Positive assurances & highlights of note for the Board/Committee
	• The Charity has once again organised an excellent range of fundraising events during the last quarter and continues to benefit from local commercial links. In particular the Committee were advised of the following:
	  • A new partnership with Tilbury Douglas Ltd, the ED Department constructor.
	  • The Trust has been nominated as the 'Charity of the Year' by the extremely active 'Business in Walsall' organisation.
	  • Continued work as the named charity with Walsall Football Club and Home Serve Ltd.
	• Current Projects highlighted include £18,000 to refresh the Neonatal Child Development Centre, noting that there was some contribution from the League of Friends).
	• It was noted that an amount of £130,000 is to be donated by a local family from a sale of a property, as a legacy gift to the Well Wishers Charity.

Recommendation(s) to the Board/Committee	• None
Changes to BAF Risk(s) & TRR Risk(s) agreed	• None

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• None
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• The Committee considered a working draft of the Fundraising Strategy update, which will be presented to the Corporate Trustees in the Summer.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Dr Radford, Consultant in Occupational Health, addressed the Committee to seek support for a bid to NHS Charities for £95,000 over 2 financial years for the employment of an Organisational Psychologist to study the impact of the Covid pandemic on staff in the Trust and to advise on longer term well being measures and effective support mechanisms. The Committee supported the bid, whilst suggesting that the scope of the study be extended to embrace Wolverhampton.
Matters presented for information or noting	• None
Self-evaluation/ Terms of Reference/ Future Work Plan	**Well Wishers Events Programme 2022** • Quiz 7th April The Bell, Walsall • Fashion Show 9th May • MLCC Well Wishers flower bed 3rd week of May • Manor site Memorial Garden (1 year on) 1st week of June • Manor Site Jubilee Celebrations 1st, 2nd & 5th June Manor site and community settings • Sky Dive 9th July Nottingham • Welsh Walk 10th September Barmouth • Boxing Event 14th October Rushall Labour Club • Make a Will Fortnight November (TBC) Enoch Evans • Quiz November (TBC) The Bell, Walsall • Trust got Talent & Christmas Party 16th December Rushall Labour Club • Christmas Celebrations 2nd December onwards Manor site
Items for Reference Pack	•

Trust Board Meeting
Chair Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Audit Committee
Date(s) of Committee/Group Meetings	7th February 2022 – Virtual meeting
Chair of Committee/Group:	Mary Martin
Date of Report:	14 March 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The internal audit report Infection, Prevention and Control – Board Assurance Framework Review was rated Partial assurance with improvement required. The committee was very disappointed with the findings of the audit and an action was agreed to escalate the report to the Board who in turn could stress how seriously they take the recommendations of the report.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The internal audit report, Core Financial Controls was rated Significant assurance with some improvement required. The main concerns were around written procedures for collecting non-NHS debt • The internal audit report, Staff Survey was rated Partial assurance with improvement required. Action plans are being followed up with the Director of people and Culture. • The Board Assurance Framework mechanism is under review and the Corporate Risk Register is moving to a new platform. • The management of declaring Conflicts of Interest is being moved from ESR to a new system. It is estimated it could take 2-3 years to have the information properly stored. • The outcome of the procurement process to appoint new Internal Auditors and Local Counter Fraud services has resulted in RSM being appointed for both.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Good progress has been made on closing audit recommendations. One medium risk action was overdue but being followed up. • The external audit plan is in place and the timeline agreed.
Recommendation(s) to the Board/Committee	• Recommendation to the Board to approve the Trust Counter Fraud Strategy.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• None
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Early warning alerts from Performance and Finance Committee regarding efficiency programme for Financial Year 22/23 and reliance on substantive staff reducing reliance on agency staff and agency staff expenditure. • From TMC, the reduction in Covid-19 funding potential impact.

ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Review of the reporting and monitoring of Single Source Waiver application. • Internal Audit Report on Core Financial Controls – significant assurance. • Internal Audit – Staff Survey – further actions for review at PODC. • Internal Audit Plan progress reported on and reviewed
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Review of Counter-Fraud Strategy for approval at Board. • Review of Internal Audit – Infection Control Board Assurance Framework (IPBAF) requires improvement – alignment actions and alert to Board. • Review of Board Assurance Framework (BAF) and Corporate Risk Register with review and revision of BAF Risks to follow.
Matters presented for information or noting	• Losses and payments • Local counter Fraud Progress Report • Clinical Audit Plan now QPES business • Use of Trust Seal now reported at Confidential Board • Revised approach tom Conflicts of Interests Registers noted with report on current registers to follow
Self-evaluation/ Terms of Reference/ Future Work Plan	• The meeting reviewed the process of preparation for the Audit Programme commencing April 2022.
Issues identified potentially relating to Equality, Diversity, and Inclusion	• Staff engagement in staff survey to be reviewed further at PODC.

MEETING OF TRUST BOARD – 6th APRIL 2022			
2021 National Staff Survey Results			
Report Author and Job Title:	Clair Bond, Deputy Director of People & Culture	**Responsible Director:**	Catherine Griffiths, Director of People & Culture
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Assure	• The Board can be assured that a detailed and full understanding of the results of the 2021 National Staff Survey has been developed following analysis of the results; the summary is at appendix 1. • The Board can be assured there was full engagement with the staff survey with a response rate of 53% which is above the sector average of 46%. • The NHS Staff Survey results 2021 show improvement in staff experience generally relating to the NHS People Promise with all but one indicator within the 40% to 60% range for the benchmark group. The baseline for Walsall was bottom 20%. • The NHS Staff Survey Oversight group is designing and delivering action to address the outlier metrics within the data set, it represents all divisions, staff-side, FTSU guardians, cultural ambassadors, staff network members. • There has been a significant improvement in the representation of BAME colleagues at senior levels Band 8a and above within the Trust during 2021-2022 year.		
Advise	• The Trust Board Pledge sets a standard for a healthy organisational culture in which colleagues feel valued and will advocate for the Trust as a place to work and a place to be treated. These metrics are measured as part of the NHS Staff Survey. • The Board can be assured that the Trust Board Pledge metrics have been reviewed with areas of success noted and areas improvement identified shown below in the 'Alert' section. • The Race Code Accreditation provides a framework for assurance on the element of the Trust Board Pledge relating to being an anti-racist organisation.		
Alert	• Advocacy for the trust remains an issue and remains significantly below sector – recommend Walsall as a place to work and as a place to be treated has declined along with national trend. • There has been a reduction of 7% on reporting that '*We are safe*		

	and healthy' Just 23% of respondents feel there are enough staff at the Trust to enable them to do their job properly compared to 30% in 2020. The benchmark average is 26% (a reduction of 10% compared to 2020) • Culture is an issue – compassionate culture not evident consistently across the Trust with the staff survey results still showing bullying and harassment as above the national average, this element of the NHS People Promise requires improvement. • Staff experience is not consistent across the Trust – the divisional map shows variation, further analysis initiated. • The results report more incidences of discrimination on the grounds of; gender, sexual orientation and disability than in 2020. Discrimination on the grounds of religion has decreased from 11% to 9% in 2021 but remains an outlier compared to the sector average of 5%. Discrimination on grounds of race remains high at 46%, this is a 5% reduction on 2020 result and is now below sector average 48%. • The indicators on WDES – workforce disability equality standard have worsened in year and show differential experience.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Report related to Risk ID 2489 - Poor colleague experience in the workplace and Strategic Objective ("SO") as set out within the BAF SO 04 - Value our Colleagues*; we will be an inclusive organisation which lives our organisational values at all times*	
Resource implications	There are no resource implications associated with this report. The interventions outlined from the detailed analysis will require consideration of resources.	
Legal and/or Equality and Diversity implications	Data relating to equality, diversity and inclusion is provided within the staff survey results. Responses provided to questions indicate the experience of staff in terms of inclusion and equality of opportunity. Full benchmark information will include Workforce Race and Workforce Disability Equality Standards data.	
Strategic Objectives	Safe, high-quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

