Bundle Public Trust Board 8 June 2022

0 Housekeeping

Lead: Keith Wilshere, Interim Company Secretary
Board members are meeting face-to-face. All members of the public and any members of staff in attendance have been invited to join via microsoft teams.
Fire exits/any fire alarm testing
Refreshments and breaks
Car Parking: Please let Jas Toor have your car registration at some point before lunch - this will be shared with reception so that you are not charged for car parking.

1 09:30 - Chair's Welcome; Apologies and Confirmation of Quorum

Lead: Prof. Steve Field, Chair
Apologies Received: Sally Rowe
Quoracy:
In attendance:
Amanda Hennessey and Bridgette Hill, CQC
Umar Daraz, BCU
Prof. Patrick Vernon, Chair, Walsall Together (ACTION: ITEM 12.1 -Walsall Together, Chair's report to be presented by Patrick Vernon before IQPR as Patrick Vernon will need to leave earlier)

2 09:32 - Declarations of interest

Lead: Prof. Steve Field, Chair
Action: Board Members to advise of any conflicts of interest pertaining to the agenda and not confirmed on the attached register

2. Public Declarations of Interest APRIL 2022 v 270422.docx

3 09:34 - Minutes of the last meeting

Lead: Prof. Steve Field, Chair
Action: To receive and APPROVE as a true and accurate record

3. Public Board Minutes - 0604.22 first Draft CD-JT-KW.docx

4 09:39 - Matters Arising

Lead: Prof. Steve Field, Chair
Action: Any matters arising not on the agenda

5 09:44 - Action Log - no outstanding items.

Lead: Prof Steve Field, Chair
Action: There are no outstanding actions

6 09:49 - Trust Values and Nolan Principles

Lead: Prof. Steve Field, Chair
Action: Board to note

5.2 Vision Values and Objectives v.2.pdf

5.1 The Seven Principles of Public Life - Nolan Principles.pdf

7 09:54 - Chair's Report - Verbal

Lead: Prof. Steve Field, Chair
Action: To Inform

7.1 10:04 - Board Member Attendance

Lead: Keith Wilshere, Interim Company Secretary
Action: To Inform and Assure

Attendance report for Trust Board.docx

8 10:09 - Chief Executive's Report

Lead: Prof. David Loughton, Chief Executive
Action: To Inform

Chief Executive report, 08.06.22.docx

8.1 10:19 - Chair's Trust Management Committee Report

Lead: Prof. David Loughton, Chief Executive
Action: To Inform

TMC 26.04.22, Report for Trust Board, 08.06.22.docx

TMC 24.05.22, Report for Trust Board, 08.06.22.docx

9 10:24 - Patient Story - Alicia's Story (youtube link in description box below)

Lead: Carla Jones-Charles, Divisional Director of Midwifery, Gynaecology and Sexual Health
Action: For Information
Youtube Link (please copy and play via your chrome browser)
https://youtu.be/Ai_65qBKOy0
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 10:34 - Integrated Quality and Performance (IQPR) - Summary

IQPR_Summary.pdf

10.1 10:34 - Quality, Patient Experience and Safety - Chair's Report

Lead: Dr Julian Parkes, Non-Executive Director
Action: To inform

QPES Board report 20_5_22.docx

10.1.1 10:39 - IQPR Quality, Patient Experience and Safety (Reference Pack for Information)

Action: To Inform, followed by Questions

IQPR_QPES.pdf

10.2 10:44 - Performance, Finance and Investment - Chair's Report

Lead: Paul Assinder, Chair, PFIC
Action: To Inform, followed by Questions

PFIC Chair's Report May .docx

10.2.1 10:49 - IQPR - Performance, Finance and Investment (Reference Pack for Information)

IQPR_PFIC.pdf

10.3 10:54 - People and Organisation Development - Chair's Report

Lead: Junior Hemans, Chair - PODC
Action: To Inform, followed by Questions

May 22 PODC Chairs highlight report FINAL.docx

10.3.1 10:59 - IQPR - People and Organisation Development (Reference Pack for Information)

IQPR_PODC.pdf

11 11:04 - Provide Safe, High Quality Care (section heading)

11.1 11:04 - Director of Nursing Report

Lead: Lisa Carroll, Director of Nursing
Action: To Inform

DoN report to Public Trust Board 8th June 2022.docx

11.2 11:09 - Patient Experience (& Complaints Report) - Annual Report

Lead: Lisa Carroll, Director of Nursing
Action: To inform and assure

Patient Experience Annual Report.docx

11.3 11:14 - Continuous Quality Improvement (CQI)

Lead: Simon Evans, Interim Chief Officer for Strategy
Action: To Inform

WHT TB Quality Improvement Report Merged May 22.pdf

11.4 11:19 - Divisional Director's Midwifery Service Report

Lead: Carla Jones-Charles, Divisional Director of Midwifery, Gynaecology and Sexual Health
Action: To discuss Inform and Assure

DoM Report Public Trust Board June 2022.docx

11.5 11:24 - Infection Prevention Control Annual Report

Lead: Lisa Carroll, Director of Nursing
Action: To APPROVE, inform and assure

Front sheet IPC Annual Report - Public Trust Board June 2022.docx

Public Trust Board IPC Annual report 2021-22 June 2022.pdf

11.6 11:29 - Audit Committee Annual Review of Activities Report

Lead: Mary Martin, Audit Committee Chair/Russell Caldicott, Chief Finance Officer
Action: To inform and assure

Audit Committee Annual Report.docx

11.7 11:34 - Pharmacy and Medicines Optimisation Report

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To inform and assure

Medicines Management Report.docx

11.8 11:39 - Safeguarding Adults and Children - Quarter 4 Report

Lead: Lisa Carroll, Director of Nursing
Action: To assure

Safeguarding Q4 Report.docx

Safeguarding Q4 Report Appendix 1 Walsall Partnership PRG meeting feedback April 2022docx.docx

Safeguarding Q4 Report Appendix 2 Safeguarding Development Plan May 2022.docx

Safeguarding Q4 Report Appendix 3 Safeguarding Children Q4 2022.docx

Safeguarding Q4 Report Appendix 4 SafeguardingDashboard_202203v2.pdf

11.9 11:44 - Nursing Bi-annual Skill Mix Review

1.Front sheet Biannual skill mix review - Public Trust Board June 2022.docx

Public Trust Board WHT Skill Mix Review January 2022 (report date 26052022).docx

12 11:49 - Care at Home, Work Closely with Partners (section heading)

Section Heading

12.1 11:49 - Walsall Together - Chair's Report

Lead: Prof. Patrick Vernon, Chair, Walsall Together
Action: To inform

Walsall Together Partnership Board Highlight Report v2.docx

12.2 11:54 - Care at Home Executive Report

Lead: Matthew Dodds, Director of Transformation

Care at Home Report Jun22 v1.docx

Care at Home - Appendix 1 Partnership Operational Performance Pack May 2022.pdf

12.3 11:59 - Information Governance Strategy & Policy Documentation Report

Lead: Kevin Bostock, Director of Assurance
Action: To inform and assure

WHT Public Trust Board 08.06.2022 IG Strategy and Policy Documentation.docx

12.3.1 12:04 - Information Governance: 2021/22 Data Security & Protection Toolkit (DSPT) Submission Report

Lead: Kevin Bostock, Director of Assurance
Action: To inform and assure

WHT Public Trust Board 08.06.2022 DSPT Report May 22.docx

12.4 12:09 - Trust Strategy Update/revision/progress

Lead: Simon Evans, Interim Chief Officer for Strategy
Action:

1_BoardBriefingPaper_StrategyJune2022Final.docx

Appendix 1_Guide to Trusts Strategic Documents and Structure.docx

12.5 12:14 - Green Plan & Sustainability Update

Lead: Simon Evans, Interim Chief Officer for Strategy
Action: To Inform

WHT TB Sustainability Report May 22.pdf

13 12:19 - Use Resources Well (Section Heading)

13.1 12:19 - Audit Committee - Chair's Report

Lead: Mary Martin, Chair, Audit Committee
Action: To Inform

WHT Audit Committee Chairs Reports 09.05.22.docx

14 12:24 - Value our Colleagues (Section Heading)

14.1 12:24 - Freedom to Speak Up

Lead: Catherine Griffiths, Director for People and Culture
Action: To discuss, inform and assure

TB F2SU Q4 21_22 report_.docx

14.2 12:29 - Staff Networks

Lead: Catherine Griffiths, Director of People and Culture
Action: To inform and assure

TB Staff Network Front Cover .docx

Staff Network Presentation - TB.pdf

14.3 12:34 - Guardian of Safe Working Hours - Quarterly Report

Lead: Dr Manjeet Shehmar
Action: To discuss, inform and assure

GOSW TB Front Cover .docx

GOSWH Aug Sep Oct 21 quarterly report appendix a.docx

GOSWH Nov 21 Dec 21 Jan 22 quarterly report appendix b.docx

GOSWH Feb Mar Apr 22 quarterly report appendix c.docx

15 12:39 - Reports for Information - Minutes of Committee Meetings (section heading)

Lead: Keith Wilshere, Interim Company Secretary
Action: Confirmed minutes of Committee meetings held in May - For Information Only

15.1 Quality, Patient Experience and Safety Committee - Meeting held April 2022

3. Minutes of the QPES Committee 29th April 2022.docx

15.2 People and Organisational Development Committee - Meeting held April 2022

3. Minutes - People and Organisational Development Committee, April 2022.docx

15.3 Walsall Together Partnership Board - Meeting held April 2022

3. WTPB Minutes - 20th April 2022 - APPROVED.docx

15.4 Performance, Finance and Investment Committee - Meeting held April 2022

3. Minutes of the (Part 2) PFIC 27.04.2022 RC PA draft.docx

16 12:44 - Any Other Business

17 12:49 - Date and Time of Next Meeting

Lead: Prof. Steve Field
Action: To Inform

18 12:50 - Questions from the Public/Commissioners

Lead: Prof. Steve Field, Chair

19 12:55 - Resolution

Lead: Prof. Steve Field, Chair
Action: To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudicial to the public interest

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 April 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 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 Commonwealth Associated
		Member – Royal College of Nursing – UK
		Member – Greater Birmingham Chamber of Commerce Commonwealth Group
		Teaching Fellow – Higher Education Academy

Name	Position held in Trust	Description of Interest
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.
		Chief Executive Office r- Dudley Integrated Health & Care Trust (ceased February 2022)
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	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
		Chair – West Midlands Cancer Alliance

Name	Position held in Trust	Description of Interest
Prof Ann-Marie Cannaby	Interim Deputy Chief Executive/Chief Nursing Officer	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
		Member of the Cavell (Charity) Advisory Panel (Volunteer role) commenced April 2022
Mr Russell Caldicott	Chief Officer for Finance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
		Director of Plan 4 E-Health
Dr Manjeet Shehmar	Chief Medical Officer	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

Name	Position held in Trust	Description of Interest
		Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar
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 Patrick Vernon	Chair, Walsall Together	Non-Executive Director, Birmingham and Solihull ICS
		Chair of Citizens Partnership, Health Care Investigation Branch
		Specialist Adviser, Centre for Ageing Better
		Sister works as a senior manager at NHS Resolute
		Director - Windrush Legal Advice Clinic
		Director - 38 Degrees
		Director – The Bernie Grant Trust
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

Name	Position held in Trust	Description of Interest
		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

NHS
Walsall Healthcare
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD
HELD ON WEDNESDAY, 6TH APRIL 2022 AT 09.30AM
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members	
Prof. S Field CBE	Chair of the Board of Directors
Ms M Martin	Non-Executive Director
Mr P Assinder	Non-Executive Director
Ms D Brathwaite	Non-executive Director
Mr R Virdee	Associate Non-executive Director
Dr J Parkes	Associate Non-executive Director
Ms O Muflahi	Associate Non-executive Director
Prof. D Loughton CBE	Chief Executive
Prof. A-M Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive
Mr R Caldicott	Director of Finance and Performance
Mr N Hobbs	Chief Operating Officer
Ms L Carroll	Director of Nursing
Ms C Griffiths	Director of People and Culture
Dr M Shehmar	Chief Medical Officer
Mr K Bostock	Director of Assurance
Mr S Evans	Interim Chief Strategy Officer
Ms S Evans	Interim Director of Communications and Engagement

In attendance	
Mr M Sharon	Strategic Advisor to the Board
Mr K Stringer	Interim Director for SIRO and IT
Mr K Wilshere	Interim Company Secretary
Ms C Jones-Charles	Divisional Director of Midwifery, Gynaecology and Sexual Health
Mr S Mirza	Divisional Director –Division or Surgery
Ms M McManus	Acting Head of Transformation, Walsall Together
Ms M Lawrence	Interim CQC Standards Assurance Lead (observer)
Mr G Perry	Associate Director of Patient Experience
Ms C King-Stephens	Midwife (shadowing Ms Carroll)
Ms F Pickford	Head of Safeguarding
Ms C Young	Deputy Director of Education and Training - RWT
Ms C Hill	Medical Directorate Programme Lead
Ms J Kaur Toor	Senior Executive Assistant/Senior Operational Coordinator

Apologies	
Ms G Augustine	Director of Planning and Improvement
Mr J Hemans	Non-Executive Director
Ms S Rowe	Non-Executive Director
Prof. L Toner	Non-Executive Director
Mr M Dodd	Director of Transformation, Walsall Together

256/22	**Welcome, Apologies and Confirmation of Quorum**
	Prof. Field welcomed everyone to the meeting and apologies received were noted. Prof. Field welcomed the new Non-Executive Directors to the Trust Board. Ms Brathwaite, Ms Muflahi and Dr Parkes thanked Prof. Field and provided brief overviews on their backgrounds.

	Prof. Field confirmed that Prof. Loughton been appointed to the substantive role of Chief Executive at Walsall Healthcare.
257/22	**Declarations of Interest**
	Prof. Loughton declared his interest as CEO at the Royal Wolverhampton NHS Trust and Mr Assinder reported an amendment to his declaration which should read his interest as Chief Executive Officer - Dudley Integrated Health & Care Trust was no longer a potential conflict as he had since retired from that position. Prof. Field confirmed there were no further interests declared to those advised. **Action: Ms J K Toor to update the Declarations of interest for Prof. Loughton and Mr Assinder.**
258/22	**Minutes of Last Meeting**
	Prof. Field confirmed that the minutes of the meeting held on 2nd February 2022 as received and approved as an accurate record. **Resolved: that the minutes of the last meeting be received and approved.**
259/22	**Matters Arising and Action Log**
	Prof. Field received the action log and noted that: Action 152: Sickness hot spots – this action had now been completed. Action 150: Patient story – this action had now been completed. **Action: Ms J K Toor to close Actions 151 and 150.**
260/22	**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.**
261/22	**Chair's Report**
	Prof. Field reported on a meeting with the Chairman of West Midlands Ambulance Trust in which they had reflected on the positive work of the team handling the patient flow through the system and the work of Prof. Loughton as Chief Executive of both Walsall and Wolverhampton NHS Trusts. Prof. Field reported on the collaborative work with other Black Country acute trusts that had agreed to meet quarterly as Chairs of Boards and confirmed the next meeting would be held in June, chaired by Sir David Nicholson. **Resolved: that the Chair's Report be received and noted.**
262/22	**Chief Executive's Report**
	Prof. Loughton reported that six Consultant appointments had been made and the joint working between Walsall and Wolverhampton was paying dividends in recruiting good quality clinical and nursing staff. Prof. Loughton reported that he had participated in the ICS Masterclass session with David Meates (New Zealand Healthcare system) and had been interested to hear how the mental health challenges had been addressed following a major earthquake. He said that similar challenges had been seen as a result of Covid-19 and the cost of living rises which had more effect on the mental health of younger people. He suggested a Joint Board Development session regarding how to address these issues. Prof. Loughton reported a positive meeting had taken place with Jatinder Sharma, Principal and Chief Executive and Senior Team Members of Walsall College, Louise Nickell, Director of Education and Training (RWT/ WHT) in forging stronger relationships.

	Prof. Loughton highlighted his concern with the West Midlands Ambulance 'drop and go' system operated pre-Covid-19 where patients were off-loaded from ambulances even if bays were not immediately available as this practice created pressure throughout the system. Mr Assinder referred to collaborative working with education providers and explained he was on a college board involved with the HS2 project group and said that links to local education providers was key in development of the future workforce. Mr Sharon echoed Mr Assinder's comments and stressed links with social care were also important. **Resolved: that the Chief Executive's Report be received and noted.**
STAFF STORY	
263/22	**Patient Story – Ashley's story by his mother Donna**
	Mr Perry introduced 'Ashley's' patient story which had been recorded by Donna who had been a patient at Walsall Manor Hospital for birth of her baby (Ashley). She said that throughout her care, and the care of Ashley, staff had reassured her and her husband. She said the nursing care received was fantastic and staff from all areas in the department as they worked well together, from clinical and nursing to the cleaning staff and she thanked them for their dedication and commitment. Mr Perry said it was important that they continue to have recordings of patient stories to share their experiences and comments and that it was pleasing to hear of good patient stories. He advised that a digital option of recording praise was being worked on together with the development of 'praise pods' for recording live feedback. Mr Perry said that Donna exemplifies the excellent work that goes on in children and young peoples' wards and services. He was working with Donna as a prospective patient involvement partner recruited to help co-design improvements. Prof. Loughton expressed his thanks to Mr Perry and his team for the excellent work they did. **Resolved: that the Patient Story be received and noted.**
264/22	**Integrated Performance and Quality Report (IPQR) Executive Summary**
	Mr Caldicott introduced the report and thanked Zoe Marsh from RWT and WHT Performance Manager Amanda Cater, for their involvement in the development of the Trust's Integrated Quality & Performance Report (IQPR). Mr Caldicott said the Trust had endorsed the format for the IQPR through Executive, Trust Management Committee, Chairs of Committees of the Board, the Performance Finance & Information Committee and Trust Board and this was the first presentation in the Board cycle, and he welcomed any feedback to further refine the process. He explained the format of the report, contained in a one-page summary, referencing key messages produced by each lead Executive for Quality, Workforce, Performance and Finance and included the Committee highlight reports presented by the Chairs of Committee to Board. Mr Caldicott explained that the report contained a table of key focused metrics for each domain as determined by relevant sub-committees and these were traffic lighted based on the delivery of targeted performance and positive assurance from the Statistical Process Charts (SPC) modelling. Dr Shehmar presented the metrics for Quality, highlighting VTE compliance had improved from 91% (in January) to 93% in (February), Falls per 1000 bed days was 4% in February 2022 and a deep dive review undertaken had identified an increase with "frequent fallers" and this was being progressed by the falls accountability meeting. She said that the Trust

	target for *C.Difficile* 2021/22 had been internally agreed at 29 cases and confirmed cases were in line with the trajectory. She reported that the Mental Capacity Act Audit indicated that 46% of patients who lacked capacity had a stage 2 assessment undertaken, a decline from 52% in January 2022. She said that Safeguarding adults and children's training achieved trust target level 1 and level 2 training, but Level 3 adult and children's training needed further focus. Mr Hobbs presented the Performance metrics, highlighting that the Trust continued to deliver some of the best Ambulance Handover times in the West Midlands, and had been the top performer for 11 out of the last 12 months. He said that despite recent challenges in the sonography and MRI service, the Trust's 6 Week Wait (DM01) Diagnostics performance remained strong. He reported that services for patients referred on 2 week wait suspected cancer and Breast symptomatic pathways was a risk due to experiencing longer waiting times due to the continued challenges in Outpatient waiting times. Ms Griffiths presented the Workforce metrics, highlighting that the most significant risk regarding staff sickness absence that had contributed to a rise in short-term absence. She said that training compliance remained within an improved trend but had fallen back in the 24-month performance range, missing the 90% target for the first time since summer 2021. She reported a fall in training completion amongst medical colleagues, specifically amongst level 3 Safeguarding competencies, that had contributed to a short-term decline in overall compliance rates and noted that annual appraisal compliance was within an improving trend. Mr Caldicott presented the Finance metrics, highlighting that the Trust had attained a surplus of c£0.6m as at the 28th February 2022 and was on plan to attain a surplus at close of the financial year. He said that the Sustainability & Transformation Partnership had exceeded plans and was forecasting a c£23m surplus and the risk share entitled the Trust to receive a share of this surplus with a forecasting attainment of a c£3m surplus for the year. He said that significant works were in progress with the capital programme, including ward refurbishments, theatre upgrades and the development of the new Emergency Department. He said the Trust was required to submit the final financial plan by 28th April 2022, with the STP plans articulating a £48m deficit and the Trust plan (as part of the £48m deficit) a £6.6m deficit and the Executive continued to work to develop financial plans within the resources. **Resolved: that the Integrated Performance and Quality Report (IPQR) Executive Summary be received and noted.**
265/22	**Quality, Patient Experience and Safety Chair's Report**
	Dr Parkes thanked everyone for welcoming him to the meeting and he presented the Quality, Patient Experience and Safety Chair's report, highlighting that the percentage of Sepsis patients screened who received antibiotics within one hour was low however work had progressed with aligning the E-sepsis data with manual audits and improvement was expected. He said that MRSA/MSSA bacteraemia, '*C-Difficile'* cases and pseudomonas were low and below trajectory. Dr Shehmar referenced the mental health capacity audits explaining that with the new electronic patient record, the role specific training and mandatory training programme was required for the future support of clinicians to have discussion with families. She confirmed work was being undertaken with the e-sepsis module provider to tackle technical issues preventing accurate reporting and this was supplemented with manual audits in ED which had indicated improved compliance, and which was now being used across the wards with compliance monitored and reported. She confirmed the action regarding controlled drug audits had improved supported by the pharmacy governance team with training to address any specific issues. She added that electronic drug cabinets had been ordered for securing drugs.

	Ms Carroll made reference to the sepsis audits and confirmed that the data from manual audits received that morning indicated that 99% of patients had received antibiotics within one hour in February giving assurance and evidence that patients with sepsis had been treated appropriately. She reported that the Falls team had held drop-in sessions regarding the mental capacity act and RESPECT forms to improve knowledge around appropriate assessments. Prof. Field said that further discussion was required to ensure that there was no duplication of date and information in the nursing and quality aspects. Mr Virdee asked whether the breast cancer performance was due to the impact of Covid-19. Mr Hobbs explained that breast services had been challenged at the Trust and across the Black Country for capacity to see patients within two-weeks for some time and had been further exacerbated by a rise in referrals during wave 1 and the sickness absence of 2 of 3 Consultants at the Trust. He advised that mitigations had been put in place for outpatient capacity through mutual aid with RWT and Dudley Group and a new post was being recruited to for a breast care practitioner to provide outpatient capacity and he confirmed there was no pressure regarding the treatment of breast cancers. Prof. Loughton said that the problems in breast care services had been reported for several years prior to Covid-19 and solutions were not readily available due to the lack of relevant trained workforce but collaborative working with RWT would help with workforce flexibility. Ms Brathwaite noted the appointment of a practitioner and asked if the intention was to increase the number of such practitioners. Mr Hobbs said that the breast care practitioner was additional to the existing clinical nurse specialist and confirmed the capacity pressure in breast services was the outpatient initial consultation process. Ms Martin asked for a review of the format of the new IQPR report. Mr Caldicott agreed to action. **Action: Mr Caldicott to further review the IQPR report format.** Mr Evans said the IPQR route was the right direction in assessing performance and advised that as additional support, combined Board development sessions for Board members had been booked in May and June with the National Quality Team to better understand performance reporting and the use of SPC charts. **Resolved: that the Quality, Patient Experience and Safety Chair's Report be received and noted.**
266/22	**Performance, Finance & Investment (PFIC) Chair's Report**
	Mr Assinder reported that the Committee had met on 30th March 2022 and reviewed performance to end February 22. He highlighted that the performance within emergency and elective services was on par with most regional organisations and was exceeding nationally in ambulance handovers. He reported an area of concern with the 2-week wait breast cancer pathway as previously discussed and he advised that this would be continually monitored by PFIC. Mr Assinder reported a good financial performance as the Trust had attained a surplus of c£0.6m at end February and was forecasting a c£3m surplus at year end. Mr Assinder advised that the Committee had debated the draft 2022/23 financial plan and had significant concerns around the ability to produce a balanced financial plan for final submission by 28th April 2022 and recommended a special meeting be convened prior to submission to discuss and address any outstanding issues or concerns and agree the plan.