2021 NHS Staff Survey Results for Walsall Healthcare NHS Trust

1. Introduction

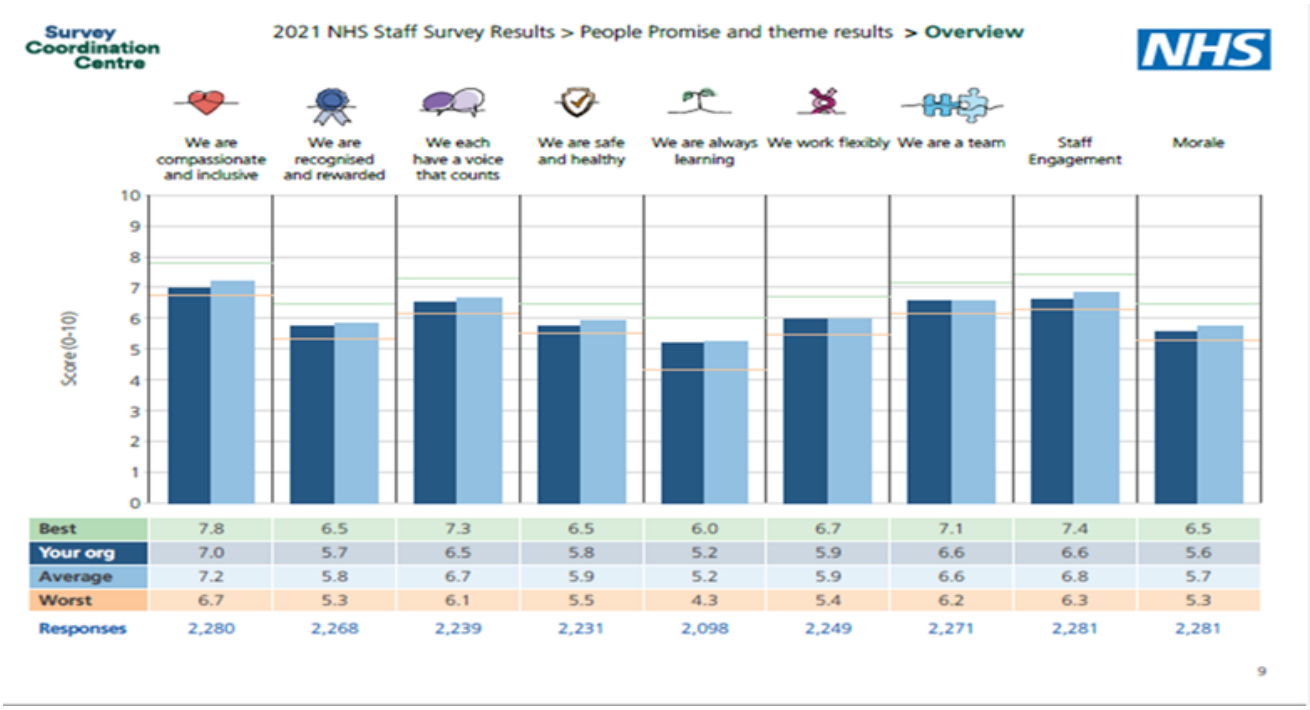
The 2021 NHS Staff Survey ran from mid-September to end of November 2021. Since reporting the early analysis to TMC in February, the confirmed benchmark reports have been provided and remained under embargo until 31 March 2022.

The median response rate across the 2020 benchmarking group (Acute and Acute & Community Trusts) is 46%. The response rate for the Trust was 53% (an increase from 33% in 2020); in terms of number of respondents to the survey this equates to 2,288 staff. All staff employed as of 31 August 2021 were invited to participate in the survey via a mixed delivery model (paper and digital surveys).

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In addition there are two themes reported in previous years (Staff Engagement and Morale). The reporting also includes new sub-scores, which feed into the People Promise elements and themes.

An overview of the results is set out below.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.0	5.7	6.5	5.8	5.2	5.9	6.6	6.6	5.6
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,280	2,268	2,239	2,231	2,098	2,249	2,271	2,281	2,281

2. Executive Summary

- The Trusts scores are below the sector benchmark average for 6/9 indicators. *We are always learning, we work flexibly* and *we are a team* match the sector benchmark average.
- The Staff Survey WRES indicators demonstrate improvements on the experience of BME colleagues at WHCT, however, the results remain a concern as they remain some distance behind the benchmark average.
- 7/8 WDES indicators reflect that the experience of staff with long term conditions or illness has generally worsened compared to 2020 results.
- Staff engagement has decreased by 0.1%. Of the three elements that form the staff engagement score; motivation, involvement and advocacy – advocacy has seen the sharpest decline of 0.26%
- Less staff are advocating for the Trust; staff recommending WHCT as a place to work has decreased from 52% to 48% and staff recommending WHCT as a place to be treated has decreased from 53% to 47%. Whilst this follows a national downward trend, the 2021 results are more aligned to pre pandemic results received in 2019 and a significant distance from the average sector benchmark
- At 5.58 the score for staff morale has not significantly changed (-0.02) compared to 2020. More staff at WHCT have indicated that they are thinking of leaving compared to 2020 results, however this is a national trend across the NHS.
- There has not been the significant improvement that was aspired to in terms of reducing conflict in the workplace. In all questions relating to bullying and harassment (Q14a,b,c) the Trusts responses are above the benchmark average which remains relatively static compared to 2020. That said, it is important to note that the number of colleagues reporting managers as the source of harassment, bullying or abuse in the workplace has reduced from 18% in 2020 to 14.6% in 2021 (against a national average of 11.9%).
- Although experience of discrimination on the grounds of ethnicity remains high (46%) it is now lower than the sector benchmark average of 48% and is a Trust 5% improvement compared to 2020 (51%). Conversely the results report more incidences of discrimination on the grounds of; gender, sexual orientation and disability than in 2020. Discrimination on the grounds of religion has decreased from 11% to 9% in 2021 but remains an outlier compared to the sector average of 5%.
- Colleagues are continuing to have an increasingly positive experience of their immediate line manager in the workplace (*compassionate leadership* and *we are a team*)

- The number of staff working additional paid and unpaid hours remains significant, which increases the potential of staff burn out and frustrations and conflict within the workplace. Q10b, identifies that compared to 2020, 10% more staff undertake additional paid hours (43.1%) compared to a benchmark average of 38.4%.

3. Survey Results

3.1 There have been improvements which exceed the average benchmark scores in the following areas: -

- 67.4% of staff advised that their immediate line manager worked with them to understand their problems compared to a benchmark average of 65.4% *(Q9f) We are compassionate and inclusive; compassionate leadership.*
- 67.3% of staff advised that their immediate line manager care about their concerns compared to a benchmark average of 66.9% *(Q9h) We are compassionate and inclusive; compassionate leadership.*
- 64.1% of staff advised that their immediate line manager takes effective action to help them with the problems they face compared to a benchmark average of 63.3% *(Q9i) We are compassionate and inclusive; compassionate leadership.*
- 51% feel involved in deciding changes affecting their team/work (2021 benchmark average: 48.9% (Trust 2020: 47.7%) *(Q3d) We each have a voice that counts; Autonomy and control.*
- 54.6% feel able to make improvements happen in their area of work (2021 benchmark average 53.3%, Trust 2020: 52.6%) *(Q3f) We each have a voice that counts; Autonomy and control.*
- 69.7% of staff fed back that their immediate line manager encourages them at work compared to a response of 67% in 2020 and a benchmark average of 69%. *(Q9a) We are a team; line management.*
- 62.3% fed back that their immediate line manager gives clear feedback on work and improvement for the third consecutive year (from 60.6% in 2020) against a benchmark average of 60.7%. *(Q9b) We are a team; Line management*.
- 56.4% of staff advised that their immediate line manager asks for their opinion before making decisions that affect their work compared to 54.2% in 2021 and a benchmark average of 55.7%. *(Q9c), We are a team; Line management.*
- 67.1% of staff responded that their immediate line manager takes a positive interest in their health and well-being. Although a reduction from 69% in 2020, the Trust response is above the benchmark average of 66.3% in 2021. *(Q9d) We are a team; Line management.*

- More staff are involved in deciding changes that affect their work/area/team/department 51% compared to 47% in previous 2 years against a benchmark average of 48.9%. *(Q3e) We each have a voice that counts; autonomy and control.*

3.2 There have been improvements on 2020 results in the following areas:

- More staff report receiving respect from colleagues at work 2021 66% up by 1% from 2020. Benchmark average 69.7%. *(Q7c) We are a team; team working.*
- 70% of respondents believe their line manager encourages them at work compared to 67% in 2020. *(Q9a) We are a team; line management.*
- More staff report feeling secure to raise concerns about unsafe clinical practice. 2021: 70.1% v 2020: 67.4%. (Q17a) *We each have a voice that counts; raising concerns*.
- More staff report feeling they receive the respect they deserve from colleagues in 2021 compared to 2020 (66.4% compared to 65%) against a benchmark average of 70%. *(Q7c) We are a team; team working.*

3.3 The most significant areas of concern where results have worsened or are 3% lower than the benchmark average

- *(Q3i) We are safe and healthy. Negative reduction of 7%*
  Just 23% of respondents feel there are enough staff at the organization to enable them to do their job properly compared to 30% in 2020 and 27% in 2019 & 2018. The benchmark average of 26% has reduced by 10% compared to 2020.

- *(Q5c), Morale, stressors. Negative increase of 4%*
  More people report strained work relationships 2021: 41% compared to 37% in 2020. The benchmark average has positively reduced from 45.4% in 2020 to 42.8% in 2021.

- *(Q4a) We are recognised and rewarded. Decrease for 5th consecutive year.*
- The number of respondents advising they get recognition for good work has decreased for the fifth consecutive year 48.6%. The peer benchmark average has significantly decreased to 50.5%.

- *(Q21e) We each have a voice: Raising concerns. Negative decrease of 6%.*
  Only 53.2% of staff feel safe to speak up about concerns in the Trust compared to 59% in 2020: 59%. It is worth noting that there has been a 5% national decline in this area from 2020: 65% to 2021: 60.7%.

- *(Q21f) We each have a voice: Raising concerns. 7% lower than benchmark average.*
- Only 40.6% of respondents felt confident that if they spoke up the Trust would address their concern (2020 Av 47.9%).

- *(Q11d) We are safe and healthy, negative experiences. Negative increase of 5%.* 59% said they have come into work in the last three months, despite not feeling well enough to perform their duties. This is a significant deterioration compared to 54.2% and follows a significant negative increase across the NHS.

- *(Q20b) We are always learning; development. 5% below benchmark average.* 47% believe there are opportunities to develop their career in the Trust compared to the benchmark average of 52.1%.

- *(Q8a) We are a team; team working. 7% below benchmark average* 44.7% of respondents feel teams within the Trust work well together to achieve their objectives compared to a benchmark average response of 52.5%.

3.4 It is also worth noting the Trusts progress in the following areas where the benchmark average has declined:

- 51% of respondents felt that the Trust act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age compared to 48.8% in 2020. The peer benchmark average reduced to 55.7% in 2021 compared to 56.2% in 2020. *Q15.*

- There has been a slight increase in staff reporting they are confident the Trust will address their concern. 2021: 50.2% v 2020: 49%. The benchmark average declined from 59% in 2020 down to 57.9% in 2021. *(Q17b) We each have a voice that counts; Raising concerns*.

- 52% of respondents advised they had adequate materials, supplies & equipment to do their job compared to 45% in 2020 (7% increase). The benchmark average reduced by 3% in 2021 *(Q3h) We are safe and healthy.*

- The areas that require the most improvement across the board are *staff engagement*, we are *compassionate & inclusive*, *we each have a voice that counts* and *we are a team*.

4. The Trust Board Pledge

The Trust Board Pledge provides a set of metrics to measure progress against the areas of concern: bullying, harassment, discrimination and behaviours outside of trust values. These are likely to impact adversely on staff advocacy for the trust as a place to work and a place to be treated.

"***To demonstrate through our actions that we listen and support people. We will be an anti-racist and anti-discrimination organisation that treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you***".

The measures agreed by the Committee for assurance have been reviewed and updated as set out below: -

Measure	2019	2020	2021
1. Employee Engagement Score (NSS indicator)	6.6	6.7	6.6
2. % of staff saying the organisation takes a positive interest in their health and wellbeing (NSS indicator) This indicator has been reframed win the 2021 NSS to "My organisation takes action on health and well-being" (Q11a)	26.5%	26%	52% (benchmark average 56.4%)
3. No of SA days taken as a result of bullying and harassment.	4.64 days	3.77 days	3.68
4. Reduction in voluntary turnover rates	82%	82.7%	81.7%
5. Reduction of B&H and Grievance case work relating to behaviours.	32 cases (August 2019-2020)	37 cases (Sept 2020 – March 2021	34 cases (April 2021 to March 2022)
6. Increased BAME representation in B7 and above roles	Total 18.81% B7 9.5% B8a + 4.6%	Total 19.17% B7 9.7% B8a + 4.7%	Total 23% B7 22% Ba + 25%

The data demonstrates incremental improvement across indicators and for some of the indicators relating to representation, a step change particularly at senior level.

5. Conclusion

The Trust 2021 NHS Staff Survey results demonstrate continued progress in many areas particularly in relation to team working and experience of line manager. The following themes are recommended areas for organisational and local leadership attention.

We are compassionate and inclusive: Achieving a greater consistency in terms of positive experiences of compassionate and inclusive leadership and management in practice will enable the organisation to improve the workplace experience of all staff. Continued focus on management and leadership development is vital along with dealing swiftly and decisively with discriminative actions and behaviours and supporting leaders and staff to deal effectively with conflict in the workplace.

We are safe and healthy: Continuing to invest in the workforce both in terms of increasing establishment, ensuring colleagues have the resources necessary to do their job and the means by which to develop their skills and career are critical factors to

achieve fulfilling roles, support health and wellbeing at work and increase staff engagement and morale.

We each have a voice that counts: Building a psychologically safe place to work that involves and distributes decision making to colleagues. Our results highlight that developing the ability to deal with constructive conflict through dialogue and debate would positively inform organisational learning and develop the culture of teams.

6. Recommendations

The Trust Board are asked to note and consider the contents of this report.

- Results and Trust level plans will also be reported to the following groups and committees: Equality, Diversity and Inclusion Steering Group, Trust Management Committee, JNC and LNC.