	He reported further work was required as the plan assumed a £5.3m efficiency delivery but the last Committee meeting recognised only £4.1m of efficiency savings identified concerns around the delivery of the efficiency ask, the increase in inflation with the unfunded £21m of operational projects. Prof. Field recommended Board members be invited to the special PFIC Committee meeting to discuss and approve the final 2022-23 financial plan prior to submission. Ms Martin asked for assurance that as each part was reviewed in preparation for the final submission, robust quality impact assessments had been undertaken. She said she also had concerns with the £21m of business developments not included in the budget and she cautioned against driving for a balanced budget at the expense of quality & safety. Prof. Loughton agreed with Ms Martin and said the whole Board should be involved in the final financial plan discussions and approval at PFIC. Dr Shehmar assured Ms Martin that a process had been agreed between herself, Ms Carroll and Mr Hobbs that schemes have quality impact assessments undertaken and Mr Evans confirmed the process was in place and operational run by the Efficiency Group. Mr Virdee asked for confirmation that equality impact assessments were included with the as quality assessments. Ms Muflahi agreed with Mr Virdee. Prof. Field agreed that a separate special meeting of WHT PFIC was to be arranged for the approval of the final financial plan. Ms Martin referred to the predicted deficit of £6.6m identified on the draft budget and said she was concerned about the £21m business cases that were crucial. She referred to the home working report later on the agenda and that initiatives would have to stop due to lack of funding but with no explanation having been provided regarding the impact. Mr Assinder reported that discussions were ongoing around the ambitious capital plan for 2022/23 which was currently underfunded in addition to the revenue plan. He confirmed the Committee had considered the business case for the collaborative urology service and was supportive of the financial and business aspects of the case. He said that they had also considered the updated Emergency Preparedness Resilience and Response (EPRR) plan which confirmed that the Trust was substantially compliant. **Resolved that the Performance, Finance & Investment Chair's Report be received and noted.** **Resolved: that the approval of the Budget for 2022/23 be delegated to a special PFIC meeting open to all Board members.** **There was a break from 11.00am to 11.10am.**
267/22	**People and Organisational Development Chair's Report**
	Ms Griffiths reported that the Committee had reviewed the full NHS Staff Survey results which had showed improvements. She said that 'deep-dive' sessions would be held with each of the divisions and the Oversight Group to further analyse the results. She said that all of the indicators on the National People Promise, apart from Inclusive and compassionate leadership and consistency, had been met, however with concerns regarding staff advocacy. Ms Griffiths said that they had improvements in relation to the Trust Board pledge of 'zero tolerance' of bullying and living by Trust values with further improvements required in respect of discrimination and culture. She noted concerns with short term sickness impact

	on the workforce and said the Committee had commissioned a review of short-term sickness to profile the expected timeframe for improvements to the position. **Resolved: that the People and Organisational Development Chair's Report be received and noted.**
PROVIDE SAFE, HIGH QUALITY CARE	
268/22	**Director of Nursing Report**
	Ms Carroll highlighted the significant number of Falls reported at the previous meeting, which had decreased in February, and with 'repeat fallers' being identified. She said a thematic review had been undertaken to ensure patients were appropriately assessed with details reviewed at the Falls Accountability meeting. She added that a similar approach was being taken with tissue viability and pressure ulcer management and the CCG had agreed a rapid review process of reviewing pressure ulcers within 5 days of reporting. Ms Carroll reported one unavoidable case of '*C-Difficile'* in February 2022, the total for the year as 27 within the trajectory set of 33 per year and said that there had been a number of bay closures as a result of incidental findings of Covid-19. She added two wards had closed early March 22, due to cases of norovirus that were managed using the outbreak processes and confirmed that both wards had since re-opened. Ms Carroll reported significant improvements in recruitment with a reduction in the number of vacancies and 189 overseas nurses had commenced in post with more joining over the coming months, together with other appointed nursing and midwifery staff. She said there were concerns with recruiting to the health visiting team and confirmed an implementation plan of possible options was in place to prioritise vacancy recruitment. She said the aim was to cease use of the temporary workforce from the beginning of April 22 which had been reducing, however they had had to use agency staff to maintain safety, due to short term staff absences in March 22, related to Covid-19 or Covid-19 like symptoms. Ms Carroll reported that Emergency Department (ED) and Ambulatory Medical Unit (AMU) Business Cases were in progress and if approved would reduce the agency staffing usage in those areas. She said the Staffing Hub continued to monitor staffing daily and redeploy nursing staff to areas of need as required to reduce agency staffing. Ms Carroll reported the nursing strategy approved in 2019 had not been completely embedded due to the pandemic and that a nursing away day had taken place with nurses, midwives and AHPs that had started work on developing a 'clinical systems framework'. She said that the concept of the framework would be launched to the wider workforce on International Nurses Day on 12th May. She advised T34 syringe drivers purchased in 2021 had not been rolled out due to the pandemic but would be later this year following technical updates and appropriate training. She said the AMU improvement plan was in place and the AMU Group met in March 2022 to review actions and evidence to ensure of assurance around the AMU improvements. Ms Carroll said there was to be insight maternity visit on 15th June 22 where the regional team would be looking at maternity services in relation to Ockenden and Kirkup. Dr Shehmar confirmed the actions from the Health Education England (HEE) review were on track relating to two patient safety alerts and said that the HEE were satisfied with the actions taken, and the full response was being submitted the following week. She referenced the AMU Improvement work confirming adverts for consultant recruitment were progressing and RWT were supporting consultants to reduce agency usage. She advised there was a new clinical lead in the AMU and the education tariff had been amended and agreed for all junior doctors for the support and training required. She said that support was in place for the development and leadership of nursing and medical leadership roles. Mr Virdee referenced the international nurse recruitment and asked if there were plans to

	look at local nursing appointments in the longer term, and he queried the increased number of Covid-19 cases. Ms Carroll advised that international nurse recruitment was an important part of the workforce strategy and would continue but all other options were also being explored including increasing the number of students in the hospital and continued work with local colleges for healthcare support workers and other training opportunities. She said that it was difficult to predict the Covid-19 situation but new government guidelines were changing regularly as the situation changes with new variants. Prof. Cannaby added that healthcare workforce was a global problem as nurses and doctors were moving around the globe gaining experience on an earn, learn and return programme. She said that this was an attractive opportunity and the nursing strategy looked to increase the numbers of students in placements as the issue was staff retention post Covid-19 and an ageing workforce. Ms Martin asked about the mortality performance report and Dr Shehmar advised it was a quarterly report to QPES and Board. Ms Martin suggested that as the Board now met bi-monthly, that the reporting cycle for this report be amended and it be received bi-monthly moving forward. Dr Shehmar agreed. **Action: the cycles of business to be updated to receive the mortality report bi-monthly moving forward.** Ms Muflahi reported on her observations from her first maternity walkabout and said it was refreshing to see a number of students in the area which confirmed the reports presented by Ms Carroll and Prof. Cannaby. **Resolved: that the Director of Nursing Report be received and noted.**
269/22	**Patient Experience Bi-monthly Report**
	Mr Perry presented the report highlighting the trends in relation to the Friends and Family Test (FFT) responses. He said that the numbers providing recommendations had increased recently due to the focussed work undertaken on FFT and the alternative means of providing feedback that was now available. He said that next step was to use the data collected for further improvement actions. Mr Perry confirmed the complaints response timeframe remained in or above target, a significant improvement with the Trust in the top 25 of adopters nationally of the new parliamentary complaint standards. He said further feedback was received from the mystery patient feedback, collected via a bedside/departmental poster that included a link to provide friends and family feedback via a QR code associated with the area, sent to divisions daily to share with staff to pick up and act on any areas of concern. Mr Perry highlighted the new Manor Staff Well-being Lounge had opened funded from the NHSE/I Voluntary Services Fund and in partnership with Manor Farm Community to support staff well-being and morale. Mr Perry extended an open invitation to Board members to visit at any time and said the Welcome Hub continues to provide invaluable support for patients, family and carers. Ms Evans said she had visited the Manor Lounge that demonstrated the organisations commitment to the staff health and well-being and it currently relied on donations and she was looking at how support could be continued. Mr Perry explained the volunteer service had been expanded and the number of Enhancing Ward Experience (EWE) volunteers also continued to increase. He said this was partnered with Juniper Training and EWE's supporting ward and clinical areas with new EWE roles in place in the Emergency Department and Maternity services. Mr Virdee asked about poor feedback on the Friends and Family Test (FFT) regarding post

	and antenatal care data and whether the breakdown on ethnicity and other characteristics was collected. Mr Perry advised that the feedback on FFT for all maternity settings had reduced and was a national issue and the FFT had been reset with the provider from 1st April 22 with a reminder service commenced to enable more opportunities to feedback. He added that statistical breakdowns would be provided in the Annual Report when all data was collected and presented in June 22. Ms Muflahi thanked Mr Perry for the clarity of the report and said there would be multiple opportunities to ensure the voice of staff and patients in maternity services was heard as evidenced by some of the actions being implemented. Ms Jones-Charles confirmed the maternity service was working to engage with patients and staff to ensure positive feedback and a good experience. **Resolved: that the report from the Patient Experience Bi-monthly Report be noted.**
270/22	**Black Country Ockenden and Kirkup Bay Report – March 2022**
	Mrs Jones-Charles advised that the new format of the report provided the Board oversight of the maternity services declaration of compliance of part 1 of the Ockenden and Kirkup reports and that all evidence had been reviewed by the Director of Nursing. Mrs Jones-Charles said Part 2 of the Ockenden report was published last week and this report focussed on Part 1 published in December 2020. She said that all Trusts had been working to provide assurance against the framework and she confirmed that there were internal maternal networks to refer patients, however the regional networks were in their infancy control. Mrs Jones-Charles confirmed work with the communications team to develop the trust website to enable direct access to maternity services to women if they chose to have their care with the Trust. She advised that since the Kirkup Report of 2015, services had moved on significantly, but due to issues in East Kent, all maternity services had been required to provide assurances against the Kirkup recommendations and she was pleased to report the evidence had been demonstrated and all the standards were met including the increased number of students and return to practice midwives. Mrs Jones-Charles explained that the Black Country submission required the Local Maternity Systems to submit assurance to the regional NHSE/I team which the Director of Nursing had signed off for submission on 15th April 22. **Resolved: that the Black Country response to the Ockenden and Kirkup Morecombe Bay Reports be noted.**
271/22	**Safeguarding Adults and Children Quarter 3 Report**
	Ms Pickford reported that Safeguarding Training Level 3 (adults and children) compliance had shown a slight variation and as a result there would be an overall review of the delivery of the programme during 2022. She confirmed that Safeguarding Training compliance overall was maintained in line with WHT and CCG expectations, with the exception of Level 3 training, and work was continuing with divisions to meet the trajectories. Ms Pickford advised that substantial work had been completed with the Safeguarding Development Plan and subsequent work on actions to complete and provided assurance that the majority of the actions had been concluded, with positive feedback received from various agencies. She said further work was required on audit programmes with a plan in place. She added that, as a result of the Safeguarding Development Plan, a business case for expanding the team was completed, funding had been received and was in the process of being recruited to.

	Ms Pickford advised that an internal group had been formed to pull together outstanding actions from various Walsall Partnership reviews and provide an interface with the Safeguarding Committee. She highlighted Safeguard concerns had been a key feature during the pandemic with an increase in domestic violence and cases were monitored and support provided at the multi-agency Safeguarding Hub in Wolverhampton. Ms Pickford reported the team had participated in Walsall Partnership assurance audits regarding compliance with Section 11 (Children Act 2004) and Care Act 2004 during Q3 and the feedback from the partnership was that WHT had good governance arrangements in place. She added that a Special Educational Needs of Disability (SEND) inspection was due in Walsall and work was in place to support the process. Prof. Field congratulated the team on their hard work and progress made and said he felt more assured of the situation which also reflected in the feedback from Ms Rowe at Walsall Council. Ms Muflahi queried why the safeguarding training compliance had been consistently low. Ms Pickford explained that during the reporting period there had been significant staff sickness absence and issues in delivery of the training as staff were unable to be released to undertake training. She explained that future delivery options for training were being explored. Ms Carroll added that Safeguarding training was monitored by the Safeguarding Committee that she Chaired and confirmed that trajectories for achieving compliance of the current training had been requested from all divisions. Prof. Cannaby thanked Ms Pickford and her team for the work in developing improvements in the systems and processes over both Trusts. Ms Brathwaite asked for clarity around SEND inspections and assurance that progress was made. Ms Pickford reported on the work that Walsall had undertaken, working with the Clinical Commissioning Group to look at the oversight of support services. Prof. Loughton said the capacity in the safeguarding team required reviewing as the number of domestic violence case were likely to increase due to financial pressures. **Resolved: that the Safeguarding Adults and Children Quarter 3 Report be received and noted.**
CARE AT HOME	
272/22	**Walsall Together Partnership Board Chair's Report**
	Mr Sharon recorded his thanks to Mr Dunn, Non-Executive Director for his chairing the meeting over recent months following the departure of the previous Chair. He explained that Walsall Together was a partnership of local providers and Mr Patrick Vernon had been appointed as an independent Chair for Walsall Together and had commenced in post on 1st April 2022 and he would be invited to attend to present the Walsall Together Chair's report at future Trust Board meetings. Mr Sharon positively commented on resilience and sustainability of the workforce and the challenges around recruitment and retention of staff in moving to an integrated workforce across health and social care. He said that one of the major work programmes of Walsall Together agreed during a recent Away Day was a development programme with several worksteams focussed on changes in functionality and PLACE based partnerships. Ms McManus outlined the key points of the anchor employment network approach to working with public sector organisations and education providers and said that meetings had taken place with representatives from Birmingham to look at work they had undertaken and

	how it might be scaled up in Walsall. She said there was good engagement with Walsall partners which also linked into the wider Black Country work through Ms Griffiths and her team. **Resolved: that the Chair of Walsall Together Partnership Board be received and noted.**
273/22	**Care at Home Executive Report**
	Ms McManus provided, in the absence of Mr Dodd, the highlights from the Care at Home report advising that the demand for Community Locality Services reduced in February 2022 and whilst the Care Navigation Centre saw a sustained level of high demand, Primary Care Networks (PCNs) reported continued demand on primary care services during February. She said the Trust Board had previously been informed about the impact of the shortage of staff in care agencies and said that in February there was more capacity provided by Care Agencies for domiciliary care. She said that while the Care Homes reported less infection control outbreaks and reduced business continuity pressures resulting in fewer delays for Walsall residents with complex needs being discharged from hospital, they continued to have concerns around market stability due to market rates and funding issues. Ms Martin reported she had recently visited Blakenall Health Centre, a community service, and had been impressed with the enthusiasm of the team and diversity of what they were doing for patients to support them to continue living in their care home setting rather than coming to hospital. She raised concerns about funding for future initiatives and queried how impact assessments would be undertaken. Ms McManus explained there were two pieces of work being undertaken and the services provided by Walsall Healthcare were not expected to stop but there were pressures in other parts of the system that would have an impact on demand particularly around domiciliary care. Mr Caldicott confirmed Walsall Trust services were resourced, but a key concern was the level of resource invested in community-based models through other partner organisations and discussions had taken place with partners and Mr Dodd was reasonably assured that resources would be secured through allocations held mainly within council-based service provision. He said the Trust was waiting for written confirmation of outcomes of discussions. Mr Virdee asked about locality capacity and noted the initiative of overseas recruitment and highlighted that the income levels of domiciliary care staff was different to the overseas nurses and wanted to ensure appropriate packages of support were in place. Prof. Loughton said the same package of care would be provided to any overseas staff whether they be nurses, doctors or domiciliary staff. **Resolved: that the Care at Home Executive Report be received and noted.**
274/22	**Charitable Funds Chair's Report**
	Mr Assinder reported the tremendous generosity of the Patel family in gifting a legacy of £130k to the Well Wisher's Charity. Mr Assinder reported the Committee was currently reviewing the draft 3 year fundraising strategy developed in conjunction with RWT charity colleagues and added the Committee had received a presentation from Dr Radford, Consultant in Occupational Health and had supported Dr Radford's 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-19 pandemic on staff in the Trust, and to advise on longer term wellbeing measures and effective support mechanisms. He said the Committee had supported the bid and suggested the scope of the study be extended to embrace the Royal Wolverhampton NHS Trust. Prof. Loughton added his support

	Mr Assinder commended the varied range of events scheduled throughout 2022 and encouraged members of the Board to attend or participate in events where possible. **Resolved: that the Charitable Funds Chair's report be received and noted**
USE RESOURCES WELL	
275/22	**Audit Committee Chair's Report**
	Ms Martin reported that the internal audit report on Infection, Prevention and Control (IPC) rated the Trust as 'partial' assurance with improvement required and a number of recommendations had been made. She said the Committee was very disappointed with the findings of the audit and an action plan had been agreed. Ms Martin added that the Counter Fraud Strategy was also submitted for Board approval. Ms Carroll reported that everything highlighted in the internal audit had been picked up in the IPC Business Assurance Framework that had been presented to the Board and confirmed that actions were underway with improvements being made. She said that a number of the elements in the report had related to the Trust's old estate. **Resolved: that the Audit Committee Chair's Report be received and noted.**
VALUE OUR COLLEAGUES	
276/22	**2021 National NHS Staff Survey**
	Ms Griffiths assured the Board that a detailed understanding of the results of the Staff Survey had been developed following analysis which illustrated improvement in staff experience generally. She said that there were challenging workforce issues with an area of concern with regards to the decline in advocacy score as this related to recommendations as a place to work or be treated. Ms Griffiths thanked Ms Evans and her team for the positive communication messages and said they would review what was positively reinforced. Prof. Field acknowledged there had been a change since the previous staff survey with the increased response rate and the effective medical and nursing leadership now in place. He said that the improvements that had been made were having a positive effect on staff. **Resolved: that the Audit Committee Chair's Report be received and noted.**
277/22	**Education and Training**
	Ms Young reported that good progress had been made against the Education and Training Steering Group workplan including the corporate level risk (2664) AMU Improvement Plan being finalised for submission to HEE by 12th April 22. She advised of the continued collaboration with the Royal Wolverhampton NHS Trust that provided solid infrastructure for educational leadership and medical education. Ms Young confirmed the Physicians Associate business case had been approved and work was progressing and the better National Education and Training Survey (NETS) engagement required for WHT learners as the latest Nov 2021 NETS data released showed postgraduate medical training performance with 141 total respondents before masking and 107 respondents after masking, which was a great improvement on June 2021 survey, with room for improvement. **Resolved: that the Education and Training report be received and noted.**
278/22	**Staff Story – International Nurses**
	Ms Griffiths reported that the People and Organisational Development committee had received a presentation from Aaron Bates, Ward Manager Ward 2 who had shared a story on the international nurse programme. She said the presentation had been a tribute to compassionate and inclusive leadership of how Aaron and the team had operationalised the

	plans to ensure pastoral care support for the nurses arriving on the international programme. She said that they heard from the nurses on that programme who had felt welcomed and supported having made the difficult decision to leave their Country and families. Ms Griffiths acknowledged Aaron's work in consistently showing compassionate leadership and Ms Carroll echoed the comments adding that Aaron and the team understood not only the needs of the international nurses from a nursing viewpoint but their day to day needs outside of work and that it was humbling to hear about what these nurses had left behind to come to the organisation. Ms Carroll said Aaron and the team were now supporting other wards and the wider trust in assisting the international nurses in other areas. Mr Hobbs reported he had spent time shadowing on Ward 2 recently and said the comments made on how the ward had embraced international nurses went above and beyond international nurses as the commitment to inclusive and compassionate leadership and development of staff of all professions and stages of their career was palpable on ward 2. Prof. Loughton agreed with Mr Hobbs comments that the international nurses must feel welcomed and part of the organisation as they had left homes and families to come to this Country. **Resolved: that the Staff Story – International Nurses be received and noted.**
CLOSING ITEMS	
279/22	**Any Other Business**
	Prof. Field noted that no other business was raised.
280/22	**Date and time of the next meeting**
	Prof. Field confirmed that the next meeting was to take place on Wednesday, 8th June 2022.
281/22	**Resolution**
	To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudicial to the public interest. **Resolved: that the resolution be approved.** **The meeting concluded at 12:58pm**

Our **Vision, Objectives & Values**

Walsall Healthcare NHS Trust is guided by five strategic objectives which combine to form the overall 'vision' for the organisation.

Complementing this are our 'values', a set of individual behaviours that we wish to project amongst our workforce in order to deliver effective care for all.

Our Vision: **Caring for Walsall together**

"Caring for Walsall together" reflects our ambition for safe integrated care, delivered in partnership with social care, mental health, public health and associated charitable and community organisations.

Our Objectives: **Underpinning the vision**

The organisation has five strategic objectives which underpin our vision of 'Caring for Walsall together', and they are to:

Provide Safe, high-quality care;
We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022.

Care at Home;
We will host the integration of Walsall together partners, addressing health inequalities and delivering care closer to home.

Work Closely with Partners;
We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.

Value our Colleagues;
We will be an inclusive organisation which lives our organisational values without exception.

Use Resources Well;
We will deliver optimum value by using our resources efficiently and responsibly.

Walsall Healthcare NHS
NHS Trust

Our Values: **Upholding what's important to us as a Trust**

Our values, coupled with individual behaviours, represent what we wish to project in our working environments.

Respect	**We are open, transparent and honest, and treat everyone with dignity and respect.** • I appreciate others and treat them courteously with regard for their wishes, beliefs and rights. • I understand my behaviour has an impact on people and strive to ensure that my contact with them is positive. • I embrace and promote equality and fairness. I value diversity and understand and accept our differences. I am mindful of others in all that I do.
Compassion	**We value people and behave in a caring, supportive and considerate way.** • I treat everyone with compassion. I take time to understand people's needs, putting them at the heart of my actions. • I actively listen so I can empathise with others and include them in decisions that affect them. • I recognise that people are different and I take time to truly understand the needs of others. • I am welcoming, polite and friendly to all.
Professionalism	**We are proud of what we do and are motivated to make improvements, develop and grow.** • I take ownership and have a 'can-do' attitude. I take pride in what I do and strive for the highest standards. • I don't blame others. I seek feedback and learn from mistakes to make changes to help me achieve excellence in everything I do. • I act safely and empower myself and others to provide high quality, effective patient-centred services.
Teamwork	**We understand that to achieve the best outcomes we must work in partnership with others.** • I value all people as individuals, recognising that everyone has a part to play and can make a difference. • I use my skills and experience effectively to bring out the best in everyone else. • I work in partnership with people across all communities and organisations.

The Seven Principles of Public Life
‘Nolan principles’

The Seven Principles of Public Life (also known as the Nolan Principles) apply to anyone who works as a public office-holder. This includes all those who are elected or appointed to public office, nationally and locally, and all people appointed to work in the Civil Service, local government, the police, courts and probation services, non-departmental public bodies (NDPBs), and in the health, education, social and care services. All public office-holders are both servants of the public and stewards of public resources. The principles also apply to all those in other sectors delivering public services.

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

MEETING OF THE TRUST BOARD – 8th June 2022			
Board Attendance 2021-22			
Report Author and Job Title:	Keith Wilshere Interim Company Secretary	**Responsible Director:**	Keith Wilshere, Interim Company Secretary
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	To assure the Trust Board of Board member attendance at Trust Board meetings held in public and to assure of quoracy at meetings. To provide the evidence to assure the Board and the Chair that those who should attend the Board in the year have done so.		
Advise	To advise that there were 10 Trust Board meetings held in the period 1st April 2021 to 31st March 2022.		
Alert	There are no Alerts to note		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	There are no risks identified relating to Board attendance.		
Resource implications	None		
Legal and/or Equality and Diversity implications	There are no implications from the report identified.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Board Member Attendance Record
2021-22

1. PURPOSE OF REPORT

The purpose of the reports is to inform and assure Board attendance at Trust Board meetings held in 2021-22.

There were 10 Trust Board meetings held in public in the period 1st April 2021 to 31st March 2022.

Board Member	Job Title	No. available to attend	No. attended
Prof. Steve Field	Chair	10	10
Paul Assinder	Non-Executive Director	10	10
Junior Hemans	Non-Executive Director	10	10
Mary Martin	Non-Executive Director	9	9
Louise Toner	Non-Executive Director	2	2
Sally Rowe	Associate Non-Executive Director	10	5
Rajpal Virdee	Associate Non-Executive Director	10	8
Dawn Brathwaite	Non-Executive Director	1	0
Prof. David Loughton	Chief Executive	9	8
Prof. Ann-Marie Cannaby	Interim Deputy Chief Executive/Chief Nursing Officer	9	9
Russell Caldicott	Chief Officer for Finance	10	10
Ned Hobbs	Chief Operating Officer	10	8
Dr Manjeet Shehmar	Chief Medical Officer	6	6
Matthew Dodds	Director of Transformation (Walsall Together)	6	6
Catherine Griffiths	Director of People and Culture	10	9
Glenda Augustine	Director of Performance	5	5
Lisa Carroll	Director of Nursing	7	5
Mike Sharon	Strategic Advisor to the Board	7	7
Kevin Bostock	Director of Assurance	5	5
Kevin Stringer	Interim Director of IT and SIRO	2	2
Simon Evans	Interim Chief Officer for Strategy	4	4
Sally Evans	Interim Director of Communications and Stakeholder Engagement	9	5
Board Members that left the Organisation in the period 2021-22			
John Dunn	Non-Executive Director	10	9
Pam Bradbury	Non-Executive Director	10	8
Anne Baines	Non-Executive Director	6	6
Ben Diamond	Non-Executive Director	5	5
Ann-Marie Riley	Director of Nursing	3	3
Daren Fradgley	Director of IT, Transformation and Integration	5	5
Matthew Lewis	Chief Medical Officer	4	4
Jenna Davies	Director of Governance	6	3

2. RECOMMENDATIONS

To receive and note the report for assurance.