- The Staff Engagement and Experience Oversight Group recommenced in March 2022 to agree responses and actions. The People and Organisation Development Committee will receive monthly updates of progress and key actions.

APPENDICES

1. 2021 NHS Staff Survey Results Resource Pack – Executive Summary

Walsall Healthcare NHS
NHS Trust

Staff Survey 2021
Executive Summary

Resource Pack

March 2022

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

Background and context

One of the largest workforce surveys in the world which has been conducted every year since 2003.

The results are reported against the 7 elements of the people promise and two themes of; staff engagement and moral.

The 2021 National Staff Survey took place between 26 September and 26 November 2021.

An independent company Quality Health was commissioned to conduct the survey to ensure total confidentiality of results.

The Trust is benchmarked against a peer group of 126 other Acute and Acute & Community Trusts.

A complete census of all 4,395 staff employed as of 31 August 2021 across the Trust were asked to complete a survey.

Completion of the survey is not mandatory and was enabled by both paper and digital questionnaires.

The Trust achieved a response rate of **53%** equivalent to 2,288 questionnaires. A **20%** increase from **2020.**

The median response rate for Acute & Community Trusts was 46%.

The results will be used as a base line to measure the impact of the People Plan at a national level

Both NHSI and the CQC review trust survey results to help decide who, where & what to inspect.

The extent to which our staff feel valued and cared for directly impacts on the quality of care received by our patients.

The Trust received 3 x standard reports: (i) Full, (ii) Summary and (iii) Directorate. A report detailing results at Care Group Level has been commissioned.

Walsall Healthcare NHS Trust

Executive Summary

- For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the **things that would most improve their working experience**, and is made up of seven elements:

- The majority of the People Promise scores for the 2021 NHS Staff Survey for Walsall Healthcare NHS Trust are in line with the sector scores. This is an **improvement on previous performance** for Walsall.

- **Response rate was significantly higher** (**53%)** than sector scores and **20% improvement** on last year

- One of the seven People Promise themes is **significantly lower** than the sector scores for similar organisations surveyed by Quality Health (**'We are compassionate and inclusive**"), the determinants of this promise are compassionate culture, diversity and equality, we are safe and healthy, staff engagement, advocacy and thinking about leaving.

- The themes of Morale and Staff Engagement remain key performance indicators for organisations. While **staff engagement** scores at Walsall Healthcare NHS Trust are reported to be **significantly lower** than the sector scores, Morale among staff is in line with sector scores.

- The Staff Experience Group key requirement **achieving consistency of Staff Experience across the Trust.**

Headlines

Walsall Healthcare NHS
NHS Trust

- Significantly improved engagement with the NHS Survey **highest ever response rate of 53%** which was a **20% increase** from 2020 and 7% above the median national average response rate for the sector of 46%.

- This year the survey is benchmarked against the **NHS People Promise** which places the **spotlight on Staff Experience.**

- The Trusts scores for ***we are always learning, we work flexibly*** **and** ***we are a team*** match the sector benchmark average, this is **a significant improvement** for Walsall as the baseline for the Trust was in the lowest 20% of Trusts nationally.

- The majority of the People Promise scores for the 2021 NHS Staff Survey for Walsall Healthcare NHS Trust are in line with the average sector scores. This is an **improvement on previous performance** for Walsall, however to note the scores have not yet matched sector average (although within the 40% to 60% of all Trusts range).

- One of the seven People Promise themes is **significantly lower** for Walsall than the sector scores for similar organisations surveyed by Quality Health ('**We are compassionate and inclusive**"), the determinants of this are compassionate culture, diversity and equality, we are safe and healthy, staff engagement, advocacy and thinking about leaving. Some of these indicators remain in the lowest 20% of Trusts nationally.

- The Staff Survey WRES indicators demonstrate **significant improvement relating to representation of BAME colleagues at senior level 6.9% increase in bands 8a and above** and **improvement relating to disciplinary, recruitment and access to training**. However **culture and the experience of BAME colleagues remains a significant concern**, it is well above the benchmark average, which itself shows a significantly adverse experience for BAME colleagues.

- The **WDES indicators are of significant concern** and reflect that the experience of staff with long term conditions or illness has generally worsened across 7 of the 8 WDES indicators compared to 2020 results.

Headlines

Walsall Healthcare NHS
NHS Trust

- **Advocacy has declined** less staff are advocating for the Trust; staff recommending WHCT as a place to work has decreased from 52% to 48% and staff recommending WHCT as a place to be treated has decreased from 53% to 47%. Whilst this follows a national downward trend, the 2021 results are more aligned to pre pandemic results received in 2019 and a **significant distance from the average sector benchmark**

- The number of **colleagues reporting managers as the source of harassment, bullying or abuse in the workplace has reduced** from 18% in 2020 to 14.6% in 2021 (against a national average of 11.9%).

- Although **experience of discrimination on the grounds of ethnicity remains high (46%) however it is now lower than the sector benchmark average of 48% and is a Trust 5% improvement compared to 2020** (51%).

- Conversely the results report **more incidences of discrimination on the grounds of; gender, sexual orientation and disability than in 2020.**

- Discrimination on the grounds of religion has decreased from 11% to 9% in 2021 but **discrimination on grounds of religion remains an outlier** compared to the sector average of 5%.

- **Colleagues are continuing to have an increasingly positive experience of their immediate line manager** in the workplace (*compassionate leadership and we are a team)*

Headline Recommendations – Quality Health

Recommendation: Look at each of the questions which make up the motivation score. It is likely that by identifying and resolving other issues from the survey, that these scores will also improve.

Recommendation: Work with staff to develop a culture of kindness, respect and appreciation of each other. Look to understand why some staff do not think that the people they work with are understanding and kind, polite and respectful, and show appreciation to each other. Drill down into the data to see if there are any particular areas where this is more prevalent and work with team leaders to address issues.

Recommendation: Ensure that patient experience data is regularly shared with staff to highlight areas which are positive (and should be celebrated) as well as areas to target improvement. Ensure that staff at all levels are involved in improvement of work where appropriate.