MEETING OF THE PUBLIC TRUST BOARD – 8 JUNE 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.		
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/or 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 two Consultant Appointments since I last reported: **Emergency Medicine** Dr Syed Sibtain Dr Ashajyothi Srirajamadhuveeti
3.0	**Policies and Strategies**
	Policies for April 2022 • CP62 V4 – Consent for Post-mortem Examination and Retention and Use of Organs Policy • OP79 V3 – Water Safety Policy • CP914 VS – Oxygen Delivery to Adults within Walsall Healthcare NHS Trust (acute and inpatient sites) Policy • GP02 V8 – Anti-Fraud, Bribery and Corruption Policy • HR911 V4 – Annual Leave Policy • HS33 V2 – The Health Care Travel Cost Policy • IP909 V5 – Management and Prevention of Tuberculosis Policy • MP910 V6 – Recall of Defective Medicines Policy • MP912 V4 – Self-Administration of Medicines by Patients' Policy • MP915 V4 – To Take-out (TTO) Medicine Pack Policy • OP26 V5 – Security Policy • OP104 V1.5 – Lockdown Procedures and Policy • OP110 V2 – PREVENT (risk of being drawn into terrorist related activities) Policy • OP917 V6 – Incident Reporting, Learning and Management Policy • CP66 V1 – Enhanced Supervision Policy • Visiting Healthcare Inpatient Settings during Covid-19 Pandemic Policy **Policies for May 2022** • Policy Report of 10 May 2022 • CP922 V2.1 - Slips Trips and Falls Policy • HR913 V4 - Employment Break Policy • HS920 V2.1 - Laser, Ultraviolet and Hazardous Light Source Safety Policy • MP918 - Antimicrobial Prescribing Policy • OP 01 V9 - Governance of Trust-Wide and local Policies' Guidelines and Standing Operating Procedures (SOPs)

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
- 22 March 2022 - participated in the virtual ICS Masterclass follow-up session with David Meates (New Zealand Healthcare system)
- 24 March 2022 – participated in the virtual Deputy Chief Medical Director interviews, virtually presented the new Cancer Dashboard to the national NHS Improvement/ England Team and participated in the Black Country Collaboration Board
- 25 March 2022 – participated in a virtual Regional Chair and Chief Executives meeting with Sir David Solman – NHS Chief Operating Officer
- 28 March 2022 – chaired a virtual staff briefing on NHS Staff Survey Results
- 29 March 2022 – participated in the virtual Regional Research Network Workshop and chaired a virtual staff briefing on the NHS Staff Survey Results
- 30 March 2022 – chaired a virtual staff briefing on the NHS Staff Survey Results
- 31 March 2022 – participated in an Executive Board Session
- 1 April 2022 – participated in the virtual institute of Health and Social Care Management IHSCM Competency Framework Advisory Board Meeting
- 7 April 2022 – undertook a site visit at Manor Hospital and participated in a virtual NHS England/ Improvement Ockenden – Final Report webinar
- 8 April 2022 – participated in a virtual IHSCM Executive Advisory Committee Meeting
- 12 April 2022 – participated in a Trust Orthopaedic event, participated in the virtual Joint Liaison Committee with Skanska
- 14 April 2022 – chaired a virtual Gold Command meeting
- 20 April 2022 – opened the staff Aspiring Leadership Development programme, chaired a virtual Staff Briefing
- 21 April 2022 - participated in the virtual Joint Negotiation Committee (JNC) and participated in virtual Black Country Collaborative – Programme Executive meeting
- 25 April 2022 – participated in a virtual OptiPrem stakeholder event: Evaluating best place of care for babies born between 27-31 weeks gestation in the UK
- 26 April 2022 – participated in a West Midlands Combine Health Authority – Health of the Region Roundtable and participated in the Walsall Council Health and Well Being Board
- 27 April 2022 – participated in the Finance and Performance Committee – budget presentation
- 28 April 2022 – participated in a NHS England/ Improvement (NHSE/I) National Leadership event
- 29 April 2022 - participated in the virtual Regional Cancer Board
- 3 May 2022 – hosted a visit from Dr Martin Marshall - Chair of Council, The Royal College of GPs
- 5 May 2022 – hosted a visit from Hanna-Leena Markki, Director of Central Satakunta Social and Health Care – Finland

	• 6 May 2022 – participated in the NHS Regional – Operating Model session – Midlands • 10 May 2022 - chaired the virtual West Midlands Cancer Alliance Board • 11 May 2022 – participated in a RWT/ WHT Joint Board Development session and virtual presented the newly developed Cancer Dashboard to a National NHS Conference • 13 May 2022 - participated in the virtual Walsall Proud Partnership (WPP) meeting
5.0	**Board Matters**
	There were no Board Matters to report on.

MEETING OF THE PUBLIC TRUST BOARD – 8 June 2022			
Chair's report of the Trust Management Committee (TMC) held on 26 April 2022 – to note this was a virtual meeting			
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.		
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/or 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 • Nursing - WHT – NHS England /Improvement (NHSE/ I) Feedback Letter • 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 • National 2021 Staff Survey Results Report • Walsall Together Update Report • Trust Financial Position (Revenue and Capital) - Month 12 Report • Integrated Quality Performance Report (IQPR)
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**
	• Acute Collaboration Report • Medicine Management and Pharmacy Report • Research and Development Report • Estates Strategy and Capital Plan Report • ICS Development Report • PLACE Scores Report • Annual Plan – 2022/23 National Submission Report • Five Year Joint Strategy Development between WHT and RWT - Update Report • Urgent and Emergency Care Centre's Capital Build Update Report • Commonwealth Games (CWG) Update Report • Visitor Car Parking Report • WHT Annual Report 2021-22 - Verbal Report
5.0	**Business Cases – approved**
	• Orthopaedic Surgeons Business Case • Nursing Associate to Registered Nurse (RN) Top--up Apprenticeship Business Case • Nursing Workforce in the Emergency Department Business Case • New Governance Posts Business Case • Same Day Emergency Care in Acute Medicine (Ambulatory Emergency Care) Business Case

	• Emergency Department (ED) Medical Workforce Business Case
6.0	**Policies approved**
	• CP62 V4 – Consent for Postmortem Examination and Retention and Use of Organs Policy • OP79 V3 – Water Safety Policy • CP914 VS – Oxygen Delivery to Adults within Walsall Healthcare NHS Trust (acute and inpatient sites) Policy • GP02 V8 – Anti-Fraud, Bribery and Corruption Policy • HR911 V4 – Annual Leave Policy • HS33 V2 – The Health Care Travel Cost Policy • IP909 V5 – Management and Prevention of Tuberculosis Policy • MP910 V6 – Recall of Defective Medicines Policy • MP912 V4 – Self-Administration of Medicines by Patients' Policy • MP915 V4 – To Take-out (TTO) Medicine Pack Policy • OP26 V5 – Security Policy • OP104 V1.5 – Lockdown Procedures and Policy • OP110 V2 – PREVENT (risk of being drawn into terrorist related activities) Policy • OP917 V6 – Incident Reporting, Learning and Management Policy • CP66 V1 – Enhanced Supervision Policy • Visiting Healthcare Inpatient Settings during Covid-19 Pandemic Policy
7.0	**Other items discussed**
	There were none this month.

MEETING OF THE PUBLIC TRUST BOARD – 8 June 2022			
Chair's report of the Trust Management Committee (TMC) held on 24 May 2022 – to note this was a virtual meeting			
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.		
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/or 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 • CQC Fundamental Standards of Care Compliance Report • Mental Update Report • Midwifery Service Report • Nursing and Midwifery Workforce Report • Patient Experience Report (and Annual Complaints 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 • Walsall Together Update Report • Trust Financial Position (Revenue and Capital) - Month 1 Report • Integrated Quality Performance Report (IQPR) • Workforce Summary Report • Workforce Metrics 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**
	• Acute Collaboration Report • Research and Development Report • Property Management Verbal Update • Annual Fire Safety Report – Verbal Update • Quality Account Report • Quality Improvement Report • Sustainability Report and Green Plan Update Report • Urgent and Emergency Care Centre's Capital Build Update Report • Five Year Joint Strategy Development between WHT and RWT - Update Report
5.0	**Business Cases – approved**
	• Surgical Mutual Aid – General Surgery, Orthopaedics and Gynaecology Business Case • Therapies Intervention for Emergency and Elective Surgical Patients Business Case • Clinical Fellowship Programme – Nursing Business Case • Professorships in Nursing, Midwifery and Allied Health Professionals (AHP) Business Case

	• Nurse Workforce in Acute Medical Unit (AMU) Business • Nephrology AKI (Acute Kidney Injury) Service Business Case • Oncology Service Level Agreement (SLA)
6.0	**Policies approved**
	• Policy Report of 10 May 2022 • CP922 V2.1 - Slips Trips and Falls Policy • HR913 V4 - Employment Break Policy • HS920 V2.1 - Laser, Ultraviolet and Hazardous Light Source Safety Policy • MP918 - Antimicrobial Prescribing Policy • OP 01 V9 - Governance of Trust-Wide and local Policies' Guidelines and Standing Operating Procedures (SOPs)
7.0	**Other items discussed**
	There were none this month.

Walsall Healthcare NHS
NHS Trust

Integrated Quality & Performance Report

April 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.

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 91.66%, a decrease in compliance from 93.86% in March 2022. Divisional teams continue to report on their performance and improvement plans into Patient Safety Group (PSG). • The prevalence of timely observations in April 2022 was 90.69%, a slight decrease from 91.19% in March 2022 and is above trust target. • Falls per 1000 bed days was 3.68% in April 2022 and in line with the previous consistent performance. • The Trust target for Clostridium difficile 2022/23 has been set at 27 cases with no C.Diff cases reported for April 2022. • The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 69.08% by E-sepsis audit in April 2022. Manual audits have consistently shown higher levels of compliance but issues have been identified with data collection in the manual audits. • Mental Capacity Act Audit shows that 71.05% of patients who lacked capacity had a stage 2 assessment undertaken, an increase from 62.50% in March 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 the best Ambulance Handover times (<30 minutes) in the West Midlands, (14 out of the last 15 months), despite April being the 5th highest month of Type 1 ED attendances on record and whilst supporting neighbouring Trusts with mutual aid with 148 ambulances intelligently conveyed away from neighbouring Trusts. • 4-hour Emergency Access Standard performance in April 2022 had 74.6% of patients admitted or discharged within 4 hours of arrival to ED. The Trust was ranked 29th nationally out of 111 Trusts, with 13 of the last 14 months being in the Top 30 nationally. • In March 2022, 62-day Cancer performance the Trust was materially better than the West Midlands average (56.0%) and consistent with the national average (67.4%) with 66.7% of our patients treated within 62 days of GP referral. • Despite challenges in the sonography and MRI service, the Trust's 6 Week Wait Diagnostics performance remains stable and is 14th best (March 2022 reporting), out of 122 reporting acute Trusts. The Recovery of non-Obstetric Ultrasound Services waiting times has been delivered and the MRI recovery plan is in place with an additional mobile MRI scanner in partnership with InHealth. Board should note the following risks: • The Trust's 18-week RTT performance is in line with trajectory with 62.03% of patients waiting under 18 weeks at the end of April, the national ranking position is stable at 69th (out of 122 Trusts) for March performance. The Trust's 52-week waiting time performance is 7th best in the Midlands (out of 20 Midlands Trusts). The Trust now has 767 patients waiting in excess of 52-weeks as at the end of April. • Suspected Breast Cancer and Breast symptomatic outpatient waiting times have been challenged for some months. Mutual aid provided from Royal Wolverhampton Trust , Dudley Group NHS Foundation Trust and Sandwell & West Birmingham.
WORKFORCE	**FINANCE**
• 7 of out 10 days lost of sickness represent long-term absences. Absence stablised at 5.8%, with stress/anxiety episodes down by 33%. • As of 06/05/2022, 88% of substantive colleagues had received their 1st dose vaccinations; 38% amongst active bank colleagues (who worked a shift during April 2022). • PDR compliance is highest amongst Healthcare Scientists colleagues (94%). Admin colleague appraisal compliance continues to improve; now 79%.	• 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. • Following Trust Board debate, Executive endorsement and PFIC approval (through delegation of powers from the Board) the Trust submitted a financial plan as of the 28th April 2022, with the STP plans articulating a £48m deficit and the Trust plan (as part of the £48m deficit) a £7.6m deficit. The Executive have met and prioritised essential developments as part of this position. • With the announcement of additional revenue funding for the NHS in mid May, there is now an expectancy all ICSs will breakeven in 2022/23. All trusts and ICSs must complete a further submission of a financial plan on 20 June 2022. Assuming delegation is given, an extraordinary PFIC will be required close to 20 June to authorise a revised financial plan. • In month 1 the Trust reported a £0.249m deficit, which is £0.546m adverse to plan. This was driven by higher than planned temporary staffing costs and non achievement of CIP plan. Capital expenditure was £1.981m against a full year plan of £37.858m. This is within expectation with larger projects due to commence later in year. The cash position remained strong.

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Quality, Patient Experience and Safety (QPES)
Date(s) of Committee/Group Meetings	20th May 2022
Chair of Committee/Group:	Dr Julian Parkes
Date of Report:	20th May 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Mental Capacity Audit shows 62.5% who lacked capacity had stage 2 audit (was 71.05%) . Discussion with the patient's relative or attorney has falled to 53.47% • Recent manual sepsis audit results 98% in A+E. Intention to review manual audit results a month in arrears as electronic system unreliable. Manual data being collected for inpatient sepsis for antibiotics in I hr • Level 3 children's safeguarding remains below target at 85% and has fallen for 3 consecutive months. Level 3 adults safeguarding training is also below target. Additional training is being provided • 41% of clinical guidelines are "past the review date." This date is set when the guidelines are approved. There are 121 past the review date, which has increased. A plan is in place and trajectories are due to be presented next month • Electronic Discharge Summaries completed within 48hrs is stable and low at 83.64%
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Wait time for "2 week wait" for symptomatic breast and suspected cancer now just over 2 weeks and specialist nurse appointed • Waiting list for domiciliary phlebotomy decreased from 240 cases to 146 and on target for 72hr waiting time by end of May 2022 • VTE Compliance is stable but below target at 93.22% but with variation in different parts of the service (MLTC 82.85%) • The 18-week RTT performance remains in line with trajectory • There are 78 open Serious Incidents on STEIS

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Timely observations are above target at 90.69% above the 85% target • Falls per 1000 bed days reduced to 3.68% • MRI and U/S performance is stable. Ultrasound waiting time 6 weeks and MRI waiting time on course to be 6 weeks by end of May 2022 • Elective and day case activity is 113% of pre-COVID level • Operating theatre capacity is being prioritized for cases that need operating theatres, moving more minor procedures to other settings • 62% of Priority 2 patients have their procedure within 28 days • Expansion of hours in Care Navigation and Rapid Response is embedded • Seven specialty areas are research active and a Director of Research is being recruited between RWT and WHCT
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)**	•
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	Presentations received included • Community Services Report • Safe High Quality Care Oversight report • Maternity Services update • Serious Incident Update • Research and Development update • Infection Control Annual Report • Paediatric Death in January Review update
Matters presented for information or noting	•
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	2022/23 Target	SPC Assurance	SPC Variation
QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE							
No.	Clostridium Difficile - No. of cases	Apr-22	0	2	27		
No.	MRSA - No. of Cases	Apr-22	0	0	0		
%	VTE Risk Assessment	Apr-22	91.67%		95.00%		
%	Sepsis - % of patients screened who received antibiotics within 1 hour - ED (Manual Audit)	Mar-22	86.26%		90.00%	Not enough data to generate SPC	
No.	Falls - No. of falls resulting in severe injury or death	Apr-22	1	0	0		
Rate	Falls - Rate per 1000 Beddays	Apr-22	3.68	6.10	6.10		
Ave	National Never Events	Apr-22	0	0	0		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	Apr-22	15				
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Apr-22	0				
Rate	Midwife to Birth Ratio	Apr-22	28.5	28	28		
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	Apr-22	7				
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	Apr-22	5				

Metric Name: Clostridium Difficile - No. of Cases

MONTH

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

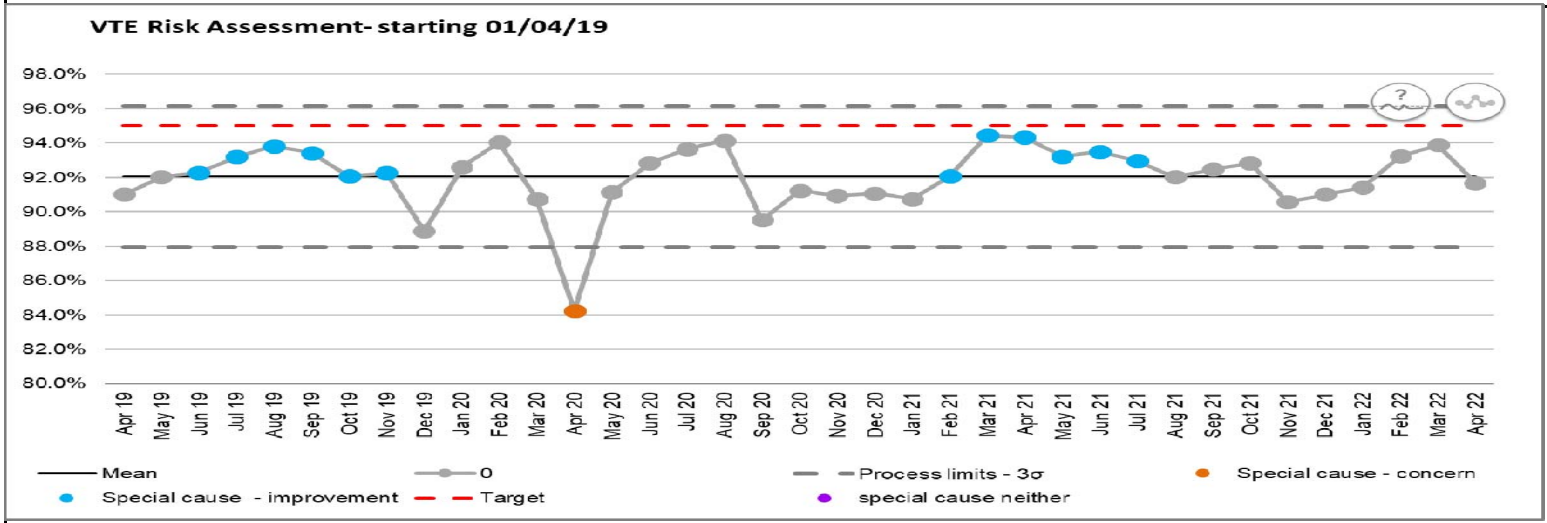
CUMULATIVE

	Actual	Traj.
Apr	0	2
May		4
Jun		6
Jul		8
Aug		10
Sep		12
Oct		14
Nov		16
Dec		18
Jan		21
Feb		24
Mar		27

Month
Apr-22
Variance Type
Target
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 2022/23 has been set by commissioners as 27.	No significant variance and year to date cases remain below year to date projected cases.	0 cases of C.Diff were reported in April 2022. .	None required	N/A

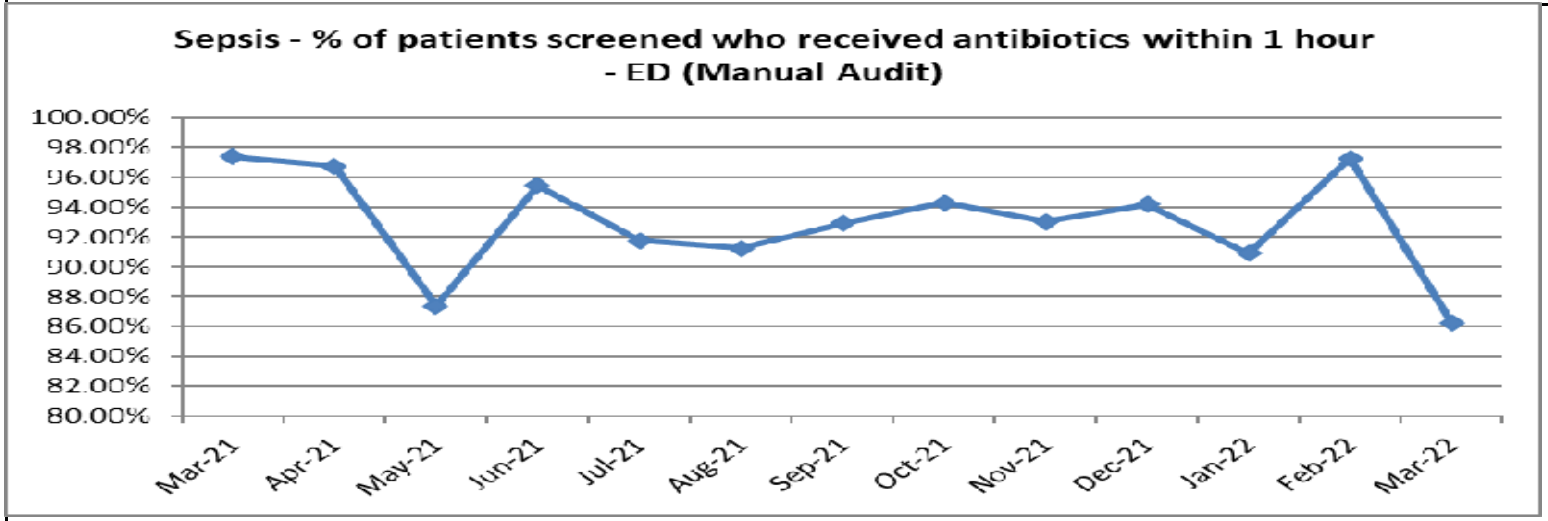
Metric Name: VTE Risk Assessment



Month
Apr-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)	Performance remains below the trust target of 95%. The previous upward trend has not been sustained in April 2022.	VTE compliance for April 2022 was 91.66% , 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
Mar-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	The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 86.26% by manual audit in March 2022, this is a decrease in performance but issues have been identified with the data collection on the manual audits.	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. Sepsis performance is now reviewed via the newly formed deteriorating patient group.	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 25th May 2022
Chair of Committee:	Mary Martin, Non-Executive Director
Date of Report:	Wednesday 25th May 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	Financial Plan 2022/23 • The Committee was advised that nationally additional funding has been made available to reduce inflationary pressures within ICS plans. • To access this there is a clear expectation that the system will return its plan to a breakeven position • A further submission of the financial plan at both Trust and ICS level will be required on the 20th of June • PFIC will require delegated authority to authorise the revised plan through an extraordinary PFIC before 20th June. Financial Position 2022/23 • The outturn position for Month 1 showed an adverse variance to plan of c£0.5m driven by temporary staffing usage and under-delivery on efficiency targets • The CIP target is presenting a real challenge as 56.3% remains rated red risk and 15.8% has yet to be identified. • There is a shortfall of funding for the Capital plan with the Theatres refurbishment works commencing at risk. In order to balance the plan, £5m of slippage or additional funding will need to be identified. Performance Issues • The continuing impact of COVID inpatients and the resulting extra work is a cause for concern although it was noted that the total number of COVID inpatients had reduced to 30 on the day of the meeting.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The report on the performance of the Integrated Supplies and Procurement Department (ISPD)noted delivery of £1.4m of savings in 2021/22 and projected savings of £1.1m in 2022/23, however inflationary pressures continue to provide a challenge. It was noted that staff recruitment is a challenge in procurement and is more acute in Walsall than across the rest of the ISPD. • An update to the Estates Strategy is progressing and presentation of this is expected in six months. Committee was reassured that there are no statutory risks but advised that a number of operational risks remain, and backlog maintenance needs to be addressed.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	<u>Financial Position</u> • The performance against the Better Payment Practice Code was strong during 21/22 whereas this was an area the Trust struggled with previously. This is crucial to the organisation at a time where supply chains are under significant strain. • The Cash position remains strong <u>Performance</u> • Elective pathways continue to show a strong position with April showing 113% of baseline activity. Diagnostic recovery continues to progress well. • The Trust has been approached by NHSEI to support the Birmingham and Solihull area with long waits and a proposal to achieve this has been approved through the Investment Group for a period of three months. • Staffing remains a pressure in Community areas, but sickness absence has improved in April. Strong performance was presented for the Integrated Assessment hub with improved admission avoidance. The medical fit list was reduced to 50 in April • Performance against the Emergency Access Standard has deteriorated slightly but remains in the top 30 nationally despite some of the highest attendances on record seen in March and April.
Recommendation(s) to the Board/Committee	• Further submission of the 22/23 plan is due on 20th June. The Committee is seeking delegation from Trust Board to approve the revised plan prior to the submission deadline.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• There were no agreed changes

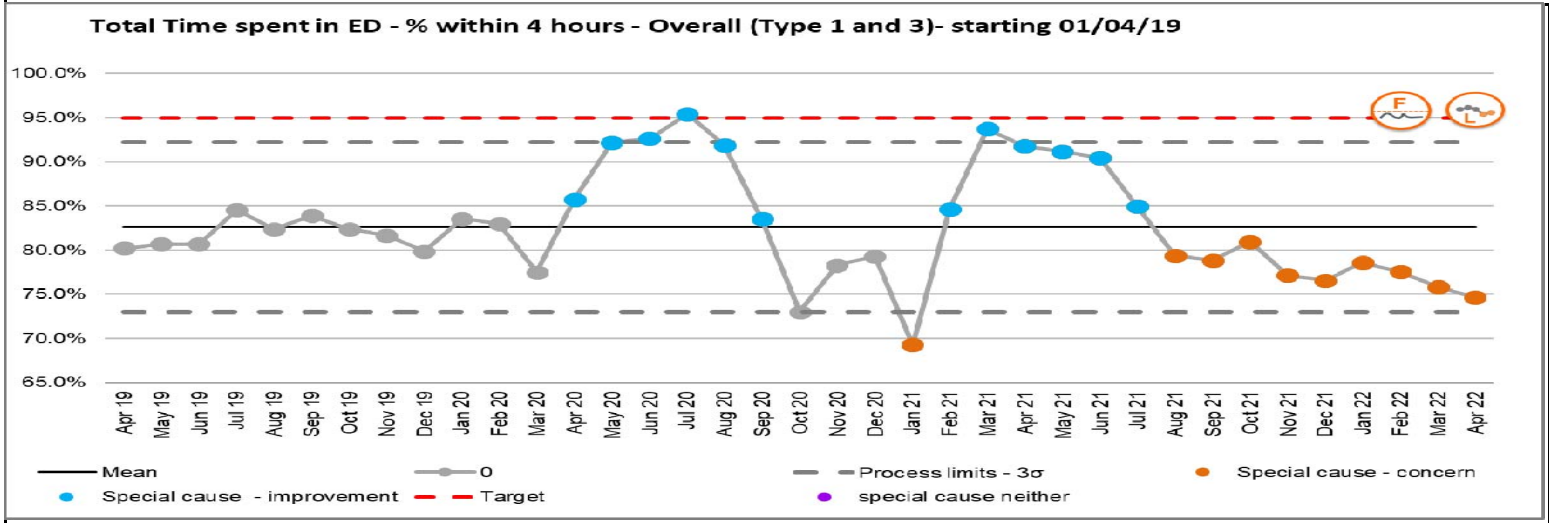
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• It was agreed to hold an extraordinary meeting of the Performance, Finance and Investment Committee to approve the revised submission of the Financial Plan ahead of the deadline of the 20th June.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• The business cases for Governance Restructure, Emergency Department Nursing, Emergency Department Medical Staffing, Ambulatory Emergency Care and Clinical Nurse Fellows were presented and approved/endorsed by the Committee and progressed to Trust Board where appropriate.
Matters presented for information or noting	• 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	2022/23 Target	SPC Assurance	SPC Variation
PERFORMANCE, FINANCE & INVESTMENT COMMITTEE							
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Apr-22	62.03%	62.29%	92.00%		
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	Apr-22	767	807	0		
%	Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED	Apr-22	89.53%		95.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment	Mar-22	70.15%		93.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	Mar-22	20.55%		93.00%		
%	Cancer - 62 day referral to treatment from screening	Mar-22	100.0%		90.00%		
%	Cancer - 62 day referral to treatment of all cancers	Mar-22	66.67%		85.00%		
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test	Apr-22	7.95%	4.69%	1.00%		
%	Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)	Apr-22	74.63%	80.00%	95.00%		
%	Locality Teams - % of Hours Demand Unmet	Apr-22	14.15%		20.00%		
Ave	MSFD - Average number of MSFD in WMH	Apr-22	50.28		50		
%	Rapid Response - 2 Hour Response Rate	Apr-22	97.70%		95.00%		

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
%	Rapid Response - % Admission Avoidance	Apr-22	91.90%		87.00%		
£	Total Income (£000's)	Apr-22	29874	See Financial Performance for further detail			
£	Total Expenditure (£000's)	Apr-22	29216	See Financial Performance for further detail			
£	Total Temporary Staffing Spend (£000's)	Apr-22	4005	See Financial Performance for further detail			
£	Capital Expenditure Spend (£000's)	Apr-22	1981	See Financial Performance for further detail			

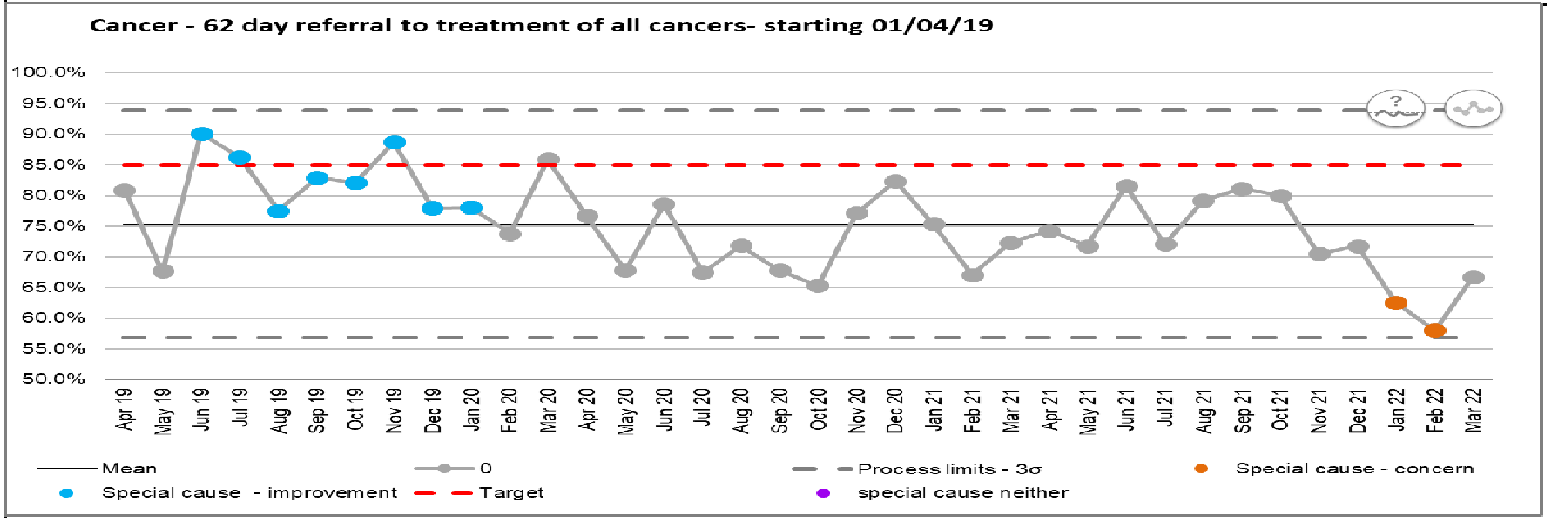
Metric Name: Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)



Month
Apr-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 2021 to date , performance continues to be lower than the average (9 data points). April's reported performance is 74.62%.	High level of emergency pressure has been experienced across the region with West Midlands Ambulance Service experiencing a critical incident on the evening of Monday 4th April following prolonged waits for handover at Emergency Departments.	More visible senior leadership on the floor. ACP Triage intervention to quickly discharge non-urgent, low acuity patients. Recruiting of a lead Progress Chaser to upskill our existing team. Review options to increase ACP & Medical cover over the next 8 weeks.	Reviewing the ED ambulatory pathway with a view to have a rapid assessment and treatment model at the front door. UTC has extended opening hours until 03:00. Post triage intervention cubicle underway during times of particularly high demand.

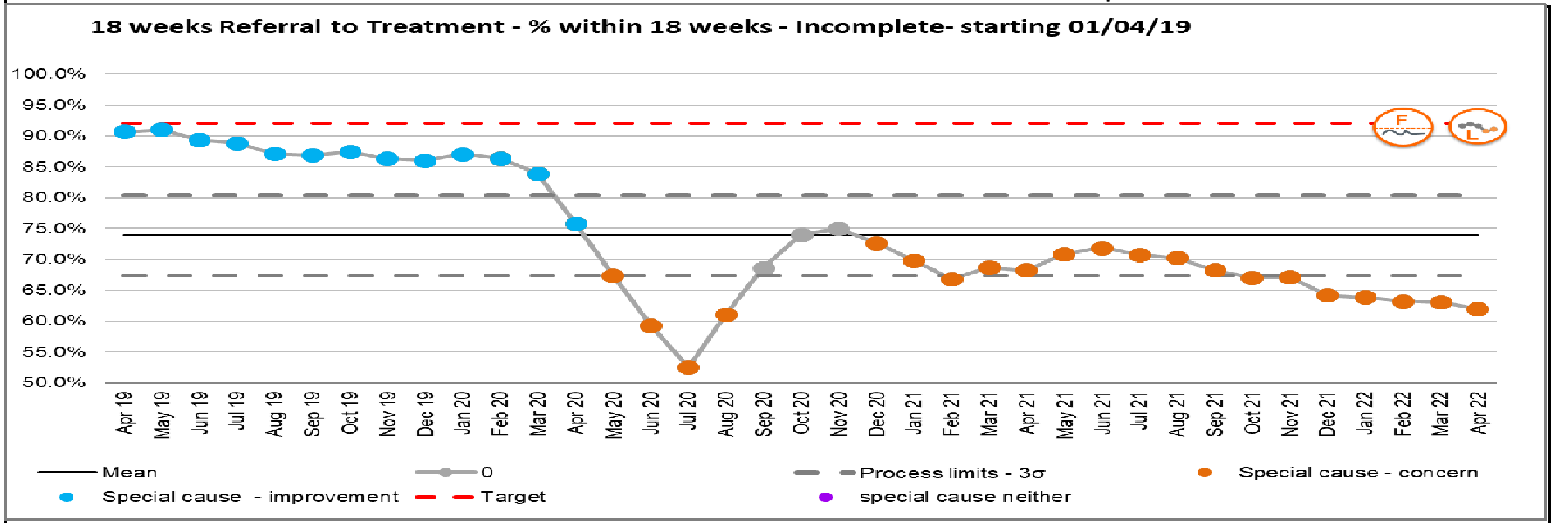
Metric Name: Cancer - 62 day referral to treatment of all cancers



Month
Mar-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
85.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	March's performance shows an improvement with a performance of 66.67% compared to February 58%.	Challenges continue for Breast and urology tumour sites. Breast first appointment waiting time reduced during April and has been back within 2 weeks during May. Focus on progressing pathways in Urology continues with senior oversight of tracking by the Cancer Manager and Lead Nurse	Additional oversight of Urology PTL in view of deterioration of 62 day performance. Weekly focused deep dive in place supported by Cancer Manager. Biopsy couch for Urology in use with one-stop prostate biopsy clinic having commenced. A one-stop Haematuria clinic is also now in place.	ICS commission review of pathways, interviews planned with MDT leads for Breast, Colorectal, Skin & Urology. Reports shared during March. Work on going from this with clear recommendations and actions. WLIs continue as required/availability of imaging and clinicians to support

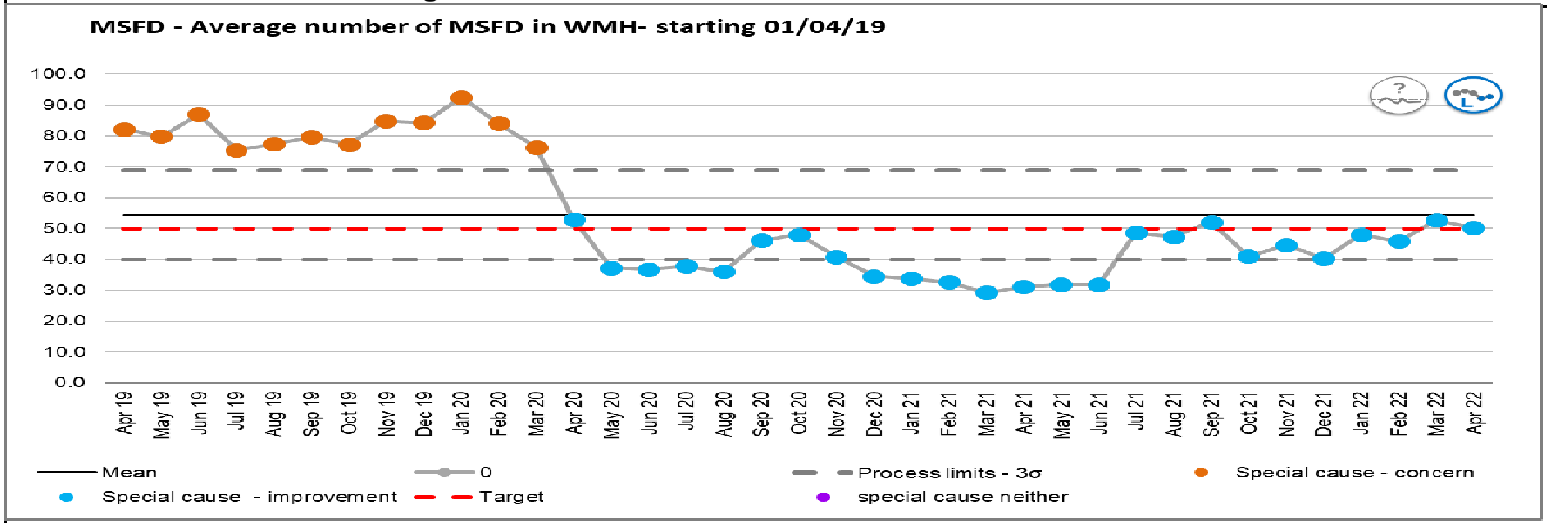
Metric Name: 18 weeks Referral to Treatment - % within 18 weeks - Incomplete



Month
Apr-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 statistically special cause concern. In April 2022, the 18 week RTT incomplete is 62.03%, which is in line with the trajectory of 62%. The number of patients waiting greater than 18 weeks increased during April by circa 720 patients (10,843 vs 11,733).	Urology remains the most challenged area and is being supported with additional weekend theatre sessions. 4 all day lists are currently scheduled Reduced activity due to the Easter break and two day bank holiday	Focus to remove non-admitted patients waiting in over 52 weeks and admitted patients waiting over 78 weeks. Initiatives continue with super clinics in Orthopaedics, outsourced support in Rheumatology, weekend operating across several surgical specialties and Endoscopy insourced capacity.	Elective cases have been assessed, in line with Federation of Surgical Specialty Associations guidance, to ensure that patients are placed in order of priority. An Artificial Intelligence Tool has been introduced to support decisions made by clinicians .

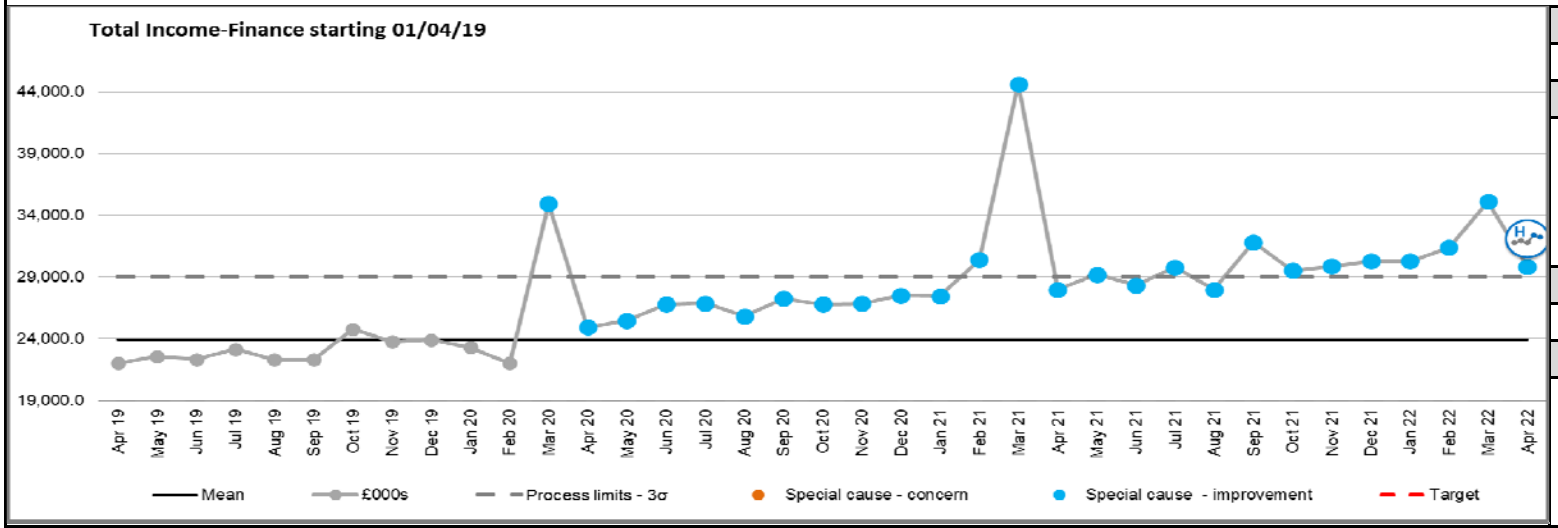
Metric Name: MSFD - Average number of MSFD in WMH



Month
Apr-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	The Service delivered a strong performance in April with the number of MSFD patients being maintained at an average of 50. Despite an unprecedented demand in referrals, the length of stay was maintained at 4 days demonstrating good flow through the pathway.	Demand in terms of the Intermediate Care Service remains high.	Work continues to make efficiencies in the discharge and ICS pathways to ensure minimal delays for patients. Further work is being completed on enabling service to ensure resilience . Number of MSFD patients were maintained at an average of 50 with the length of stay remaining stable	Actions have been taken by the Community Division in reference to the increase in demand. This will provide an increase in capacity in the Hospital Team and resilience within the service.

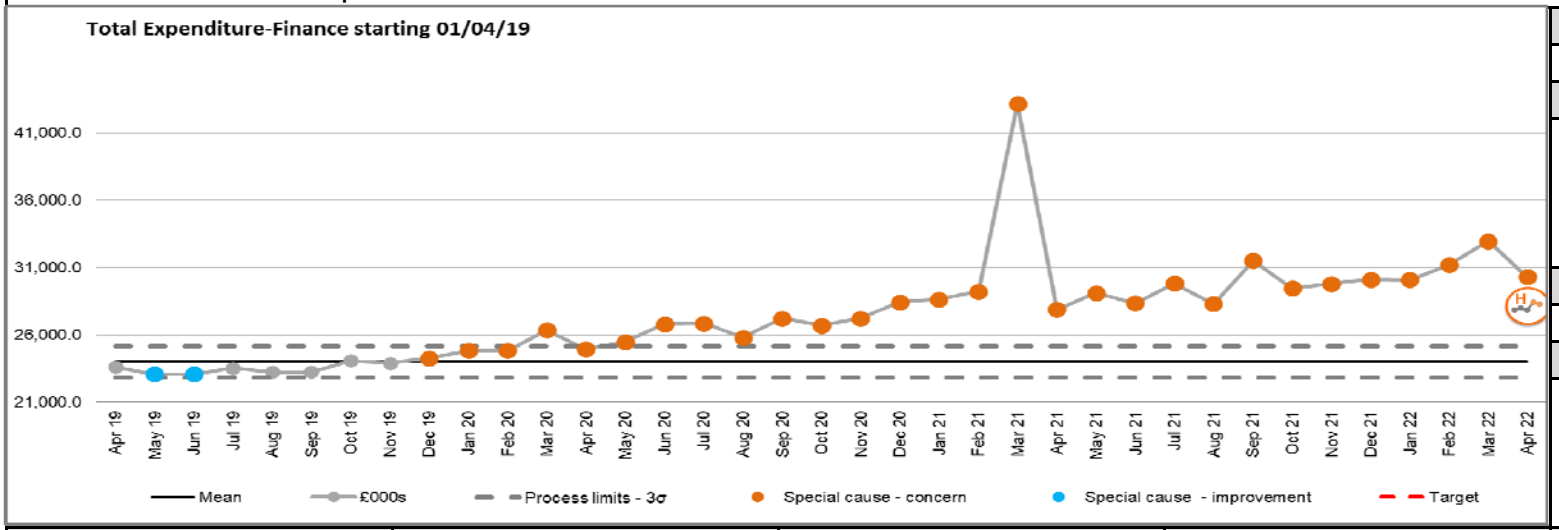
Metric Name: Total Income



Month
Apr-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. Cvodi 19 linked funding decreasing by 57% in 2022/23	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

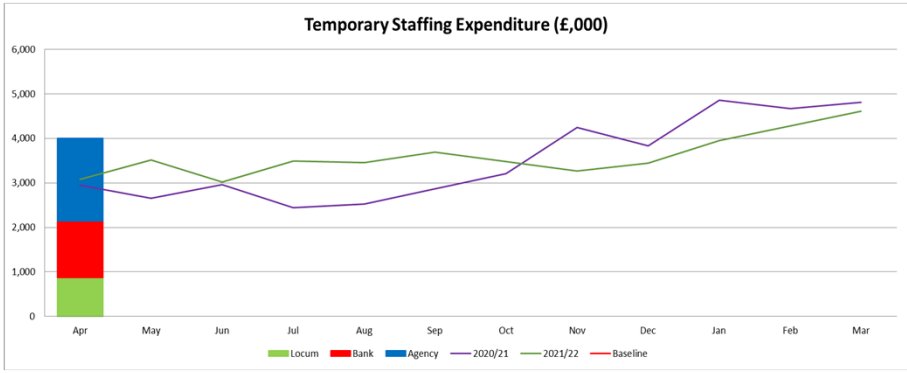


Month
Apr-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
Target Achievement

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, £6.3m in 22/23	22/23 efficiency target of £6.3m. Overseas recruitment through the Clinical Fellowship programme for Medical and Nursing staff to reduce reliance on temporary staffing

Financial Performance to April 2022 (Month 1)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Subtotal Income	**29,556**	**29,874**	**318**
Subtotal Pay Expenditure	**(19,083)**	**(19,609)**	**(526)**
Subtotal Non Pay Expenditure	**(9,625)**	**(9,607)**	**17**
Efficiency Target (Phased Per Programme)	**252**		**(252)**
Delivery of Efficiencies	**(140)**		**140**
Subtotal Finance Costs	**(951)**	**(930)**	**21**
Total Surplus / (Deficit)	**9**	**(273)**	**(282)**
Donated Asset Adjustment	16	24	8
Adjusted Surplus / (Deficit)	**25**	**(249)**	**(274)**
Additional Efficiency target (Phased evenly)	273		(273)
Adjusted Surplus/ (Deficit) per Plan	**298**	**(249)**	**(547)**



Financial Performance

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.

Following Trust Board debate, Executive endorsement and PFIC approval (through delegation of powers from the Board) the Trust submitted a financial plan as of the 28th April 2022, with the STP plans articulating a £48m deficit and the Trust plan (as part of the £48m deficit) a £7.6m deficit. The Executive have met and prioritised essential developments as part of this position.

With the announcement of additional revenue funding for the NHS in mid May, there is now an expectancy all ICSs will breakeven in 2022/23. All trusts and ICSs must complete a further submission of a financial plan on 20 June 2022. Assuming delegation is given, an extraordinary PFIC will be required close to 20 June to authorise a revised financial plan.

In month 1 the Trust reported a £0.249m deficit, which is £0.546m adverse to plan. This was driven by higher than planned temporary staffing costs and non achievement of CIP plan. Temporary spend was particularly higher in nursing. During May plans are in place to ensure zero general ward nursing agency usage.