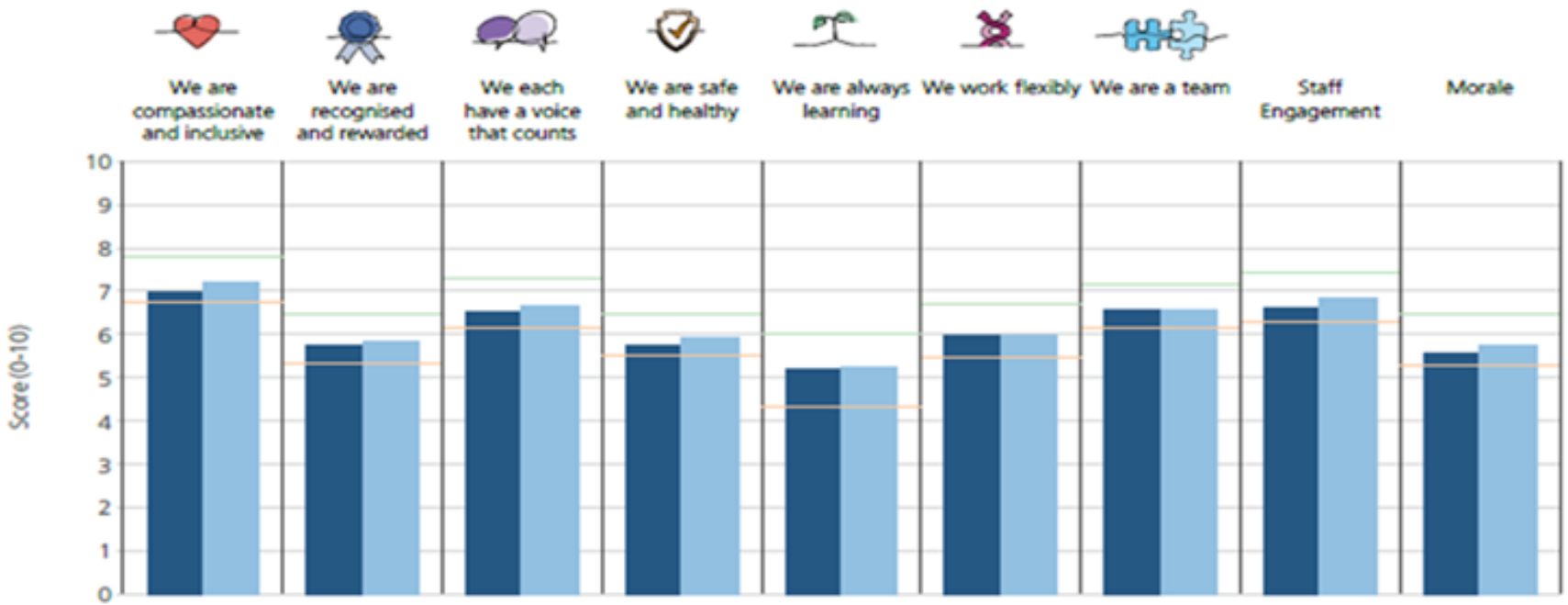
Walsall Healthcare NHS
NHS Trust

2021 Results by Themes

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.0	5.7	6.5	5.8	5.2	5.9	6.6	6.6	5.6
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,280	2,268	2,239	2,231	2,098	2,249	2,271	2,281	2,281

Walsall Healthcare NHS
NHS Trust

Divisional Overview – Need for consistency

This overview highlights the variability in the theme scores across the different divisions. Whilst this variability can in part be attributed to the difference in size and complexity of the division and the impact that Covd-19 will have had on the experience of colleagues working within the divisions, there is no difference in terms of the required ownership of results and accountability for improvement by divisional leadership teams. It should be noted that the Communication Team have reported under the CEO Department for 2021. Medical Directorate received too few responses to provide analysis against the ten themes.

	Trust	Benchmark Average	Best	Worst	Community	MLTC	Surgery	WCCSS	E&F	CEO (incl Comms)	Transformation & Strategy	Finance	Governance	Informatics	Medical Directorate	Nursing Directorate	Operations	P&C
Response Rate (%)	53%	46%			57%	42%	44%	54%	57%	68%	79%	83%	77%	62%	64%	74%	65%	84%
We are compassionate & inclusive	7	7.2	7.8	6.7	7.2	6.5	7	7.2	6.5	7.4	7.3	7.1	6.5	6.2	7.8	7.3	7.5	7
We are recognised & rewarded	5.7	5.8	6.5	5.3	6	5.1	5.7	5.9	5.2	7.1	6.8	6.4	5.6	4.9	7.5	6.4	6.5	6
We each have a voice that counts	6.5	6.7	7.3	6.1	6.7	6.1	6.6	6.7	6	6.8	6.7	6.6	6.2	5.6	7.5	6.9	7.2	6.5
We are safe and healthy	5.8	5.9	6.5	5.5	6	4.8	5.8	5.8	6.1	6.6	7	6.4	5.3	5.6	6.9	6	5.7	5.9
We are always learning	5.2	5.2	6	4.3	5.3	4.9	5.4	5.4	4.4	5.3	5.9	5.3	3.3	3.8	6.6	5.3	6.1	5.4
We work flexibly	6	5.9	6.7	5.4	6.1	5.3	6.1	5.8	5.4	6.8	8.2	7	6.5	6	7.6	7	6.4	6.5
We are a team	6.6	6.6	7.1	6.2	6.9	6.1	6.6	6.8	5.5	7	7.1	7.1	5.9	5.9	7.9	7.2	7.3	6.9
Staff Engagement	6.6	6.8	7.4	6.3	6.7	6.2	6.7	6.8	6.3	7.3	7	6.6	6.5	5.7	7.5	6.8	7.5	6.5
Morale	5.6	5.7	6.5	5.3	5.7	4.9	5.8	5.6	5.7	6.2	6.2	5.9	5	4.9	6.8	5.9	6.5	5.4

0.3 below Trust score	0.2 below Trust score	Equal to Trust score	Up to 0.2 above Trust score	0.3 & above Trust score	Equal to or above national best score	Equal to or below national worst score

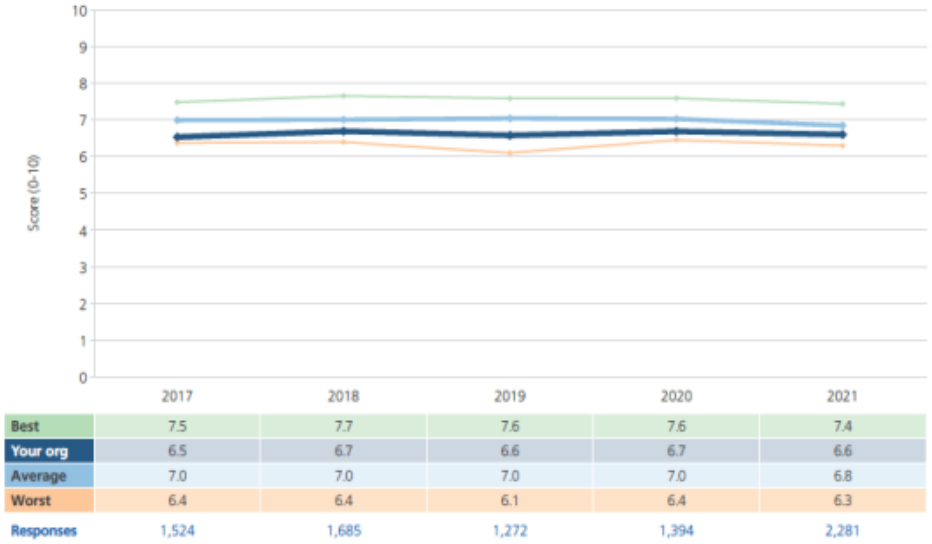
Walsall Healthcare NHS Trust

Employee Engagement Index (EEI)

The Trusts Engagement Score has decreased slightly by 0.1 from 6.7 in 2020 to 6.6in 2021 against an average of 6.8 within the benchmark peer group.

The EEI score is determined by nine indicators. Questions 2a, 2b, 2c regarding the motivation of staff, questions 3c, 4d, 3f about how involved staff feel in their role and their ability to contribute to improvements in their areas of work and questions 21a, 21c, 21d which reflect staff advocacy for Walsall Healthcare NHS Trust as a place to work and a place to be treated.

Nine of the 14 Trust Divisions / Directorates have either equaled or exceeded to Trusts score in this area, this includes three of the four clinical divisions.



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Advocacy		2016 %	2017 %	2018 %	2019 %	2020 %	2021 %	2021 Av %
21c	I would recommend my organisation as a place to work	47.5	47.3	51.7	47.8	52.3	**48.4**	58.4
21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	48.2	48.1	49.4	49	53.4	**47**	66.9

Morale

Walsall Healthcare NHS
NHS Trust

Theme score of 5.6 is consistent with previous years against a peer benchmark average of 5.7.