Capital

- The approved programme for the year includes the Emergency Department, ward refurbishment and theatres 1-4 upgrades
- Capital expenditure totals £1.981m in month 1. This is against an annual programme of £37.858m. The programme for 22/23 is not fully funded with £5m of either further funding or slippage required

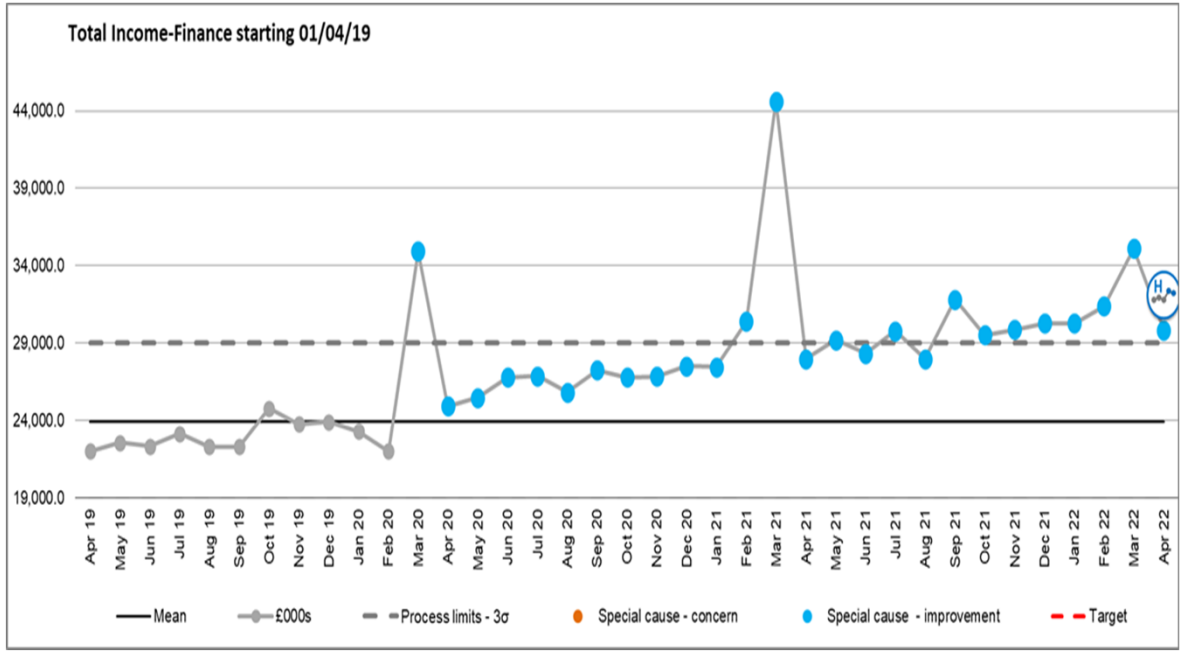
Cash

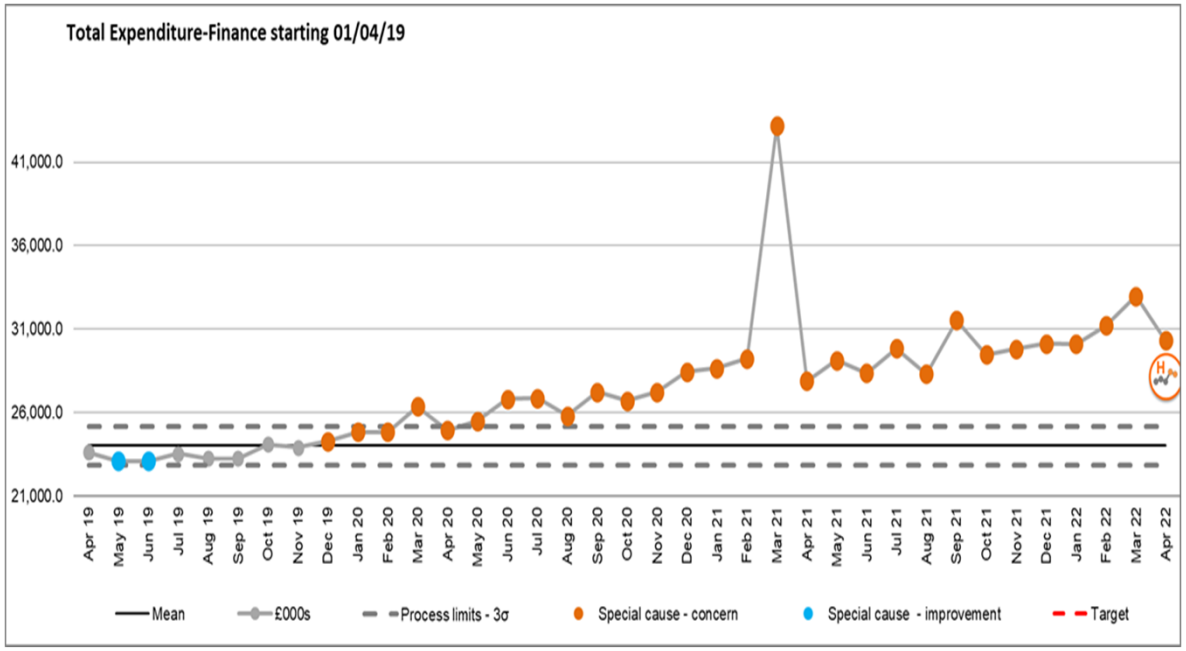
- The Trust continues to have a strong cash position which is sufficient to support a planned revenue deficit plan and the programmed capital expenditure

Efficiency attainment

- An efficiency programme of £6.3m of cash releasing efficiencies are included within the 22/23 financial plan. At month 1 there are plans of £5.347m in place to achieve this, leaving a requirement for further plans of just under £1m. Work is ongoing to identify these plans and monthly review is executive led.
- Attainment in month 1 is £140k against a plan of £252k. The YTD target (assuming 1/12ths split) is £525k. This is an adverse performance by c£273k

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 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

Trust Board Meeting
Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	People and Organisational Development Committee
Date of Committee/Group	Monday 23rd May 2022
Chair of Committee/Group:	Junior Hemans
Date of Report:	Wednesday 25th May 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The Staff Network group for Disability needs to be re-established to raise awareness of disability in the workforce, to ensure colleagues with disability are supported at work and do not suffer detriment due to their disability or lack of organisational awareness of support required. The proportion of those declaring a disability is low within the workforce, leading to their experience and voice being under-represented. The inability to secure protected time for those involved in chairing the group has slowed progress. The indicators on WDES – workforce disability equality standard worsened during the 2022-2023 year and show differential experience. • The Staff Network groups are a crucial component of staff experience and engagement. The Trust Board committed to developing a model of shared governance and decision making as part of the Trust Board pledge of ensuring staff voice is evident from ward to board. The People and Organisation Development Committee noted the requirement for protected time and budget has been identified within an investment case on improving the Trust culture. This is critical to addressing the elements relating to bullying and discrimination and this will remain a trust risk until the requisite support is in place to take the next step to empower staff to make improvements at local level. • The reports from the Guardian of Safe Working and Freedom to Speak Up Guardian both indicate inadequate response to resolving issues raised and providing a feedback loop. The committee accepted the recommendation to focus on these matters as part of the divisional performance reporting and agreed to receive an assurance report at a future people and organisation development committee.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The BAF and Corporate Risk Registers were reviewed by the committee, which noted and commended the assurance and the improvements made and the reduction in the level of risk. The committee noted that the BAF and Corporate Risk Registers are now being reviewed and updated to focus on the remaining assurance gaps relating to the people plan and agenda for organisation development and improving the culture for Walsall as a place to work and be treated, noting the supporting work on securing a patient first culture. • The committee discussed retention and the work taking place on Flex for the Future, which is a national program piloted by the Trust seeking to lever the benefits of more flexible and agile ways of designing jobs and services for the benefit of patients and in doing so to improve staff experience focusing on retention and work-life balance. The committee commissioned a board development session to support the development of the employment model. • The terms of reference for the People and Organisation Development Committee and the Annual Cycle of Business were both accepted and recommended for approval at Trust Board. • The committee received an update on improvements to the Portering services in Estates and Facilities and commended the improvement within the management approach there. The committee also noted the considerable improvement to workforce metrics, particularly noting reduction in sickness absence levels, better than trust average compliance levels for appraisal and meeting the statutory and mandatory training levels. The division have improved their recruitment profile and retention by working with partners within the Walsall Together partnership and have made a significant contribution to the anchor employer program.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The Annual Equality, Diversity and Inclusion Report and Plan demonstrates significant progress against all four Equality Objectives agreed by the Trust Board in July 2021. The committee commended the progress and recommended that the Trust Board note the achievement and approve the delivery plan for the 2023-2024 year. The Annual EDI Report and Plan is at appendix 1 for information and assurance. • The People and Organisation Development Committee received an update on the work of the Staff Networks, hearing in detail from the Women and Allies group, and noting the progress made. The committee commended the work however noted the challenges relating to securing protected time and budget to accelerate the work and outcomes. The update on progress is at appendix 2 for information and assurance. • The People and Organisation Development Committee received the safer staffing report and commended the work on recruiting to fill the revised establishments and eliminating agency use for the nursing and midwifery workforce. The committee noted the vacancy rate for nursing and midwifery is below 1% and the international recruitment program has successfully inducted 208 registered nurses to the trust. The committee also commended the program for developing the nursing associate model and the approach to offering career pathways for nursing associates to study further through to becoming a registered nurse; the program is delivered in partnership with Birmingham City University. There has been significant interest, and in addition the workforce plan provides a significant increase in student numbers, again interest levels are very high. The recruitment to CSW positions continues in order to meet additional demand for one to one and mental health support, the trust maintains a zero vacancy position for this element of the workforce. • The committee noted significant assurance on the trust meeting the requirements of the National People Plan. The committee noted the update on the People Strategy and approved extending the date for completion in line with the national People Plan. There has been a significant improvement in staff experience of the trust acting on staff health and wellbeing.
Recommendation(s) to the Board/Committee	• To note the report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• There are legal, equality and diversity implications within this report and the Trust Board pledge seeks to address these by providing a route to eliminate discrimination, measure the diversity of the workforce and equality of staff experience and access to recruitment, promotion, career progression, education and training and to improve staff experience by eliminating bullying and

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• The Staff Network group for Disability will be re-established to raise awareness of disability in the workforce. Assurance regarding the completion of this action will be provided by the Equality, Diversity and Inclusion Group. • The Committee endorses the request for protected time and budget for staff network leads and awaits the outcome of the investment case submitted to enable culture improvement. • The Committee requested greater assurance with regard to how divisions ensure feedback is provided to colleagues who raise concerns via Divisional Performance Reviews and to receive an assurance report at a future Committee. • The committee commissioned a board development session to support the development of the employment model.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• The committee noted the vacancy rate for nursing and midwifery is below 1% and the international recruitment program has successfully inducted 208 registered nurses to the Trust. •
ACTIVITY SUMMARY **Major agenda items discussed including those Approved.**	• The terms of reference for the People and Organisation Development Committee and the Annual Cycle of Business were both accepted and recommended for approval at Trust Board. • The Committee commended progress against the Annual Equality, Diversity and Inclusion Report and Plan and recommended that the Trust Board note the achievement and approve the delivery plan for the 2023-2024 year. • The Committee received an update on the work of the Staff Networks and noted the challenges relating to securing protected time and budget to accelerate the work and outcomes. •
Matters presented for information or noting	• The committee received a deep dive into key workforce indicators across Estates and Facilities noting considerable improvement to workforce metrics, particularly noting reduction in sickness absence levels, above Trust average compliance levels for appraisal and meeting the statutory and mandatory training levels. • The committee noted significant assurance on the trust meeting the requirements of the National People Plan. • The committee noted the update on the Trust People Strategy and approved extending the date for completion in line with the national People Plan.
Self-evaluation/ Terms of Reference/ Future Work Plan	•

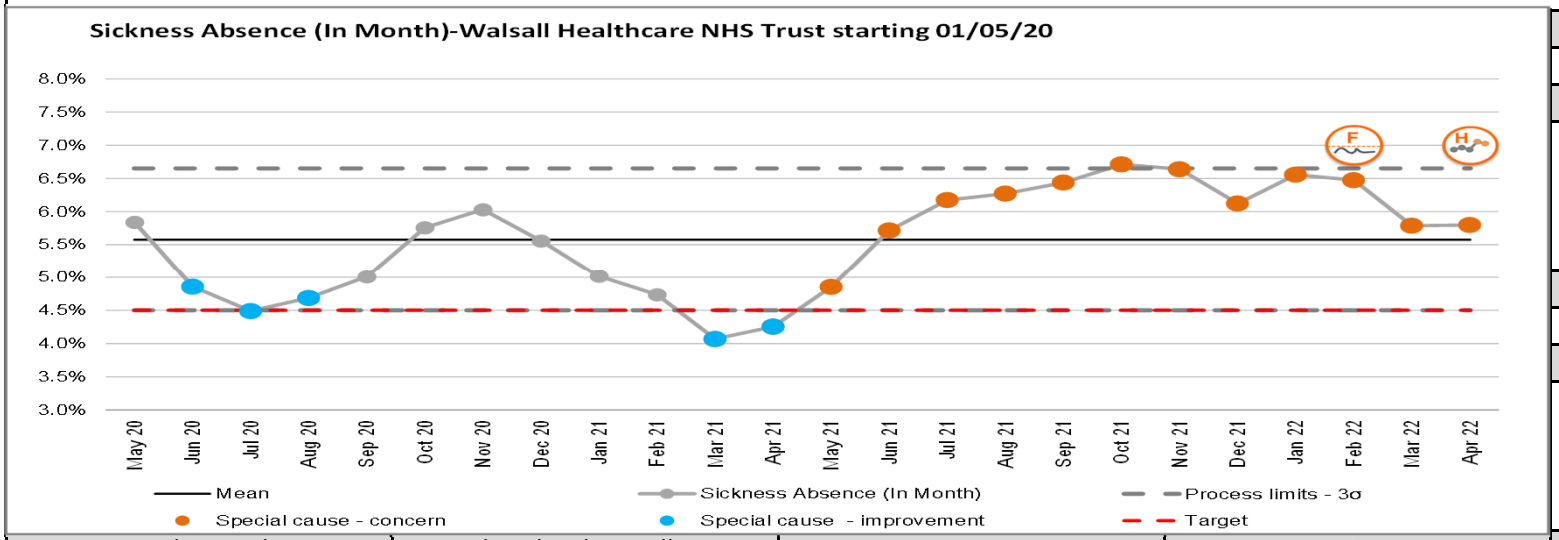
Items for Reference Pack	• The Annual EDI Report and Plan is at appendix 1 for information and assurance. • Staff Network update report.

Walsall Healthcare NHS
NHS Trust

POD

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE							
%	Sickness Absence	Apr-22	5.80%		4.50%	?	H
%	PDRs	Apr-22	82.50%		90.00%	F	H
%	Mandatory Training Compliance	Apr-22	89.09%		90.00%	?	H
%	% of RN staffing Vacancies	Mar-22	-2.45%				L
%	Turnover (Normalised)	Apr-22	12.80%		10.00%	?	H
%	Retention Rates (24 Months)	Apr-22	81.41%		85.00%	F	
%	Bank & Locum expenditure as % of Paybill	Mar-22	9.90%		6.30%	F	
%	Agency expenditure as % of Paybill	Mar-22	10.72%		2.75%	F	H

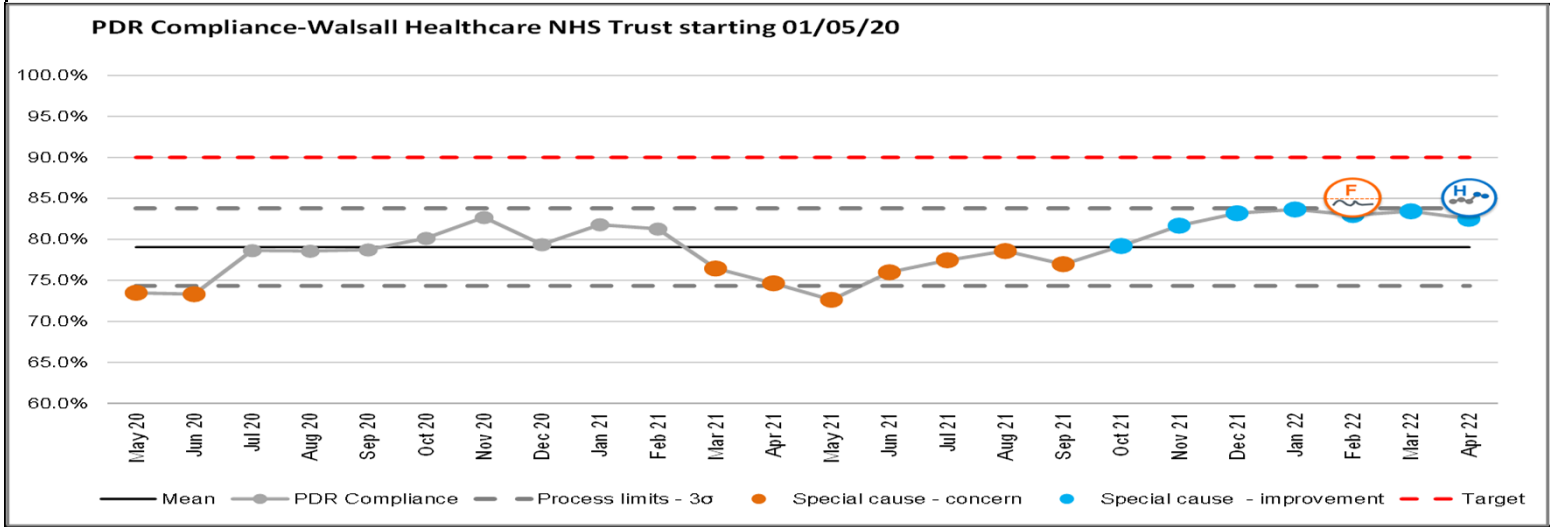
Metric Name: Sickness Absence



Month
Apr-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
4.50%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.	Absence levels are yet to revert back to a seasonal trend of low spring/summer sickness episodes, as experienced prior to the pandemic response. Absence remains within the upper threshold of the 24 month range.	7 of out 10 days lost of sickness represent long-term absences. Absence stablised at 5.8%, with stress/anxiety episodes down by 33%.	Sickness Absence data is recorded on ESR and used to generate reports to advise on hotspot areas and reasons. This information is triangulated with intelligence from Human Resources and Occupational Health which can help to identify areas of concern.	Monitoring of sickness absence includes Executive oversight at the monthly Divisional review meetings. Fast track referrals by the Occupational Health Team to Physiotherapy Services will ensure that injured colleagues receive early recovery interventions.

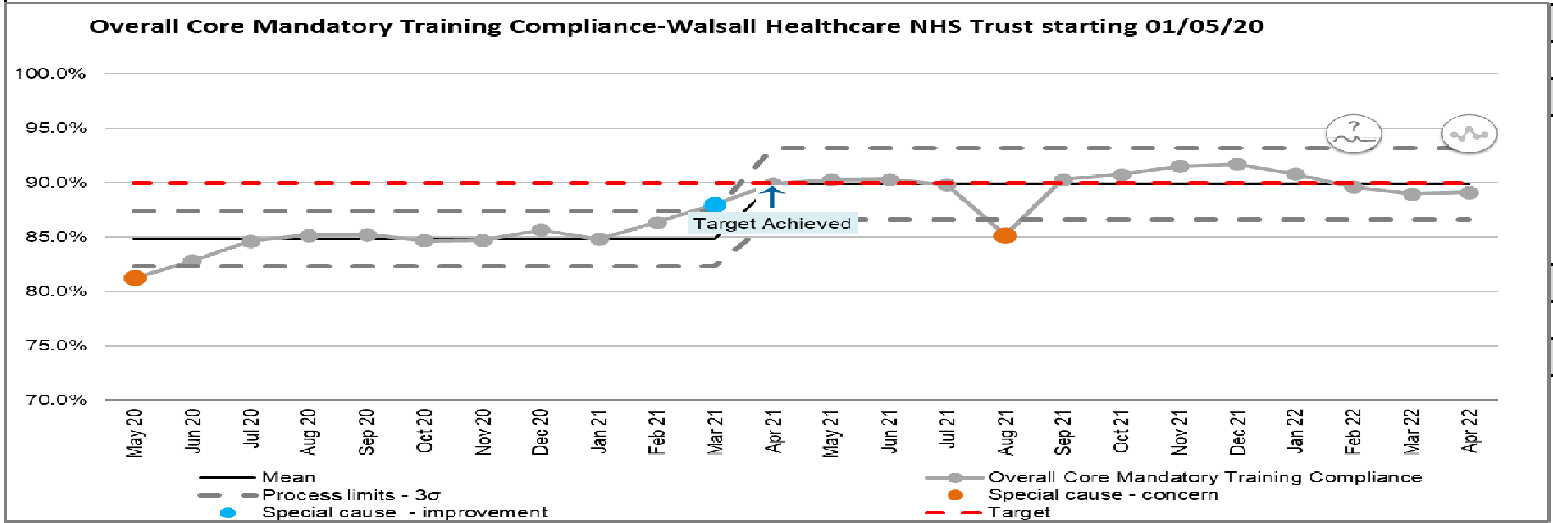
Metric Name: PDRs



Month
Apr-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 4th month of noted special cause improvement; aligned to interventions implemented by the Learning & Development team.	PDR compliance is highest amongst Healthcare Scientists colleagues (94%). Admin colleague appraisal compliance continues to improve; now 79%.	Management dashboards and reports, deployed via the ESR Business Intelligence platform, will ensure PDR compliance can be monitored in real-time using automated cues for local intervention.	Monitoring of PDR compliance is reviewed at the monthly executive led Divisional review meetings.

Metric Name: Mandatory Training Compliance



Month
Apr-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.	Process limits recalculated from the date for target achievement, to enhance scope of performance management. Evidence that compliance levels are stable around the 90% target, which has become the average for this new range.	Significant rise in classroom-based training attendance during April 2022, resulting in compliance improvements for safeguarding and fire training related competences.	Collobration with RWT colleagues continues to align requirements and delivery models for mandatory training.	The project team continues to consult with stakeholders and services to ensure implementation of the Totara LMS is carried out at a pace which does not compromise regulatory or governance commitments.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD 8th June 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	• 208 overseas nurses have arrived in the Trust with more planned every month for the next year. • No cases of Clostridium difficile toxins were reported in April 2022. • The prevalence of timely observations is 90.69% in April 2022 and is consistently remaining above trust target. 23 out of 24 clinical areas achieved more than the 85% trust target.		
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 April 2022 was 91.66% (compared to compliance for March 2022 of 93.86%), which shows a marked reduction from the previous month. • Falls per 1000 bed days was 3.68% during April 2022 (3.43% in March 2022). Weekly falls accountability meetings are continuing identifying lessons learnt and shared learning.		
Alert	• Off framework agency use has continued due to short term staff absence predominantly as a result of COVID-19. Usage has decreased during April 2022 to 1342.23 hours compared to the 2280 hours used in March 2022. • Safeguarding level 3 adults and children's training remains consistently below trust target, additional training is being made available to improve compliance. • Mental Capacity Act (MCA) audit for April 2022 shows that 71.05% of patients who lacked capacity had a stage 2 assessment undertaken (62.50% in March 2022). • Issues with SCALE2 within NEWS2 have been identified and logged as a corporate risk. Work is ongoing to load an e-Learning package onto ESR.		
Does this report mitigate risk included in the BAF or Trust Risk	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		

Registers? please outline	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' Corporate risk 2601: Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment, and treatment of the sepsis 6 (Risk Score 20). Corporate risk 2917: Inappropriate use of SCALE2 within NEWS2 (Risk Score 20).	
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 ☒	

Director of Nursing Report – June 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 Trust has reviewed all CQC action plans and identified a number of actions that whilst identified in divisional reports require corporate action. A Trust wide corporate action plan with responsible executive Directors and identified leads has been developed and agreed by the Trust Board.

Divisions maintain action plans for ownership, implementation and embedding of practice at local level. Progress is monitored through the Divisional Governance process and fortnightly assurance meeting with members of the executive team.

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Falls

The number of inpatient falls recorded for April 2022 is reported as 59 with 55 reported in March 2022.

One fall resulting in severe harm was reported in April 2022 A patient on ward 12 suffered a fractured neck of femur following a fall. The incident has been reported as a Serious Incident and is being investigated.

The Royal College of Physicians average performance of 6.63 falls per 1000 occupied bed days has been achieved continuously for the past rolling 23 months.

Falls per 1000 bed days was 3.68% during April 2022 (3.43% in March 2022).

Falls Accountability meetings commenced in April 2022. These meetings ensure a focus on identifying avoidability, levels of harm and the lessons learnt. This will drive future falls prevention strategies.

Tissue Viability

The total number of Trust acquired pressure ulcers in April 2022 is 13. There has been a reduction in pressure ulcers reported from March 2022 and remains within normal variation.

Venous Thromboembolism (VTE)

VTE compliance for April 2022 was 91.66% (compared to 93.86% in March 2022), compliance rates remain steady but below the Trust target of 95%.

95.38% of inpatients received a VTE assessment, however only 91.66% were within the 24-hour target.

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. The Sepsis Team are in place and will be presenting the work that they have been doing and audit data to the Patient Safety Group in June 2022.

Clostridium difficile (C. diff)

The Trust reported a total of 31 cases in the year 2021/22 against a national maximum number of 33.

There were no reported cases in April 2022

NHSE HCAI Trajectories for 2022-2023

NHSE published the HCAI improvement trajectories in early May 2022.

Organism	2022-2023 Trajectory	Trust position year end 2021-2022
C.*difficille*	27	31
E. Coli	50	27
Pseudomonas	10	1
Klebsiella Spp	27	18

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 al patients admitted to the Trust for COVID-19 and has a programme for repeat screening during a patients stay.

Screening guidance and the management of the step-down of patients who are COVID contacts has been updated following completion of a risk assessment, to reflect the changes in national guidance.

Percentage of observations undertaken within timeframe

The prevalence of timely observations has decreased slightly to 90.69% in April 2022 from 91.19% in March 2022 and remains above the Trust target of 85% for the thirteenth month running. It has been agreed that the target will change to 90% in line with Royal Wolverhampton target performance; the date of change is yet to be confirmed.

Mental Capacity Assessment (MCA)

Audit for April 2022 shows that 71.05% of patients who lacked capacity had a stage 2 assessment undertaken: an increase from 62.50% in March 2022. Discussion with patient's relatives or attorney has slightly decreased to 53.13% (March 53.47%) of cases audited.

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.

Additional level 3 safeguarding training sessions are taking place from June 2022.

Safe Staffing

Vacancy position

The RN and Midwifery vacancy rate for March 2022 was reported as < 1%.

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. A task and finish group are focussing on Health visiting recruitment and ensuring the team continue to deliver a safe service.

Recruitment

208 overseas Nurses have commenced working within the Trust as of the end of April 2022.

A business case to support the continuation of international recruitment for the next three years has been approved.

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.

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

Forty-nine student nurses attended a careers event where they indicated an interest in being recruited to areas within the Trust in September 2022.

The business case to support Nursing Associates to train to become Registered Nurses has been supported by the Trust. This will enable 10 NAs to commence the 2 year training programme with Birmingham City university in September 2022. Recruitment commenced in mid May 2022.

Temporary staffing

There has been a decrease in off framework agency use during April 2022 with a total of 1342.23 hours compared to 2280.25 hours reported in March 2022. The highest use areas for off framework agency staff are ED using 538 hours and Endoscopy using 280.25 hours.