The Trust has maintained performance in the context of a national decline in the score for this theme.

	2018	2019	2020	2021
Best	6.7	6.7	6.8	6.5
Your org	5.6	5.5	5.6	5.6
Average	5.9	5.9	6.0	5.7
Worst	5.2	5.2	5.5	5.3

The Morale score is determined by twelve indicators. Questions 22a, 22b, 22c linked to thinking about leaving, 3g,3h,3i relating to work pressure and questions 3a, 3e, 5b, 5c, 7c, 9a identifying stressors.

Improvements

- 52% of respondents advised they had adequate materials, supplies & equipment to do their job compared to 45% in 2020. (Q3h)
- More staff are involved in deciding changes that affect their work/area/team/department 51% compared to 47% in previous 2 years.
- More staff report receiving respect from colleagues at work (Q7c, 2021: 66% up by 1% from 2020)
- 70% of respondents believe their line manager encourages them at work compared to 67% in 2020.

Getting worse - would not recommend as a place to work

The results indicate that more staff (34.8%) are thinking about leaving the Trust this year compared to 2020 (32.4%), however figures are in line with pre pandemic data (2018: 34.8% & 2019: 34.7%).

There is an overall increase in work pressure, with 43% of respondents not being able to meet conflicting demands on their time at work compared to an average of 39.6% over the preceding 2 years. (Q3g)

Just 23% of respondents feel there are enough staff at the organization to enable them to do their job properly compared to 30% in 2020 and 27% in 2019& 2018 (Q3h)

Respondents report the following workplace stressors:

- More people report strained work relationships (Q5c, 2021: 41% compared to 37% in 2020)
- More people reported coming to work despite not feeling well enough to do so (Q11d, 2021 59.5% compared to 54.9% in 2020)

Conclusion

Walsall Healthcare NHS
NHS Trust

The Trust 2021 NHS Staff Survey results demonstrate continued progress in many areas particularly in relation to team working and experience of line manager. The following themes are recommended areas for organisational and local leadership attention.

We are compassionate and inclusive: Achieving a greater consistency in terms of positive experiences of compassionate and inclusive leadership and management in practice will enable the organisation to improve the workplace experience of all staff. Continued focus on management and leadership development is vital along with dealing swiftly and decisively with discriminative actions and behaviours and supporting leaders and staff to deal effectively with conflict in the workplace.

We are safe and healthy: Continuing to invest in the workforce both in terms of increasing establishment, ensuring colleagues have the resources necessary to do their job and the means by which to develop their skills and career are critical factors to achieve fulfilling roles, support health and wellbeing at work and increase staff engagement and morale.

We each have a voice that counts: Building a psychologically safe place to work that involves and distributes decision making to colleagues recognising the power of autonomy and that as a human organisation colleagues should be supported to be their whole self, every day is another key area of focus. Our results highlight that developing the ability to deal with constructive conflict through dialogue and debate would positively inform organisational learning and develop the culture of teams.

Taking Action

Walsall Healthcare NHS Trust

1. Trust level results to be communicated across the organisation via; Team Brief, Daily Dose, posters circulated, headlines shared at staff network groups, JNCC, LNC and managers briefings (to take place at the end of March).

2. Staff Engagement and experience Oversight group to meet monthly between March and November 2022. Senior leadership participation from each division / directorate required. Provision of monthly updates to PODC.

3. Provision of detailed directorate / divisional results (by theme / question). Detailed report commissioned and due to be received in May 2022.

4. Each division / directorate to communicate local results across teams.

5. Each division / directorate to agree action plan (using template provided) by end of April 2022 with a full and detailed update provided to PODC and TMC in May 2022.

Walsall Healthcare NHS
NHS Trust

Annex B: Workforce Race Equality Standard (WRES)

The Staff Survey WRES indicators demonstrate marginal improvements on the experience of BME colleagues at WHCT, however, the results remain a concern as they are significantly unaligned with the benchmark average.

	2018		2019		2020		2021	
	BME	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**
KF 25 % of staff experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months	31.1%	28.5%	27.5%	30.4%	32.9%	27%	31.9% ↓ Average 28.8%	28.1% ↑ Average 26.5%
KF26 % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	28.6%	27.4%	35.1%	29.7%	36%	27.9%	31.7% ↓ Average 28.5%	26.6% ↓ Average 23.6%
KF21 % of staff believing that the organisation provides equal opportunities for career progression and promotion	68%	82.2%	35.1%	79.8%	34.8%	53.3%	36.8% ↑ Average 44.6%	56.4% ↑ Average 58.6%
Q17 % of staff that have experienced discrimination at work from managers, team leaders or other colleagues	12.8%	5.7%	19.7%	6.7%	23.9%	7.3%	19.3% ↓ Average 17.3%	8.0% ↑ Average 6.7%

Annex C:
Workforce Race Disability Standard (WDES)

Walsall Healthcare NHS Trust

Long Term Condition or Illness

	2018		2019		2020		2021	
	LTC or Illness	Without LTC or illness	LTC or Illness	Without LTC or illness	LTC or Illness	Without LTC or illness	LTC or Illness	Without LTC or illness
% of staff experiencing HBA from patient, relative or member of the public in the last 12 months	34.9%	27.8%	37.4%	27.7%	35.3%	26.4%	↓ 38.7% Average 32.4%	26.4% Average 25.2%
% of staff experiencing HBA from manager in the last 12 months	16.3%	15.2%	21.2%	16.3%	23.8%	15.6%	↓ 21.4% Average 18%	12.2% Average 9.8%
% of staff experiencing HBA from other colleagues in the last 12 months	23.3%	20.4%	28.9%	21.7%	28.3%	21.3%	↑ 29.4% Average 26.6%	20.8% Average 17.1%
% of staff saying that the last time they experienced HBA at work they or a colleague reported it	48.6%	45.5%	50.4%	48.2%	51.6%	49.5%	↓ 50% Average 47%	48.8% Average 46.2%
% of staff who believe their organisation provides equal opportunities for career progression or promotion	76.7%	79.9%	74.0%	76.0%	71.8%	76.5%	↓ 48.6% Average 51.4%	52% Average 56.8%
% of staff who felt pressure from their manager to come to work despite not feeling well enough to perform their duties	33.8%	21.9%	28.5%	25.7%	35.2%	25%	↓ **32%** **Average 32.2%**	21.9% Average 23.7%
% of staff satisfied with the extent to which the organisation values their work	31.4%	42.5%	32.9%	42.4%	32.5%	44.1%	↓ 30.6% Average 32.6%	41.4% Average 43.3%
% of staff with LTC or illness saying their employer has made reasonable adjustments to enable them to carry out their work.	69.8%	73.4%	69.9%	73.5%	73.7%		↓ 65.3% Average 70.9%	

Template Action Plan

Element	What You Said	What We Will Do	How will you know?
We are compassionate & inclusive			
We are recognised & rewarded			
We each have a voice that counts			
We are safe & healthy			
We are always learning			
We work flexibly			
We are a team			
Staff engagement			
Morale			

Divisional Priority Focus

Area	Reason for Priority	Action to be taken	By when	Expected outcome	Measure

MEETING OF THE TRUST BOARD – 6TH APRIL 2022			
Education and Training update			
Report Author and Job Title:	Louise Nickell Director of Education and Training	**Responsible Director:**	Louise Nickell Director of Education and Training
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	• Good progress against the Education and Training Steering Group workplan • Progress is being made around the corporate level risk (2664) • Good progress is being made in collaboration with Royal Wolverhampton NHS Trust		
Advise	• Better NETS engagement required for WHT learners		
Alert	• Full resolution of the HEE risk is likely to take months/years to resolve		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	(2599) Lack of Resuscitation provision • Risk grading Amber 9 – multi-professional working group to look at needs and provision (2664) Medical Education - Health Education England visit • Risk grading Red 20 – Reviewed monthly, likely to remain red for a substantial amount of time		
Resource implications	Following the Aston Medical School business case, and the Tariff business case there are no further resource implications associated with this report		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Education and Training Update

1.0 PURPOSE OF REPORT

The purpose of the reports is to provide The Trust Board with an update of Education and Training activities through the work of the Education and Training Steering Group across the Trust.