An ED and AMU business case has been approved by the Investment Group and will replace this temporary staffing use with substantive staff. Once these posts are fully recruited to, the use of temporary staff will cease in these areas.

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 all general wards in the Trust over the next few weeks.

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 1333 hours of RN and 530.5 hours of CSW were re-deployed across the trust in April 2022. This is an increase from March 2022 for RN's when 1199.5 hours of RN time were re-deployed and a decrease in CSW time when 655.5 hrs were redeployed.

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 April 2022 there were 200 Red Flags that were raised and 40 of those were resolved and mitigated during the safe staffing meeting. For the 160 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. Red Flags are subject to a detailed review via a report to the Nursing Midwifery and AHP Advisory Forum.

Celebrations

The Trust celebrated International Day of the Midwife on the 5th May 2022 and International Nurses Day on the 12th May 2022. It was a wonderful opportunity to celebrate the work of our midwives and Nurses and to support the national launch of the Enabling Professionalism Framework 2022 and the Here for Life Campaign.

AMU improvement plan

The AMU Board meet monthly and review the assurance actions specific to the board. The business-as-usual actions are with the Task & Finish groups to progress.

Progress captured from this groups last meeting are:

- Assurance Board dashboard complete and data has been captured for 80% of it. Abstracting data for the medical workforce has been problematic due the lack of data in the system and absence of resource to manually form it. The team have been asked to scope the required resource which the board will support.
- Audits have been completed and are in place.
- The communications department will support the AMU department to improve communications within the team and trust wide
- Job planning within AMU in progress and updates due next month
- AMU leadership development plan has been devised and approved by the board
- The Education Task & Finish group have produced a Health Education England summary and General Internal Medicine rota on call rota report
- The Divisional Director confirmed the teams are on track and they have no escalations to report

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 8th June 2022**			
Patient Voice Annual Report (Patient Relations and Experience) 2021-2022			
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 NHS and Social Care Complaint regulations 2009 require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public. This report provides details of complaints and concerns received by Walsall Healthcare NHS Trust between 1 April 2021 and 31 March 2022 and overall activity of the Patient Relations and Experience team.		
Advise	The report includes identified priorities for 2022/2023		
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 ☐		

PATIENT VOICE ANNUAL REPORT 2021-2022

1. PURPOSE OF REPORT

Seeking and acting on patient feedback is key to improving the quality of healthcare services. This paper provides an annual report for 2021/22 of the Trust's activity in relation to patient experience, public engagement, concerns, and complaints and provides examples of learning and service improvement.

2. BACKGROUND

The NHS and Social Care Complaint regulations 2009 require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public. This report provides details of complaints and concerns received by Walsall Healthcare NHS Trust between 1 April 2021and 31 March 2022 and activity of the Patient Relations and Experience team.

3. DETAILS

See enclosed report

4. RECOMMENDATIONS

Members of the Trust Board are asked to:

- To note contents and progress made.
- To approve 2022/2023 service priorities

Walsall Healthcare NHS
NHS Trust

Patient Relations
& Experience

2021/22

Patient Voice

Annual Report

Contents

1.0 Introduction

The Annual Patient Voice report describes the progress we have made to ensure that patient feedback is a vehicle to improve services and how our patients feel in using them.

The Friends and Family Test remains an important part of our patient experience programme and we have strengthened this by introducing additional feedback methods to obtain point of care – near time feedback such as that provided by the mystery patient scheme. Along with FFT, from our observation, it is often an immediate and usually accurate indicator of patient experience in a particular service.

With complaints and concerns, compliments and both national and local surveys, the patient experience data is shared and welcomed by clinical and operational teams and this report describes some of the improvements we have made because of the feedback given.

Throughout the last year we have begun an exciting number of projects with the aim of enhancing the lived experiences of our patients as their journey through their time with us whether that be as an emergency, in-patient, planned admission or outpatient user.

Our volunteers and volunteer partners exemplify a decent, caring, selfless attitude to supporting others. We have built new partnerships and strengthened existing ones, we have sought to engage our communities through surveys and involvement, and we have responded compassionately to the call from family members, friends, and carers to visit loved ones taken ill in hospital.

With a strong and purposeful team, I am proud of the year's achievements. As we work more closely with our colleagues at the Royal Wolverhampton NHS Trust, we will in the coming year share all that is good, seeking to learn from each other as we pay as much attention to improvement matters as we do in measuring them.

Garry Perry
Associate Director Patient Relations and Experience

Section 1. Patient Relations

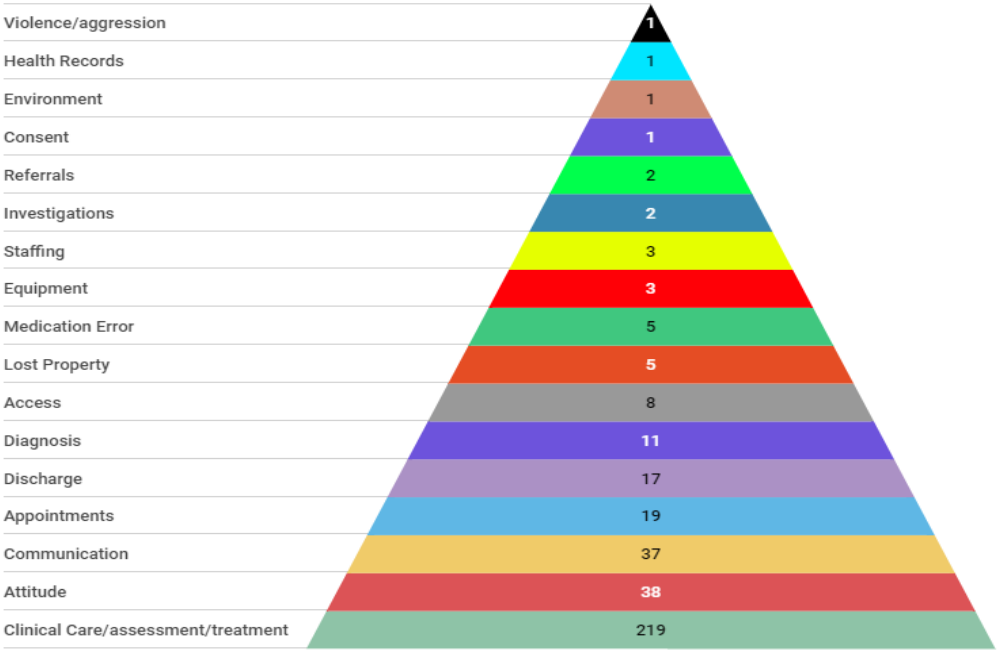
1.0 Patient Relations activity 2021/2022

During 2021/2022 a total of 4082 contacts were received by the Patient Relations Team which included a total of 361 written complaints which includes 9 informal to formal complaints and 4 MP letters (a increase of 81 complaints overall for the year compared to 2020-2021) and an average of 16 contacts per working day.

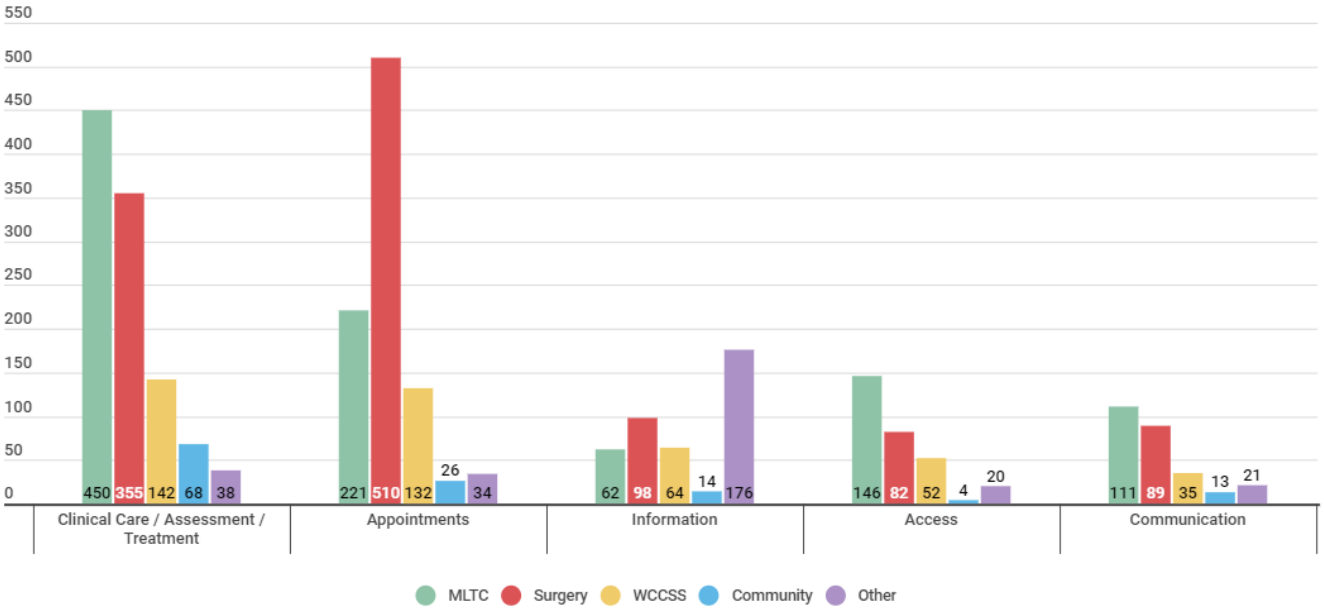
Contact Type	2019-2020	2020-2021	2021-2022
Complaint requiring a written response	309	280	361
Concern converted to a complaint	10	7	8
Concern	2306	2026	2420
Complaint converted to a concern	23	16	33
Compliment	536	416	535
Website feedback – NHS Website / Healthwatch	479	967	721
MP letter	6	7	4
Total	3660	3719	4082

1.1 Complaints by theme

During 2021/2022, there were 373 complaints raised (including Informal to Formal and MP letters) with the main theme emerging from formal complaints being Treatment care and supervision. This accounted for 58% of all complaint categories, 218 complaints fell within this domain.

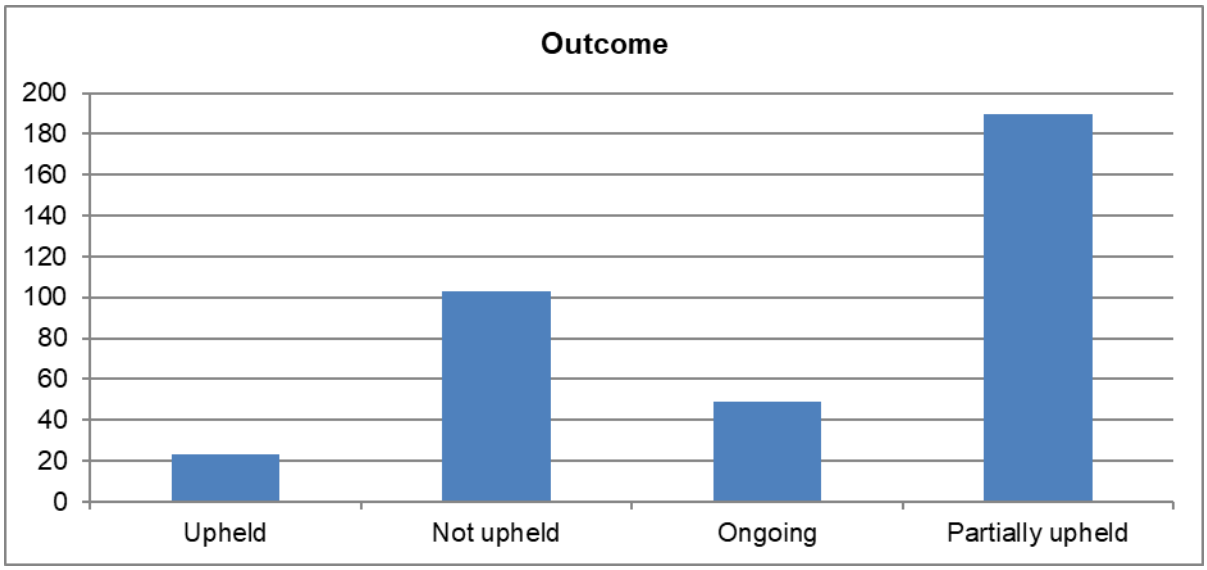


1.2 Themes by division (all types)



1.3. Complaints by outcome

At the time of completing this report, the total number of complaints resolved was 323. 23 complaints were upheld with 103 not upheld and 190 partially upheld. 7 complaints were withdrawn within this period.



1.4 Responding to complaints

Based on the table below – the overall average score (number of days to complete) is 34.3 which given the current pressures this last year is an improvement of 5.7 days compared to 2020/2021.

Division	Average Days to respond 01/04/21 to 31/03/22
Adult Community	24.9
Corporate Function	40
Estates And Facilities	65
Medicine And Long Term Conditions	35.5
Surgery	33.9
Women's Children's and Clinical Support	26.07

1.5 Assurance

Based on the table above – the overall average score (number of days to complete) is 37.5 which is a slight improvement when compared to the previous year (40).

This equates to a year end aggregated position of **81%** of all complaints received completed within 30 days or agreed timeframe. An improvement of **30%** on the previous year.

1.6 Concerns

There was a total of 3141 concerns received during 2021/2022, an increase of 132 concerns from the previous year (3009). This figure includes concerns (2420), comments, suggestions and queries and referred on (705), Family Liaison (9), Losses and Compensation 1, Health watch referrals 3, other PALS 3.

MLTC equated for 33% (1361) of the total activity (including compliments), with Surgery 33% (1350), WCCSS 14% (589) and Community 10% (414).

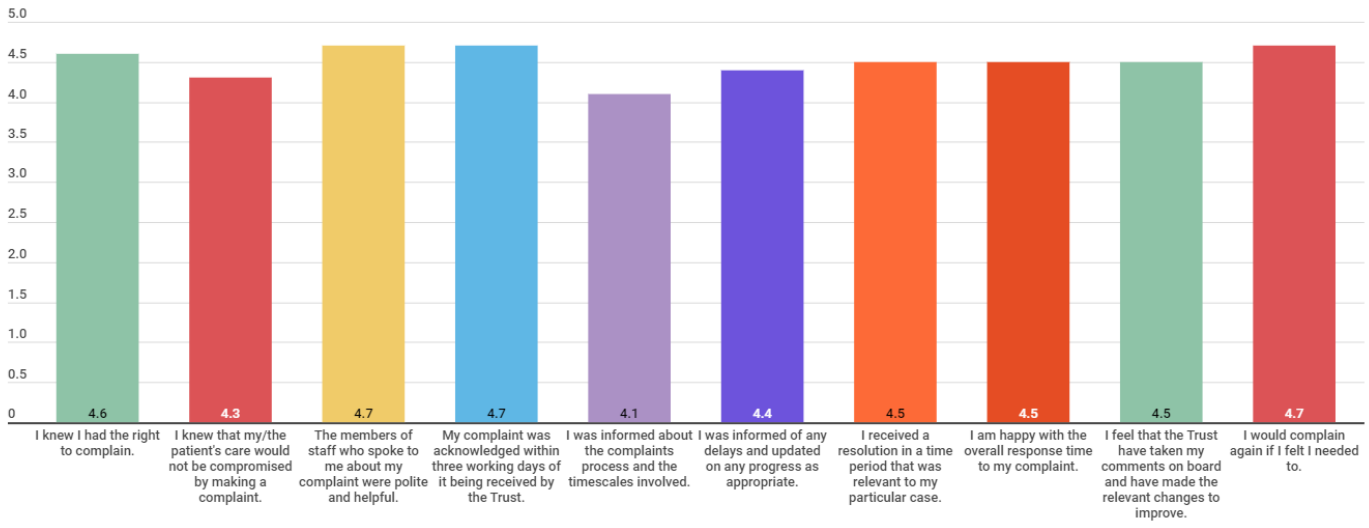
1.7 Parliamentary Health Service Ombudsman (PHSO)

In 2021/22 a total of 7 cases were accepted via the PHSO for investigation. This equates to 1.9% of all complaints received. Themes emerging include Concerns highlighted about clinical care assessment and treatment, poor communication, inadequate pain management and poor nursing care. Of those closed in in 2021/2022. 1 case was upheld, 1 case was partially upheld and 1 not upheld.

1.8 Complaint Satisfaction Questionnaire

The Parliamentary Health Service Ombudsman (PHSO) user-led vision for raising concerns and complaints in health and social care forms part of our Complaints policy. The vision was developed by the PHSO working inclusively with patients and service users. It starts with the complaint journey: a map of the route a patient or service user will go through when they make a complaint about a service they have received, and a series of simple statements that reflect what a good outcome would look like for the patient and service user at each stage of that journey. Beneath these overarching statements there are further statements that illustrate the expectations that patients and service users expressed when asked about what a good complaint journey would look like to them.

Our Trust feedback survey is based on the 'I' statements outlined in the user-led vision. Answers are requested using a scale of 0-5 with 0 as completely disagree and 5 completely agree. Feedback received is outlined as follows based on 9.1% return rate (34 responses): Average score is 4.5 out of 5



Section 2. Patient Experience

2.1 Patient recommendation to friends and family (FFT)

The following data is the confirmed performance from 2021/22. We believe that patient recommendation to their friends and family is a key indicator of the quality of care we provide. We believe our performance reflects that the Trust has a process in place for collating data on the Friends and Family Test, data is collated internally and then submitted monthly to the Department of Health and Social Care. Data is compared to our own previous performance, as set out in the table below

The friends and family test recommendation scores are illustrated in the tables below. These include percentage changes on 2020/21 and the 2021/22 response rates. The Trusts average recommendation score for 2021/22 was 82%. When looking at the different touchpoints, there is a fluctuation of 24% with scores ranging between 97% and 73%.

Friends and Family Test	Inpatients				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2021/22	87%	84%	85%	85%	91%	92%	90%	92%	80%	76%	78%	77%	94%	94%	95%	97%
Change from 2020/21	-2%	-3%	-1%	-2%	+4%	+1%	-1%	+1%	-6%	-1%	=	-5%	**			+4%
Response Rate	22.3	23.6	19.4	19.6	16.3	15.2	16.8	15.6	15.6	15.2	14.6	14.6	7.7	8.6	7.0	13.9

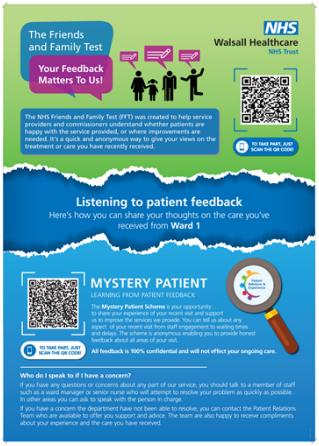
Friends and Family Test	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2021/22	74%	68%	74%	84%	83%	87%	82%	78%	73%	86%	79%	84%	88%	30%	67%	79%
Change from 2020/21	**	-23%	+4%	+10%	**	+2%	-2%	-4%	-10%	+4%	+2%	+7%	**	-49%	-7%	-13%
Response Rate	7.3	5.5	4.4	8.7	16.3	12.6	12.5	15.7	8.9	8.9	6.9	11.3	5.3	4.3	6.2	6.9

** No comparable data reported during 2020/21 to enable a comparison

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

	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
STP*	-2.4%	+0.7%	+6.6%	+2.8%	-2.6%	-5.8%	-3.1%	-14%
National	-8.8%	-1.8%	-0.8%	+0.8%	-15%	-11.4%	-14.7%	-24.9%

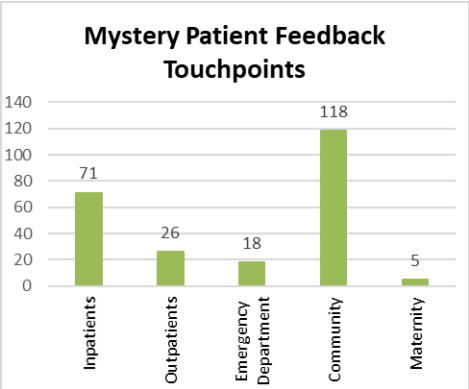
* The Black Country and West Birmingham STP



The Patient Relations and Experience team increased the opportunities for patients to provide feedback and for trust staff to respond to the 'near time feedback with real time action'. In addition to Friends and Family, Complaints, Concerns and Compliments, the 'mystery patient' scheme was initiated. 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.

2.2 Mystery Patient

The Mystery Patient Scheme was introduced to the organisation in August 2021, this scheme provides patients with the opportunity to share their experience of their recent visit and support us to improve the services we provide. The scheme is anonymous which enables the patients to provide honest feedback about all areas of their visit.



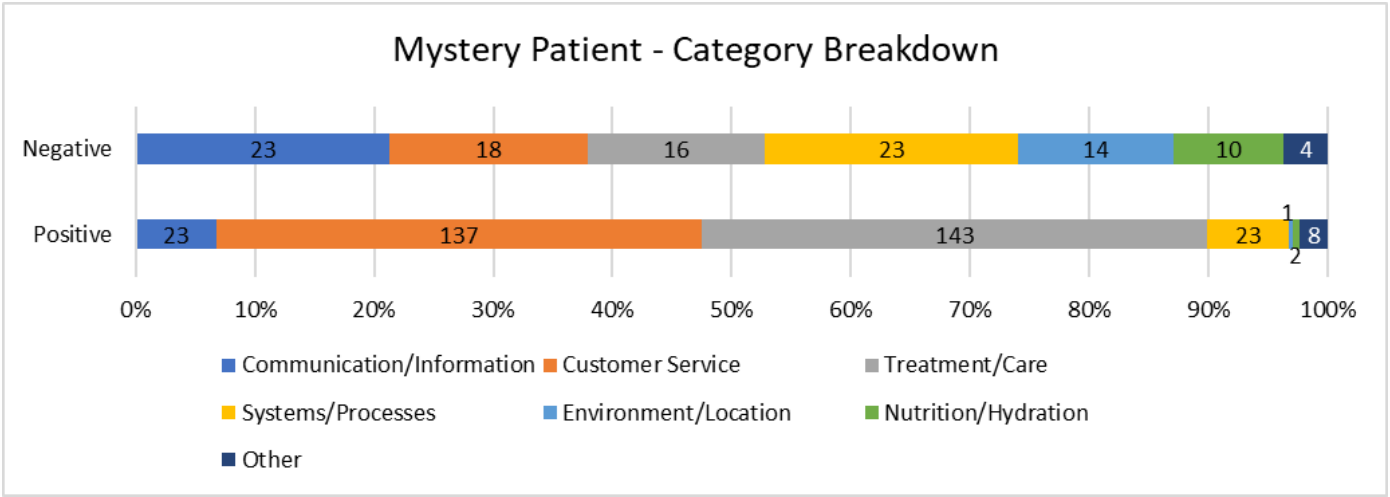
Since the Mystery Patient Scheme was launched in August 2021, we have received a total of 240 responses across the organisation, 2 of those responses did not have the area documented. Community received the most, with a total of 118 responses and Maternity received the least, with a total of 5 responses.

	Inpatients & Day Case	Outpatients	ED	Maternity	Community
The courtesy of the staff	7.9	7.8	6.1	5	9.7
The environment and hospital facilities	6.5	7	6	6.5	9.2
Were they treated with respect and dignity	8.9	8.7	7.5	7	9.9
Involvement in decisions about their care and treatment	7.4	8	7.9	6	9.6

Scores calculated using the national survey scoring process. Scores are out of 10.

When comparing the figures across each touchpoint, Community areas scored highest with scores above 9 for each of the areas. ED and Maternity received the lowest scores across the areas with scores sitting between 6 and 7.9. Inpatients and Outpatients were mostly stable across the 4 areas with scores between 6.5 and 8.9.

Free text



*Please note, number of category's does not equate to pieces of feedback as feedback may be assigned more than 1 category depending on the content.

76% of mystery patient free text is positive. The most positive free text comments were about *treatment & care* and *customer service*. **24%** of comments were negative with 43% of negative comments being about *communication & information* and *Systems & processes*.

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

2.3 National In-patient survey

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care is 60.2% based on the data for the sample year this shows the Trust as an outlier against the national average score of 67.5%. Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. The Adult Inpatient 2021 benchmark reports (due in October 2022) will include an overview of the number of questions at which the trust's performance has significantly improved, significantly declined, or not significantly changed compared with the result from the previous year.

2.4 Compliments

Compliments account for 13% of all contacts received in 2021/22, up 3% on 2020/21. 535 compliments were received by the trust.

Community		Medicine		Surgery		WCCSS*		Corporate Functions	
2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22
153	259 (+69%)	90	101 (+12%)	48	87 (+81%)	84	67 (-20%)	41	21 (-49%)

*Women's Children's Clinical Support Services

3.0 Engagement with Public and Patients

3.1 Patient Involvement Partners

Patient Relations & Experience

Patient Involvement Partners

The Patient Partner programme was introduced in 2021 and continues to evolve. Workstreams where partners have expressed interest in involvement include End of Life Steering Group, the AMU Improvement plan, the Oncology Nurse Specialist out of hours survey and the Patient Experience Group.