2.0 BACKGROUND

The Education and Training Steering Group (E&TSG) was set up in 2019 to bring together education and training teams across Walsall Healthcare Trust (WHT), through a platform of educators, organised into faculties to share ideas, provide innovation within education and training and to escalate risks and resolution of issues through joint problem solving. The group meets quarterly and reports through to PODC six monthly (previously annually) on its progress. Faculties are:

- Postgraduate Medical Education
- Undergraduate Medical Education
- Nursing Education (FORCE)
- Allied Healthcare Professionals (AHPs) and Healthcare Scientists (HCS)
- Physicians Associates

Additionally, information is provided below for Education Quality, QI training, Manor Learning and Conference Centre (MLCC) & library services, Finance, Health Education England (HEE) Education Contract (formally known as the Learning and Development Agreement - LDA), the risk register and the E&TSG workplan (appendix 1)

3.0 DETAILS

a. The following reports are the summary information bullet points captured by the various faculty and other reports

3.1 Faculty of Research and Clinical Education FORCE

- An increase in student nurse capacity in adult acute areas by 25% following introduction of the Collaborative Learning in Practice (CLiP) model in 5 ward areas with further expansion planned. RWT & WHT joint HEE bid has been submitted for CLiPP support posts on both sites
- Low number of AHP placements currently - aim to get back to pre-Covid numbers and then work to increase numbers. HEE bid has been submitted to employ a AHP Practice Education Facilitator (PEF) to support with CLiPP AHP placements
- International nurse recruitment –Team support includes Preceptorship, pastoral support, and support in clinical areas
- Practice Education Facilitator plan has been agreed and recruitment is underway for 2 Senior PEF posts and 7 PEF posts
- Two cohorts of 15 T-Level students started placements
- CPD funding:
  - All priority 1, 2 and most of priority three requests have now been granted
  - All band 8 leaders without a first level degree given opportunity to top up their qualifications
  - £390K remaining spend plan as follows:
    - Myers Briggs Type Indicator (MBTI) as part of the band 7/8 leadership programme
    - Train the Trainer (TTT) human factors course
    - Paediatric Mental Health Awareness Training

- Cultural awareness training
- Simulation (SIM) training for SIM faculty
- Prepay University for V300 qualification for newly formed Sepsis Team
- Prepay Postgraduate Certificate in Education for newly appointed PEF posts
- Accreditation of in-house courses - Health Assessment and Preceptorship

New programme developments:

- Aspiring band 6 development programme commenced September 2021. 12 study days over 12 months, including Leading Empowered Organisations (LEO)
- On-line fundamentals of care package, including 12 modules aimed at all Nurses, Midwives, AHPs and Healthcare Support Workers (HCSWs)
- Two-day face to face fundamentals of care programme for HCSWs launched September 2021
- Simulation Faculty– Band 7 Sim lead and Project support posts recruited fixed term
- Following NETs survey, a Pulse check on learners in practice developed which uses combination of NETs questions and HEI placement evaluation questions
- Advanced Clinical Practitioners strategy – work ongoing. RWT have shared their draft strategy

3.2 Undergraduate Medical

3.2.1 Aston Medical Students (AMS)

- Provisional agreement has been made to take AMS on the placements below:
  Year 4
  - Paediatrics (6 weeks, 6x/year)
  - Obstetrics and Gynaecology (6 weeks, 6x/year)

  Year 5
  - Emergency Department (2 weeks 3x/year)
  - Foundation Assistantship (6 weeks, 1x/year)

- Aston Medical School paper approved at Trust board
- Deputy Head of Academy appointment made in March 2022
- Clinical Teaching Fellow posts appointed to for 2022
- Foundation Year buddies allocated to all 3rd year medical students on placement
- Students are currently provided with ‘Base Wards’ – very good feedback

3.3 Postgraduate Medical

3.3.1 Appointments

- New Radiology College Tutor, Dr Priyo Sada, commenced 1st March 2022
- New Foundation Yr1 Training Programme Director (TPD), Dr Najma Iqbal commenced 1st March 2022
- New Paediatric College Tutor Dr Zalid Saleem, commenced 1st March 2022

3.3.2 Vacancies

- The newly appointed Clinical Tutor, Mr Thomas has unfortunately stepped down from the post, post out to advert currently

3.3.3 Foundation FY1 and FY2 Updates

- FY2 Teaching is both face to face and online. During January teaching was cancelled due to high levels of covid sickness. HEE were informed
- 2 hours of self-development time (SDT) has been incorporated every week on Tuesday following 2 hours of core teaching, commenced from February/March
- FY2 training has been reviewed to ensure relevancy to the curriculum
- The SIM lead and TPD have now agreed the topics for the SIM training relevant to the curriculum which includes all the core specialities

- Foundation ARCP's: All the Interim ARCP reviews have been completed, no concerns

3.3.4 Clinical and Educational Supervisors

- Significant work is underway ensure appropriate and adequate Clinical/Educational supervisors. 20 places on ES accredited RCP course have been booked

3.3.5 Internal Quality Education visits

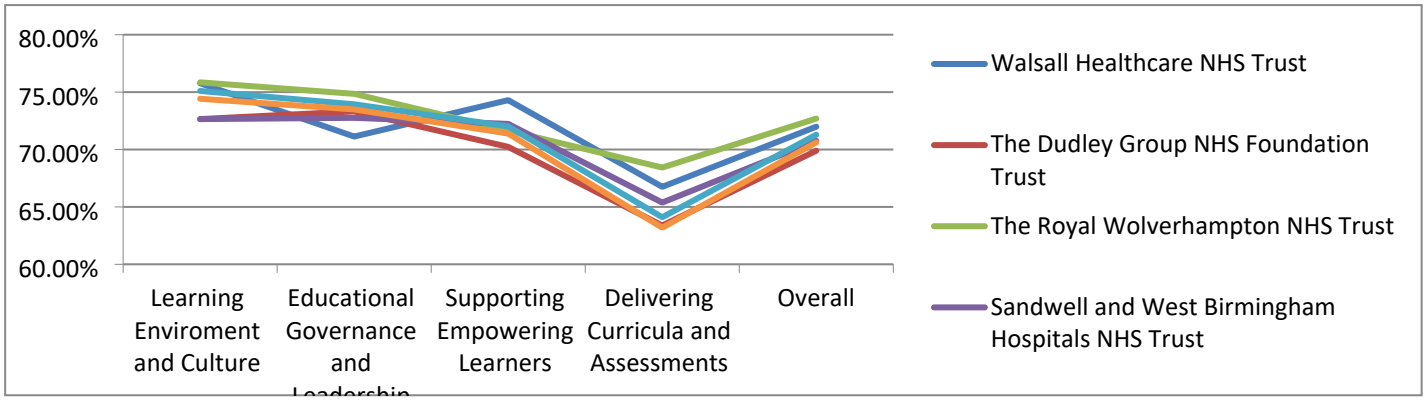
- Internal Quality Educational visit in Surgery and T&O, responses due Feb 23rd, were not received. To be managed through PGEC meeting in April

3.3.6 HEE Revisit update

- Following the HEE virtual visit on the 2nd November 2021, the trust has confirmed the final HEE Quality Report, and started on the improvement plan. Submission required by 12 April 2022 to HEE.