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

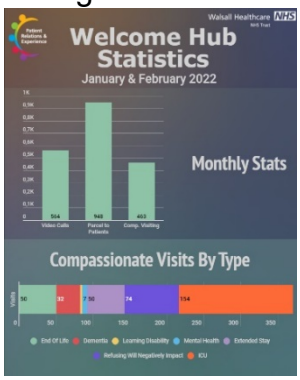
- **A patient partner** was actively involved in a faith-based improvement arising from a poor patient experience. This resulted in the purchase and distribution of 30 hand-held, pocket-sized devices with pre-enabled microchips that are programmed to play a range of Sikh prayers and hymns. They assist with daily worship at a time when patients are unable to visit their normal place of worship and might find it difficult to attend the Trust Chaplaincy Sacred Spaces, or when visiting is restricted.

- The Chaplaincy team also introduced an encounter form to capture the type and frequency of support provided. The SPaRC (Spiritual, Pastoral and Religious Care) form was introduced alongside faith profiles and was initiated following a patient story regarding access to chaplaincy particularly from the Sikh faith. Vacant posts were also recruited to.

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

3.2 Welcome Hub

Listening to families and carers affected by visiting restrictions the '**welcome hub'** was established to manage the visiting process following a period of restricted visiting. **15,048** visits were arranged between May and July 2021 and 16-31 March 2022.



Following patient feedback and survey engagement during periods of restricted visiting, Compassionate Visiting Guidance was introduced to enable a supportive visiting approach for vulnerable patients including the launch of the patient carer passport. **1209** compassionate visits were arranged. **4,737** video calls took place and **3341** parcels to patients were delivered. We surveyed visitors as part of the introduction with 82 respondents, **91%** rated their experience of booking online as Good, very good or Excellent. **73%** rated their experience of using the email or telephone visitor booking systems as Good, very good or Excellent.**96%** of respondents said that visiting had a positive impact on the patient's wellbeing. **89%** said that visiting had a positive impact on their personal wellbeing. **96%** of respondents rated their visiting hub experience as Good, very good or Excellent.

3.3 Critical Care Rehabilitation Forum

The intensive care rehabilitation service was set up to aid patients with their recovery throughout the whole of their inpatient journey, from ICU to the ward, to discharge home. The patients are then invited back to follow up clinics to ensure continuity of care when in the community. In these clinics, ran by senior nurses and a senior physiotherapist, a holistic assessment is completed looking at both physical and psychological wellbeing. Patients and relatives are also invited back to visit ICU if they wish to help aid recovery but also many just like to visit and thank staff.
Patient diaries have been introduced on ICU to allow staff members to provide daily account of the patient treatment including photos, which are then given to patients when they return to clinic. These have been found to help fill in the gaps for patients and increases their understanding of what happened to them during their stay. Snack rounds have been recently introduced on ICU with positive reviews from patients. These look to help increase protein intake which is a key factor in aiding rehab and thus increasing recovery in this patient group. Rocking R's are available for patients to watch TV or play video games, these have been made available by fundraising the team has carried out. When discharged to the

ward the same team continue to support patients both physically and psychologically carrying out holistic assessments.

When visiting was restricted in hospital, outdoor visits were arranged where possible so that the long-term patients were able to see relatives and given them that much needed psychological boost. The team have more recently set up post-intensive care rehabilitation classes for patients with the aim of establishing clear peer support links and enabling continuity of care throughout the multidisciplinary team to enhance patient experience. These classes look at combining exercise and education to allow rehab to continue even whilst discharged home we involve other members of the MDT and patients that have previously been discharged from our care to provide a personal account of their recovery to help motivate and provide positive reinforcement to aid recoveries. We have previously conducted forums similarly that have involved patient's relatives also as we have seen the impact the ICU stay has on them too and the benefits that they can have from peer support. We have had positive feedback from patients from these classes and all stating it has really helped in their recovery. Bereavement cards are also currently sent out to the families of patients we have sadly lost which include forget-me-not seeds, moving forward the team look to fully establish a bereavement service to ensure that families also require the support they may need throughout a difficult period.

3.4 Partnerships & Engagement

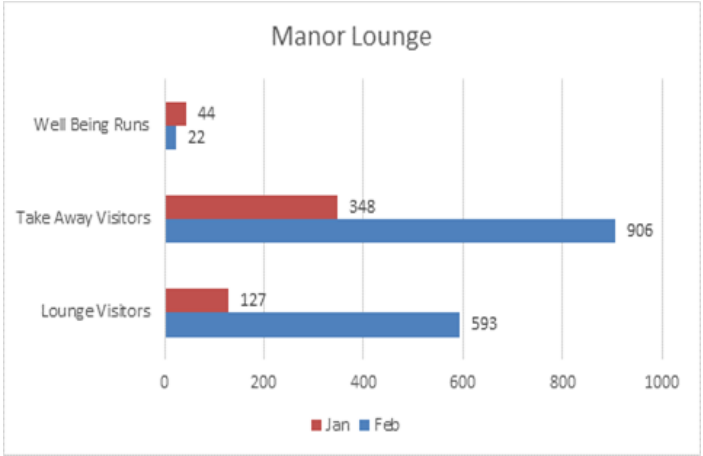
Healthwatch Walsall have regular contact with the organisation and in 2021/2022 provided feedback report on patient views regarding communication and end of life care.

The report on communication was shared with the Patient Experience team and changes made to the telephone system within the PALS office to accommodate concerns regarding call handling.

A member of the Healthwatch team sat on the Trust Learning Matters Editorial group throughout 2021/2022 and contributed via independent scrutiny to the inclusion of articles that shared learning from feedback and actions arising from complaints, incidents and mortality reviews.

3.5 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 reviewed the range of projects funded and have selected the volunteering projects at Walsall Healthcare NHS Trust as an area to celebrate and highlight.



- 66 well-being runs undertaken (hydration/snacks taken to staff/wards/departments)
- 2449 staff took refreshments away from the Manor Lounge
- 1351staff visited the lounge for a ‘break’
- 416 staff completed an experience survey with 4.98 out of 5 the average rating

The Manor Lounge has had significant impact on trust staff. Below are some highlights from a satisfaction survey completed at the lounge by over 400 staff members.

It’s always a warm welcome. It helps with my mental health at work as we do not have a rest room to take a break or eat lunch in. We must eat and drink at our desks, so we never switch off	Relaxing space whether it be for 2 minutes or a full half hour
It’s saved my sanity at times and Zoey is so kind and caring	This service makes more of a difference than you can even imagine to staff who can’t get to the shop, and who only have five minutes spare, please keep it going!

3.6 Maternity Voices Partnership (MVP)

As part of enhancing the women's and families experience at Walsall Healthcare NHS Trust, we have an MVP lead that is very active and involved in trying to support maternity services within the Trust. The MVP lead has recently appointed a deputy to support the role and the Trust to develop initiatives to ensure that the women have an experience that is second to none. The maternity service hosts a monthly meeting whereby service users, MVP members and maternity staff can get together to look at the service as a whole. During these meetings the friends and family test results are discussed we have also shared the Trust CQC Patient Experience results with them and proposed actions. Developments and conversations about the service are also highlighted such as changes to the MLU service, home birth rates and visiting arrangements. The

MVP actively supports the unit in attaining its goals as demonstrated when the MVP lead attended our recent recruitment drive to support the team and meet potential new recruit's

3.7 Public Health and Resilient Communities

Throughout 2021 we worked in partnership with public health to deliver free on-site lateral flow testing to provide a safe visiting process including arrangements for parents with children in hospital, partners accompanying women to antenatal appointments and enabling testing ahead of ward visiting where visitors had no access to lateral flow tests.

5472 lateral flow tests were undertaken with just **36** asymptomatic positive results. The partnership received positive recognition from NHSE seeing this as robust infection control practice measurements to prevent covid-19 outbreaks linked to visiting.

4.0 Voluntary Services

4.1 Juniper - Enhancing Ward Experience Volunteers

The Enhancing Ward Experience (EWE) volunteer has been introduced by Walsall Healthcare NHS Trust to not only support the organisation but to provide an opportunity for those who are interested in an NHS career to find out more about what is required.

In partnership with Juniper training during 2021/2022 **54** EWE volunteers worked at the trust and involved in a host of tasks which include:

- Answering the ward phone and taking messages
- Supporting the Patient Experience Team to carry out video calls
- Answering the ward door and assisting visitors and healthcare colleagues
- Collecting items for staff such as medical records
- Befriending: sitting and talking to patients and/or playing games with them to help reduce their boredom whilst in hospital

Aged between 16-21, the number of volunteer EWE hours completed was **1431hrs.**

4.2 Volunteering at the trust

2021-22 has been a successful year for volunteers at the trust. Our COVID response and PPE volunteers were awarded with the unsung hero award at the 2021 annual excellence awards. A great achievement for all volunteers who have supported the Trust throughout the pandemic, we thank them for their hard work and commitment. We also welcomed back many returning volunteers who were not able to attend during the pandemic.

2021/22 Volunteer Statistics

Total Volunteer Hours 2021-22

8948.32hrs

Top volunteer hours

1ST 909

2ND 428

3RD 427

Equal to

£48,496

Band 2 AfC equivalent

Recruited

82

new volunteers

133

Volunteers supported us in 2021/22

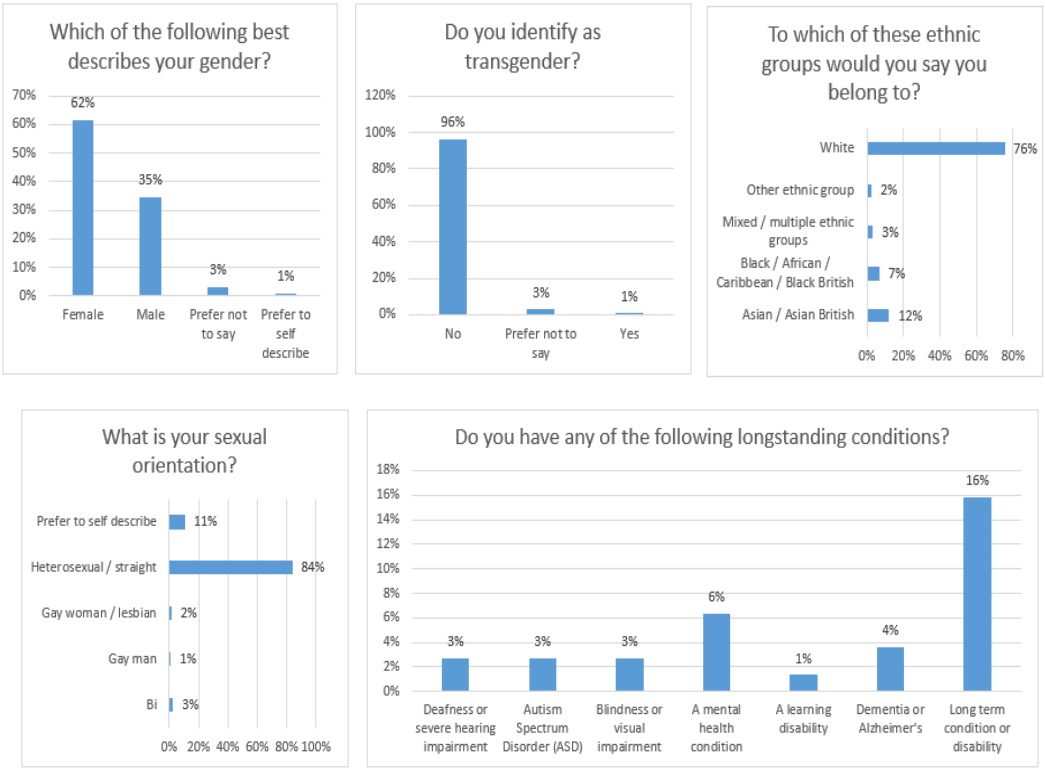
239

Full time working weeks

5.0 Equality Monitoring

5.1 Patient Experience

Patient experience feedback methods, including FFT and Mystery patients, collect optional demographic information. The below charts illustrate the received equality monitoring from those opting to participate.



5.2 Complaints and Concerns

An equality monitoring form is in place and is issued at the point of acknowledgement of a written complaint with 6% (22) returned in 2021/2022.

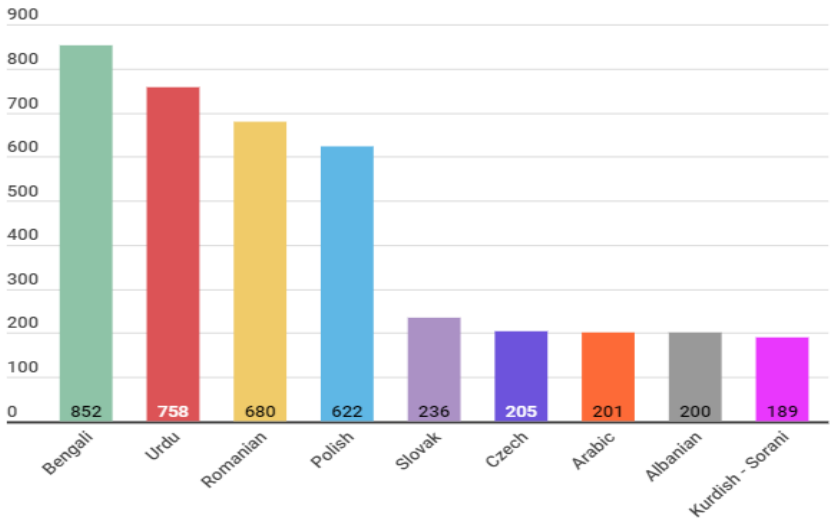
- Ethnicity: 50% of respondents identified themselves as White British, 13.6% Bangladeshi, 9% Caribbean, 9% Irish, 4.5% African, 4.5% Pakistani, 4.5% Other Mixed and 4.5% White and Black African.
- Age: 41% were aged 25-49, 22.7% 18-24, 18.1% 50 to 64, 9% 65-74, 4.5% 75-84 and 4.5% 85 years or over.
- Religion or belief: 40.9% Christianity, 36.3% no-religion, 9% Islam, 9% prefer not to say and 4.5% Buddhism.
- Sexual Orientation: 77.2% Heterosexual, 9% Homosexual/Gay Woman, 4.5% Bisexual, 4.5% Prefer to self-describe, 4.5% Prefer not to say.
- Gender: Male 54.5%, Female 36.3%, 9% prefer not to say.
- Gender re-assignment: 95.4% No, 4.5% prefer not to say
- Relationship status: 36.3% Married, 18.18% Single, 18.18% Living with partner, 13.6% Widowed, 9% Divorced and 4.5% Separated.
- Pregnancy: 95.4% were not pregnant at time of making a complaint, 4.5% were.
- 95.4% of patients do not consider themselves to have a longstanding condition, 18.1% of patients do and 13.6% prefer not to say.

5.2 Interpreting and Translation

Our usage of the interpreting and translation services provided by Word 360 has increased. In 2021/2022, 8432 bookings were confirmed, which is an increase of 2226 in comparison to

2020/2021 (6206). When comparing the total number of bookings (including cancellations), 50.6% of bookings were for telephone interpreters, with 48.9% being face to face bookings and 0.6% taking place via video. The number of video bookings is expected to increase with the introduction on the updated Wordskii app, which is expected by June 2022.

Top Languages



6.0 Achievements against priorities

6.1 Key achievements against the 2021/2022 priorities are:

Priority	Progress
Pilot the implementation of the National Complaints Framework	Early adopter status confirmed. The Model Complaints Handling procedure has been adopted. Self-assessment has been completed and actions against identified gaps progressed. E-learning module produced in collaboration with RWT. Timeframe compliance matched against new standards and response templates updated and in place.
Complete the Patient experience self-assessment framework. Delayed in 2020-2021 due to the pandemic.	Partial completion. Outstanding areas of assessment picked up as priority improvement areas for the 2022/2023 year including the production of a Patient Experience Strategy with RWT.
Raising the profile of unpaid carers.	Carer's passport soft launched and in place. Business case for carers coordinator submitted.
Volunteering recovery plan	Volunteer Policy refreshed updated and approved. New volunteer role profiles in place. Partnerships developed including Manor Farm CA, Ryecroft, Juniper and ReACT. Volunteer base opened and business case for coordinator submitted.
Friends and Family Test (FFT) refresh	Reporting structure and hierarchy reviewed and amended. FFT in focus resulting in

	improved response rates. FFT dashboard initiated and shared with divisional leads. Patient Voice reporting in place and utilised by teams.

6.2 2022/2023 Priorities

Overview of key objectives for the forthcoming year 2022/23

- With our colleagues at RWT we will publish a Patient Experience Strategy for the years **2022-2025**
- As early adopters, with our colleagues at RWT we will continue to develop and implement the new PHSO Complaints Standards including e-learning training modules and tracking progress against each Trust's self-assessment
- We will introduce a PALS Chatbot – as a virtual web assistance for key queries
- Improvement Matters – we will shift some emphasis from measurement matters to improvement matters
- Patient Involvement – we will continue to recruit, engage, and involve patient partners in organisational decision making.
- We will provide new and varying voluntary opportunities for the public hosting community recruitment events and developing a process leading to employment for those who want it.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD 8TH JUNE 2022			
Quality Improvement Report			
Report Author and Job Title:	Joyce Bradley, Head of Quality Improvement	**Responsible Director:**	Simon Evans, Interim Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• That capacity and capability building in a consistent QI Approach continues in appropriate format with social distancing • Engagement of the QI Academy by operational areas to provide QI Approach to making improvements • Addressing the CQC requirements for organisations to develop a mature QI approach		
Advise	• Walsall recognised by the national NHSE/I Increasing Capability Building and Delivery (ICDB) Team for their approach to building capacity and capability • Working more widely with partners across the Black Country and beyond		
Alert	• Opportunities for training and support to areas using a QI approach to improvement are available despite small size of the team.		
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 as a result of this report.		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

QUARTERLY UPDATE FROM THE QUALITY IMPROVEMENT ACADEMY

1. PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Committee of the progress with increasing the capacity and capability of colleagues in an agreed QI Approach, namely Quality Service Improvement and redesign (QSIR) programmes across the organisation and beyond through quarter 4 of financial year 2021/22. Further that the report highlights the extent of training and support provided to Black Country partners and organisations from further afield.

1.2 The paper also informs the Committee of the specific areas of work being supported to apply a QI approach in making improvements in the service.

2. BACKGROUND

2.1 The QI Academy was established in mid-2017 and held its first training session on 9th February 2018 delivering a range of QI tools and models.

2.2 The publication of the joint NHSI and Institute of Healthcare Improvement (IHI) document "*Building capacity and capability for improvement: embedding quality improvement skills in NHS providers"* (hereafter referred to as the dosing document) in 2017 led to the team to undertake Quality, Service Improvement and Redesign (QSIR) training to formalise the delivery of training.

2.3 The dosing document identified what level of knowledge, understanding and application was required by different colleagues within the organisation, with different authority and mandates.

2.4 The organisation became a QSIR Accredited site at the end of 2018 and started delivering the formal QSIR Programmes in January 2019 to ensure that a robust QI Approach was developed utilising the principles recommended in the dosing document.

3. DETAILS

3.1 The report sets out what has been achieved within the last quarter and particularly within the restrictions imposed by social distancing for programmes which are accredited for face-to-face delivery only and the redeployment of the members of the QI Academy during the early part of the reporting period.

3.2 The report sets out the uptake of the virtual QSIR programme in attempting to meet the identified training levels from the dosing document.

3.3 Through networking and by reputation the Walsall QSIR Virtual programme has had delegates from 15 external NHS organisations attend their programmes, new for this

quarter included delegates from Worcestershire Acute NHS Trust but also additional colleagues from Kings Lynn NHS Foundation Trust, Sandwell and West Birmingham NHS Trust and also Hereford and Worcestershire Health and Care Trust.

3.4 This quarter saw the refinement of the content to be delivered by the national ICBD Team at a Board development sessions planned for May and June 2022. This training will be co-developed between the QI Academy at WHT, the CQI Team at RWT and the national ICBD team as well as representatives form the NHSEI Intensive Support team utilising the Making Data Count training with input from the Business Information and Performance teams of both Trusts.

3.5 Specific elements of work were undertaken by the QI Academy which supported making services safer for patients and staff. This included the on-going PDSA work to evaluate a new risk assessment for the transfer of patients from ED and starting to us the assessment for transfer of patietns from AMU to deeper wards

3.6 Work has been ongoing with AMU to improve the VTE compliance by applying a QI approach to understanding the root cause for VTE assessments not being undertaken and data has been captured over time to reflect the impact of this approach

3.7 The report identifies the areas which will be the focus of work for the QI Academy during Q1 2022/23 and sets out three broad areas of work:-

- Building Capacity & Capability
- Supporting Patient Flow
- Patient and Staff Safety

3.8 The main pieces of work that will be ongoing for some time will be:-

- Co-developing the Quality Management System training for the Board – led by the QI Academy in collaboration with the CQI Team at RWT and the Leads at NHSEI ICBD Team and the NHSEI Intensive Support Team

- Triangulation of Data for Patient Safety which will help identify areas for improvement work moving forward

- Patient Flow through Gynae and Antenatal Clinics – to look at how the clinics can be supported to work more efficiently through understanding the load on each clinician, the cycle time for step and identifying any flow constraints.

3.9 Smaller pieces of work will also be undertaken and are likely to be completed within the next quarter and include:-

- Supporting the National Team in the development of a virtual facilitation package for trainers

- Refining the QSIR Delivery plan for the three QSIR programmes and Healthcare Systems engineering throughout the financial year.
- Supporting areas identified as priorities for the new ED and AMU to work through PDSA cycles to test approaches for areas including See and Treat, Ambulatory Emergency Care and development of principles for an Emergency Decision Unit
- Implementation of Improvement Huddle boards in Gynaecology Clinic, Delivery Suite and Therapies.

4. RECOMMENDATIONS

The Committee is asked to **Note:**

4.1 the ongoing delivery of face-to-face and virtual training in accordance with social distancing requirements and the delivery plan requirements

4.2 the ongoing support by the QI Academy to projects using a QI approach to make improvements in the quality or safety of services provided, led by the staff delivering the service

4.3 the plan of work for quarter 1 2022/23

Quality Improvement Academy Update

Quarter 4 – 2021/22

Quality Improvement Academy
Joyce Bradley – Head of Quality Improvement
Tom Johnson – Quality Improvement Programme Lead

Caring for Walsall together

Safe, high quality care | Care at home | Partners | Value colleagues | Resources | Respect Compassion Professionalism Teamwork

Contents

Executive Summary

The QI Academy has continued to deliver face-to-face training where it can and switch to the provision of the QSIR Virtual programme when social distancing requirements reduced the face-to-face training options.

Ongoing project were supported where it was possible in clinical settings although the ongoing requirement to only come to site when essential has hindered the QI Academy's opportunity to support all the areas which had asked for support, that plus the small size of the team. During this quarter the members of the QI Academy were also redeployed to support other areas when the Omicron variant was at its peak.

During this quarter work with the ED and AMU teams has commenced including work to improve compliance with the VTE requirements.

Working with NHSEI Improvement Capacity Building and Delivery Team on a Board development session on Quality Improvement commenced, the session is scheduled to take place during Quarter 1 of 2022/23 and will cover the elements of a Quality Management System and also a development day on Making Data Count with the National Intensive support team from NHSEI

QI Academy – The Team

The QI Academy consists of:-

1 x Trust Clinical Lead (2 PA per week) Vacant
4 x Divisional Clinical Leads
1 in post for MLTC, 1 vacant, 2 standing down at the end of March 2022
1 x Head of Quality Improvement – J Bradley
1 x Quality Improvement Programme Lead – T Johnson
1 x Quality Improvement Facilitator – Interviews held during Q4, commence Q1
1 x Medical QSIR Accredited trainer 0.9 PA per week – Dr Waterhouse

It is anticipated that the 4 vacancies will be recruited to during Q1 22-23

Capacity & Capability

QI Training Delivery

During Q4 the Omicron variant of covid 19 meant that the face-to-face training planned for both January and February had to be cancelled. This effectively removed two complete cohorts of QSIR Practitioner (the 5 day course) from being delivered. Colleagues who were booked on were moved to later cohorts one of which commenced during March 2022.

A cohort of QSIR Practitioner commenced being delivered for Sandwell and West Birmingham NHS Trust with a view to wider system working and supporting that organisation to develop its internal QSIR Faculty. This cohort will not conclude until Q1 22/23

Q4 saw 3 cohorts of QSIR V complete with delegates from Worcestershire, Barnsley, Bradford Teaching Hospitals NHSFT and Black Country Healthcare NHS Foundation Trust joining delegates from WHT on those courses.

QSIR Fundamentals training had to be cancelled during this quarter due to delegate cancellations because of operational pressures.

Redeployment

During January 2022 the members of the QI Academy were redeployed to assist with the booking of shifts for Medical students to support clinical areas as the infection due to covid19-omicon impacted on the clinical staff available. This effectively removed the QI Academy's ability to support any QI changes or projects which had been due to start or were underway.

Capacity & Capability - continued

Quality Management Systems

The process for developing the board development sessions on Quality Improvement and Measurement for Improvement has commenced. These sessions were confirmed to be delivered to both boards (RWT and WHT) delivered during Q1 22-23.

Approaches have been made to the QI Academy by both Sandwell and West Birmingham NHS Trust and the Black Country Healthcare NHS Foundation Trust for the board development approach to be shared with them for consistency across the ICS.