3.3.7 NETS Survey November 2021

- The latest Nov 2021 NETS data has been released showing postgraduate medical training performance at Walsall Healthcare NHS Foundation Trust and the comparison with neighbouring trusts, the national average and the benchmark for trust groups.
- Walsall had 141 total respondents before masking and 107 respondents after Masking, which is a great improvement on June 2021 survey, but still room for improvement.



Compared to the Benchmark and National Average:

- The trust is showing above the benchmark and National Average on 3 areas
- The trust is showing below the national average this year in Educational Governance and Leadership

Organisation Name	Year comparison		Respondents (exc. any masked)	Learning Environment and Culture	Educational Governance and Leadership	Supporting Empowering Learners	Delivering Curricula and Assessments
Walsall Healthcare NHS Trust	June 2021	Nov 2021	↑ 107 (81)	↑ 75.77% (69.98%)	↓ 71.13% (72.86%)	↑ 74.30% (69.64%)	↑ 66.75% 60.62%
The Dudley Group NHS Foundation Trust	June 2021	Nov 2021	130	72.65%	73.32%	70.23%	63.38%
The Royal Wolverhampton NHS Trust	June 2021	Nov 2021	242	75.85%	74.85%	71.65%	68.43%
Sandwell and West Birmingham Hospitals NHS Trust	June 2021	Nov 2021	180	72.65%	72.76%	72.23%	65.38%
National Average	June 2021	Nov 2021	n/a	75.10%	73.94%	72.02%	64.10%
Benchmark for Trust Group	June 2021	Nov 2021	n/a	74.42%	73.49%	71.39%	63.19%

The below chart shows the areas that the trust has performed well in, and not so well in compared to the national Benchmarks:

Post Specialty	Indicator	Average score (2022)	National Bench Mark	Offset from average Benchmark
Obstetrics and Gynaecology	Induction	90.63%	79.30%	11.33%
Obstetrics and Gynaecology	Supervision	84.38%	68.90%	15.48%
Paediatrics	Overall Experience	94.17%	75.09%	19.08%
Paediatrics	Quality of Care	91.67%	77.34%	14.33%
Paediatrics	Supervision	87.50%	71.21%	16.29%
Radiology	Induction (departmental)	12.50%	83.06%	-70.56%

3.3.8 Trust wide Junior Doctor forum

- The first of three scheduled trust-wide forums took place on the 25th January 2022, the actions required are being progressed

3.3.9 Future Actions / New developments from Medical Education:

- Advert has gone out for 1 x Medical and 1 x Surgery Chief Registrars, interviews to be held late March 2022
- Work on the new Doctors in Training monthly newsletter commences in April 2022
- Due to the delays of the new trust intranet; revamping the current page will occur

- Work schedules review- in readiness for August 2022
- A generic Doctors in Training Induction Handbook is being created
- Doctors in Training Induction will be revisited in April / May - videos to be updated
- Medical Education are reviewing the Doctors in Training awards

3.4 AHP and HCS

- Funding secured from HEE for AHP workforce supply strategy. 7 KPI's to be met
- Project overall is due to culminate at the end of March 2022 and is on track
- As part of joint work with RWT a joint Dietician link tutor split across both organisations has been appointed, and a Therapy link tutor for WHT only. Both posts to run until end of March, with plan to increase relevant placement numbers. There is also funding for a Podiatry link tutor split across RWT & WHT
- Physio (PT) & Occupational Therapy (OT) training; various therapy groups have re-launched in-service training programmes with senior AHP support to help retention within therapy areas and includes specific training sessions for Junior Band 5 staff
- New therapy apprenticeship opportunities created at WHT, putting forward 4 existing therapy support staff forward for 2x PT and 2x OT apprenticeships in 2022. Also aiming to have a direct route apprenticeship position for OT to go out in January and for PT in the spring, this would enable recruitment of individuals as apprentices who wish to study PT/OT but do not necessarily have the financial ability to commit to full time study
- AHP Care Group: Plans to move AHP groups under Matt Craven in an AHP specific care group. This will enable AHP groups to work more seamlessly and have a joint reporting structure under single AHP leadership, consequently leading to standardisation in elements such as training/placements/PDR's/supervision etc.
- Calderdale Framework Project Acute Therapies: ongoing project implementation in acute therapies, completing a skill sharing exercise between PT/OT aiming to integrate services more, reduce duplication and increase efficiency. Currently in a process of taking staff through a competency sign-off phase
- Joint training programme with Walsall Social care: 2 projects, 1 is single-handed care project and the other is hospital bed project where AHP's can order hospital beds. Both initiatives in their infancy but expected to pick up momentum in 2022

3.5 Physician Associates

- Business case for workforce plan has been approved
- Engagement with CDs to develop PA roles is well underway
- Analysis of clinical areas/directorates in terms of clinical need and the impact PAs may provide is being used for Directorate discussions

3.6 MLCC and Library

- WHT library remained open and staffed during Covid
- In addition to core library duties, the Library and Knowledge Services team was also involved in:
    - Setting up a transport service to support all Trust employees to get to work and return home owing to the reduced public transport services
    - Distributing of Lateral Flow Tests and updating records

- Reviewing applications for volunteering positions across the Trust
- Arranging swab tests and following up on return to work
- Supporting the ESR team - daily telephone check of staff COVID absences
- Providing lunch packs forward staff during the day, evenings and weekends
- Sharing the library office with the bereavement team
- Upgrading PCs and installation of MST for staff to enable remote working

- Future developments include:
  - Developing the digital platforms and remote services, establishing a formal information skill training module and a quality learning environment for users
  - Update the library strategy
  - Develop a formal information skills training programme
  - Review the library charter, service standards and key performance indicators
  - Update the implementation plan to include actions from the HEE Quality Improvement Outcomes Framework to meet levels not achieved

3.7 Leadership development training

- An agreement is in place for WHT staff to access an increasing range of behavioural and skills development programmes delivered by RWT
- These programmes include bespoke interventions such as a range of Medical Leadership programmes (such as CD bootcamp) and behavioural leadership programmes (such as Process Communication Model PCM)
- Feedback from delegates attending has been excellent

3.8 Education Contract Funds

- A report has been approved at Trust Board for the utilisation and investment of the unallocated education contract tariff. Investments include the expansion of the PA programme, consultant lead educator roles and education leadership management structure

3.9 Risks and Risk Register

- 3.9.1 Aston Medical School:
  Risk grading Red 16 – will be downgraded at next E&TSG meeting, (as approval of Aston paper)

- 3.9.2 Lack of Resuscitation provision
  Risk grading Amber 9 – multi-professional working group to look at needs and provision

- 3.9.3 Medical Education Risk Health Education England Visit
  Risk grading Red 20 – Reviewed monthly, likely to remain red for a substantial amount of time

3.10 E&TSG Work Plan 2021-22 (Appendix 1)

4.0 RECOMMENDATIONS

The Trust Board is asked to note the content of the report and accept the progress to date of the workplan for the Education and Training Group