The learning from the sessions will be shared with TMC following the events.

Health Care Systems Engineering

The Flow workshops scheduled for February and March as the initiators for applying Health Care Systems Engineering were cancelled but the interest in the processes and application of using a systems engineering approach has remained high. QI Academy members are undertaking further development to ensure that the organisation can be supported in applying these approaches and will reschedule the sessions when training room capacity is available.

Patient Flow

The limited time that the QI Academy are on site during this quarter has impacted the ability to work with some clinical teams. As a result there are only a few areas which the QI Academy have supported with patient flow during Quarter 4, these are:-

- Gynaecology Clinic observation of Patient Flow prior to changes in clinic scheduling. This work commenced just at the end of Q3 and will continue into Q4.
- Obstetric/Diabetic Clinic observation to review issues with patient flow through the clinic
- Imaging Pull system – work on stop due to higher number of mobile x-rays for positive covid patients

Patient and Staff Safety

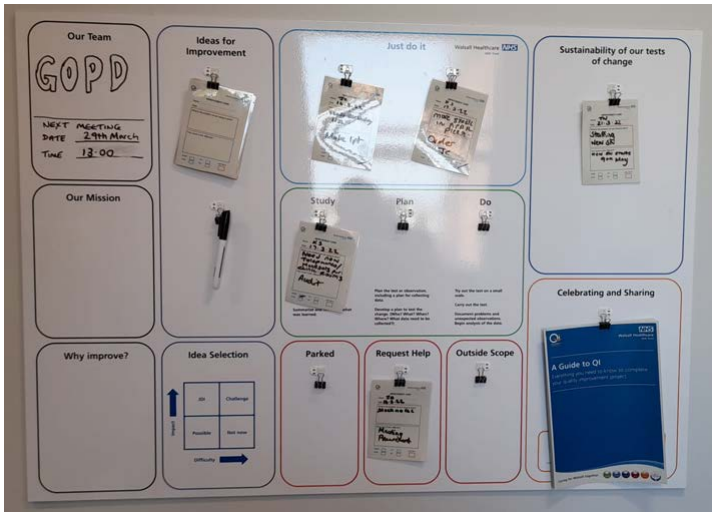
QI Huddle Boards

During Q4 the QI Academy has supported clinical teams to reinstate or start QI Huddle Boards. This is an approach which reflects practice undertaken at both Western Sussex and Birmingham Women's and Children's Hospitals where clinical teams have a structured approach to making changes in their working environment and practices to improve safety, flow or quality of the service.

The huddle boards enable teams to identify the things which impact on the service and by applying a study-plan-do approach they can work to remove these problems.

The implementation of the QI Huddle boards had been due to start during Q419/20 but were delayed due to covid19. Todate 5 huddle boards have been deployed, the use of some has been paused and refresher training is now being scheduled.

Gynae OPD have just implemented their board during Q4 and three other areas have requested boards moving into Q1 22/23



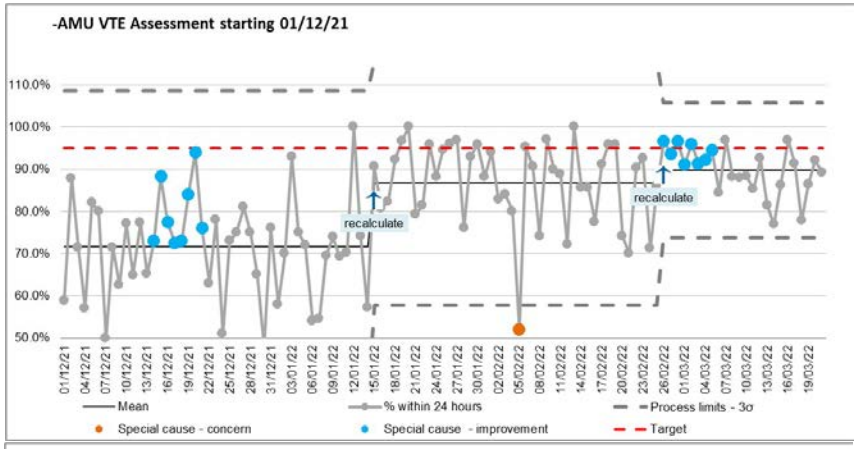
Patient and Staff Safety - continued

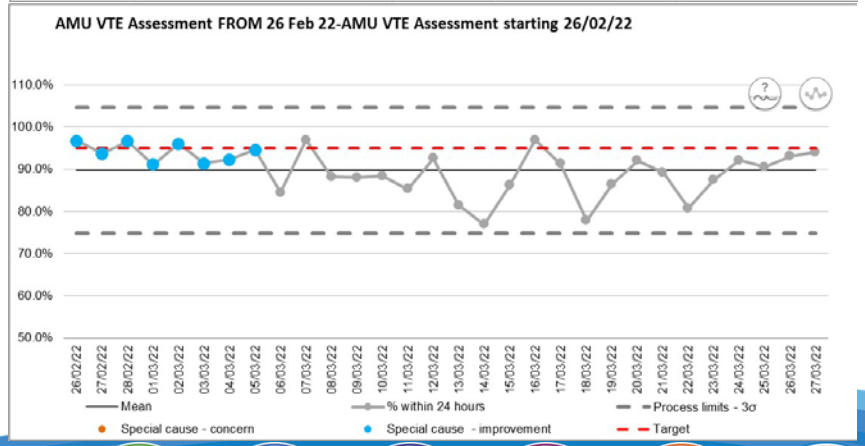
AMU VTE Assessments

The AMU team have been capturing their VTE compliance data in SPC charts to determine whether there was improvement being made from the changes that they were implementing. The work undertaken has lead to sustained improvement and the process limits have been recalculated twice.

The data is being collected daily and the second graph is the most recent data from the last time the limits were calculated. This work is supported by one of the members of the QI Leadership Team (QILT) who is a medic and also a QSIR Trainer.

Root cause analysis was undertaken to identify the potential areas for improvement and Identify if there were any unexpected areas which needed to be addressed.





Plans for Quarter 1 2022-23

Capacity & Capability

- Delivery of QSIR Practitioner, Fundamentals and Virtual cohorts subject to social distancing rules where needed
- Delivery of a QSIR Practitioner specifically for Sandwell & West Birmingham NHS Trust as part of partnership working across the region
- QSIR Fundamentals session for Regional Anaesthetics Trainees supported and promoted by the West Midlands deanery
- Working with the NHSEI Improvement Capacity Building and Delivery Team and Delivery Team and the Intensive Support Team who promote the Making Data Count on developing a training programme for both Boards – “Board leadership for developing and embedding a Quality Management System”
- Supporting the NHSEI Improvement Capacity Building and Delivery Team in developing a QSIR Practitioner programme with blended methods of delivery
- Revise the Delivery Plan for training to accommodate additional trainers who are undertaking accreditation

Plans for Quarter 1 2022-23 - continued

Patient Flow

- See and Treat, Ambulatory Emergency Care and development of an Emergency Decision Unit
- Imaging Flow – Pull system, further analysis of data, subject to processes reducing number of mobile x-rays
- Development of mini-masterclasses on Health Care Systems Engineering and Patient Flow workshops
- Gynaecology Clinic Patient Flow
- Antenatal Clinic Patient Flow work to recommence

Patient and Staff Safety

- Improvement Huddle Boards in Gynaecology Clinic, Delivery suite and discussions with Therapies
- AMU PDSA for the adoption of the Patient Transfer Risk assessment
- AMU and ED PDSA work on multiple aspects supporting development of approaches to have in the new ED and AMU including role development, Call systems, mapping current practices, observations of Patient flow
- AMU VTE Compliance work continues

Meeting of the Trust Board - 8th June 2022			
Divisional Director of Midwifery Report			
Report Author and Job Title:	Carla Jones-Charles – Divisional Director Midwifery Gynaecology and Sexual Health	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• 100% of women received 1:1 care in labour • CNST element action 8 – training is on trajectory		
Advise	• The service is continuing to work on the gap analysis and business case for the final Ockenden report.		
Alert	• There continues to be staffing pressures due to staff absence and vacancy however this continues to be managed using the escalation policy and business continuity plans. Recruitment continues.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high quality care **Corporate risk 2245** - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20).		
Resource implications	There are no funding resource implications associated with this report.		
Legal and/or Equality and Diversity implications	There are no Legal, Equality and Diversity implications associated with this report		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Divisional Director of Midwifery Report

1. PURPOSE OF REPORT

The purpose of the report is to provide an update to assure the Board on the following items;

- Midwifery staffing review
- Activity within the maternity unit
- HSIB update
- CNST
- Ockenden update

2. BACKGROUND

This report will provide a concise update regarding the on-going position on the elements cited within section 1 by exception.

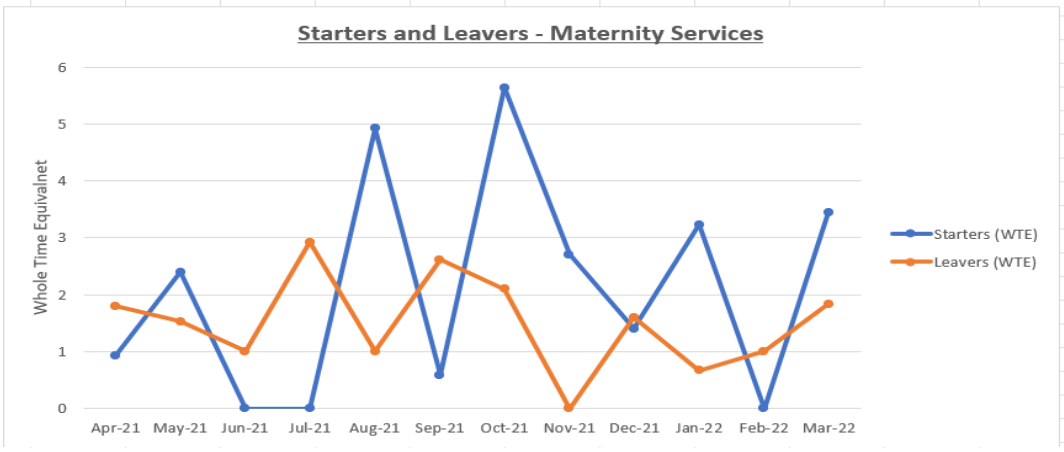
2.1. Midwifery Staffing

There continues to be challenges with staffing due to staff absences, top reason was respiratory and 2.6 wte off with stress. The current Trust uplift is 21%, this allows for annual leave, sickness and training to be covered without detriment to the service. The table below is a breakdown of absence for April 2022. The service has continued its active recruitment. The service has also doubled the number of student midwives that it will accommodate by 100% on 19/20 figures.
Active recruitment continues, please see chart 1 for starters and leavers.

Table 1

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Women's Services (Are)	Delivery Suite - Nursing	Registered Midwives	13.6%	1.1%	3.4%	9.5%	2.3%	2.2%	32.1%
		Unregistered Nurses	10.8%	0.7%		13.9%	1.1%		26.4%

Chart 1



2.2. Activity within the Maternity Unit

Table 2 highlights the delivery activity within Maternity Unit on a month by month basis and the ethnicity data is highlighted in chart 1.

Table 2. Birth Activity July 2021-March 2022

Month	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
No: Births	334	335	313	317	294	311	298	287	331	284

Graph 1

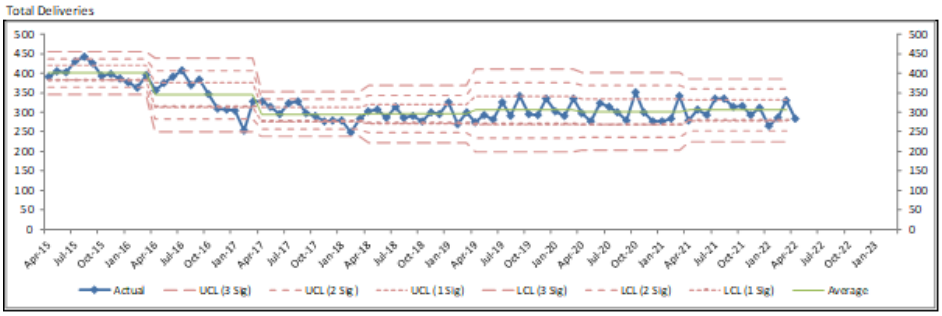
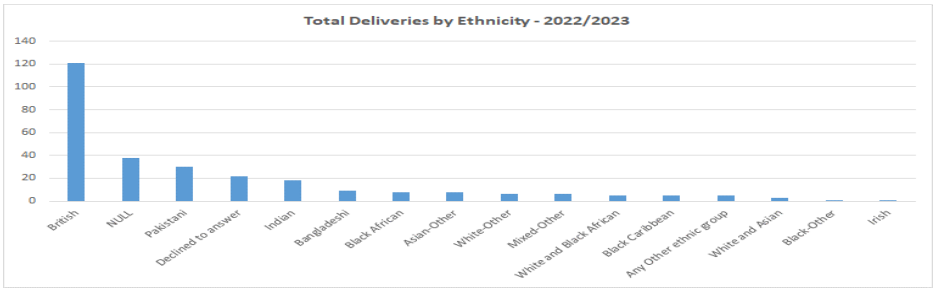
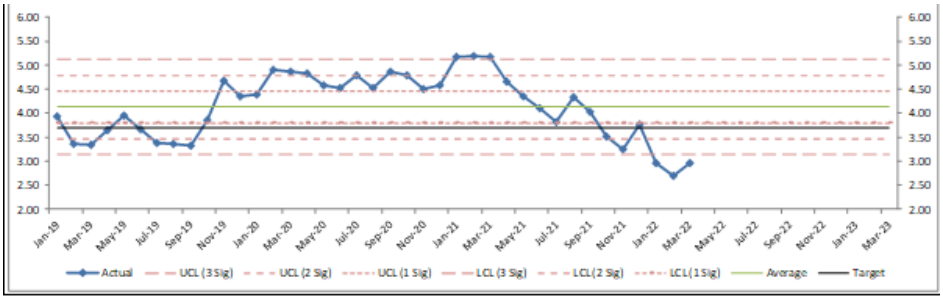


Chart 1



The maternity dashboard information continues to demonstrate a continued maintenance trajectory for stillbirth and perinatal mortality rates in graph 2.

Graph 2 – stillbirth rate

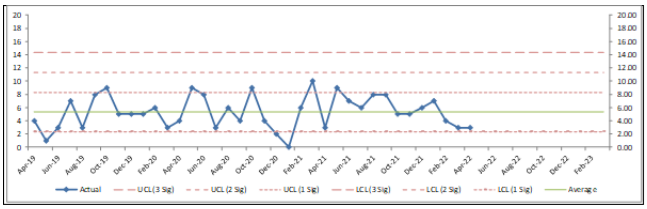


2.3 – Caesarean section data.

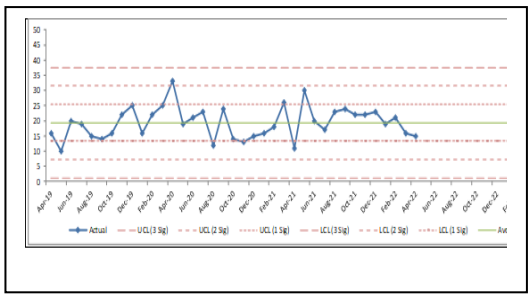
The national requirement for monitoring Caesarean section rates has changed and maternity service is required to report on Robson criteria 1, 2 and 5. There are 10 categories; table 3 below describes what the 3 elements to be monitored are. March is the first month that Robson is reported on the maternity dashboard. The service is seeing a downward trend for Robson 1 and 2 (graph 3&4)
Table 3

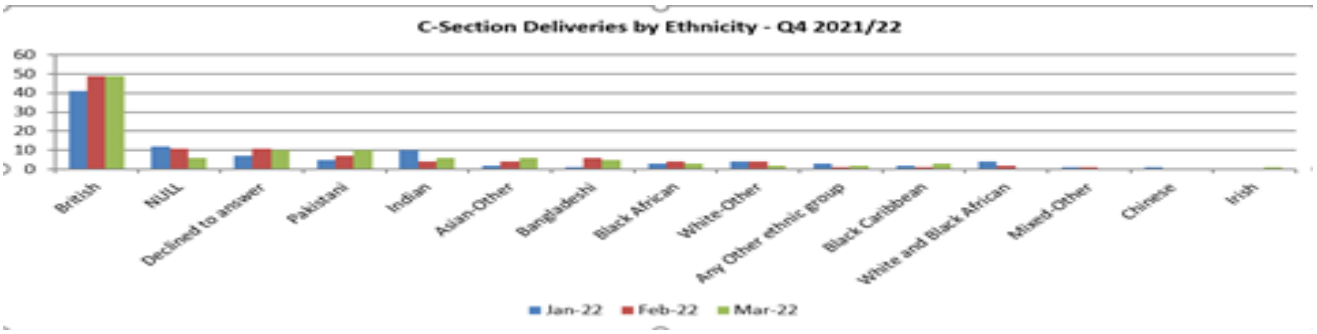
Robson 1	Women having their 1st baby who present in spontaneous labour and deliver by emergency caesarean section
Robson 2	Women having their 1st baby who are induced and deliver by emergency caesarean section
Robson 5	Women with 1 previous child who delivered by caesarean section and have a subsequent delivery by caesarean section

Graph 3 Rob 1



Graph 4 Rob 2

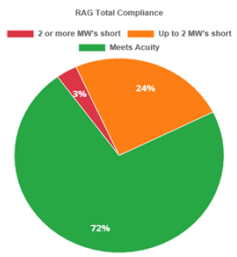




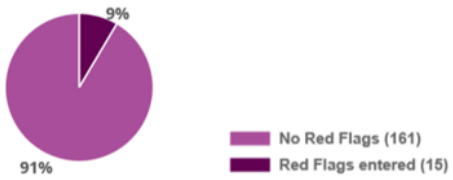
2.4 Acuity

Birth-rate Plus acuity tool is used to monitor the units acuity 6 times a day on the delivery suite and assess staffing needs based on activity and complexity of women cared for. The national recommendation is to maintain an average acuity of 85%. The average acuity for April was 72%. Graph 5 acuity for March 2022. There were no red flag events 91% of the time. There were 15 red flag events in total, graph 6. Actions taken were related to delay in induction of labour procedures, graph 7. The delivery suite team leader remained supernumerary.

Graph 5



Graph 6



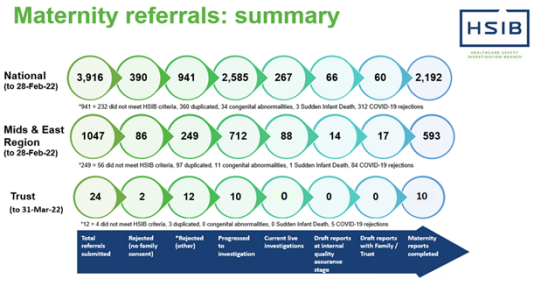
Graph 7

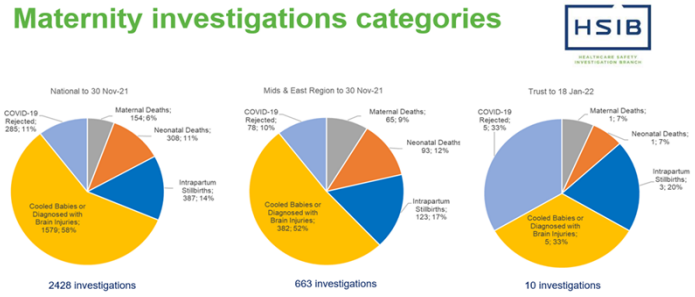
Number & % of Red Flags Recorded
From 01/04/2022 to 30/04/2022

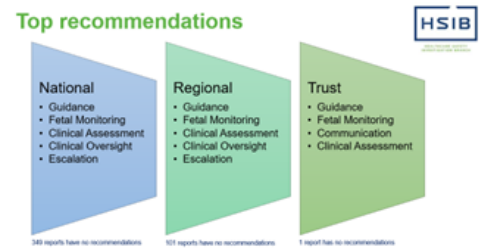
RF1	Delayed or cancelled time critical activity	15	100%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	0	0%

2.5 Health Service Investigation Branch

HSIB have been undertaking maternity investigations since 2019. This provides an update from the last quarterly report.



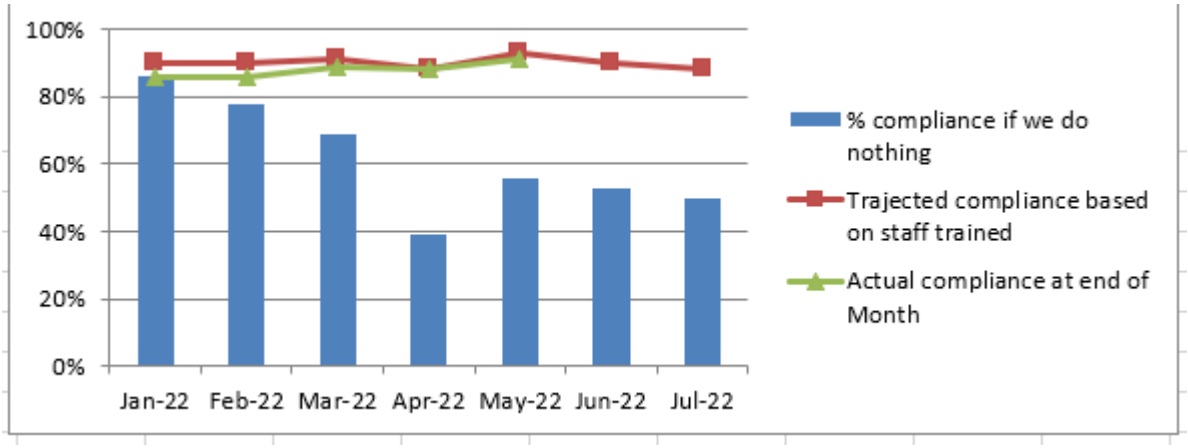




There has been a total of 10 cases accepted for HSIB investigation for WHT since 2019. The last accepted referral was in August 2022 and the completed report was received in March 2022. Final DoC has been completed with the family.

2.6 CNST – Safety Action 8

The service restarted face to face training in September 2021. The number of staff trained per session is reduced to ensure that social distancing is maintained in line with guidance. Key elements are Multiprofessional training for obstetric emergencies and training in electronic fetal monitoring. Please see trajectories below.

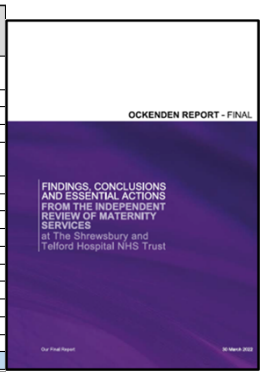


2.7 Ockenden update

The initial high level gap analysis completed by the service. The service is awaiting details from national team regarding future data submissions and evidence. Table 4 outlines the number of each element that the service feels that it is fully compliant with and those that require addition work and/ or investment. The service is developing a business case for the staffing elements that will require additional investment.

Table 4

Recommendation	Number of Actions applicable to our Trust	Number of actions not within our Trust to complete	Compliant	Partially Non Compliant	Fully Non Compliant
1.Workforce Planning and Sustainability	9	2	4	4	1
2.Safe Staffing	10	0	4	5	1
3.Escalation and Accountability	5	0	4	1	0
4.Clinical Governance-Leadership	7	0	4	2	1
5.Clinical Governance – Incident Investigation and Complaints	7	0	2	4	1
6.Learning from Maternal Deaths	2	1	2	0	0
7.Multidisciplinary Training	7	0	4	3	0
8.Complex Antenatal Care	5	0	2	2	1
9.Preterm Birth	4	0	2	2	0
10.Labour and Birth	6	0	1	5	0
11.Obstetric Anaesthesia	4	0	0	4	0
12.Postnatal Care	4	0	1	3	0
13.Bereavement Care	4	0	2	2	0
14.Neonatal Care	7	1	1	6	0
15.Supporting Families	3	0	0	3	0
Total:	84	4	33	46	5



3.0 RECOMMENDATIONS

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

MEETING OF THE PUBLIC TRUST BOARD – 8TH June 2022			
IPC Annual Report			
Report Author and Job Title:	Amy Wallett – Head of IPC and deputy DIPC Aiden Plant - Consultant Microbiologist and IPC Doctor Louise Fox – Clinical Lead Nurse IPC	**Responsible Director:**	Lisa Carroll Director of Nursing and DIPC
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Assure	• The Trust achieved the planned IPC activities outlined in the annual programme of work		
Advise	• The Trust experienced 3 cases of MRSA bacteraemia against a target of zero • There were 31 toxin positive reportable Clostridium *difficile* against a trajectory of no more than 33 • The COVID-19 was a challenging year for the IPC team and Trust, posing additional demand in the prevention and control of infection within healthcare premises • The trust is currently rated as amber by NHSE/I for IPC. The Trust received very positive feedback for progress in standards of IPC at the review in December 2021.		
Alert	• Nothing to alert		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	IPC BAF		
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 ☒		

Walsall Healthcare NHS
NHS Trust

Infection Prevention & Control Annual Report 2021/2022

Lisa Carroll
Director of Nursing and Director of Infection Prevention & Control

Amy Wallett,
Head of Infection Prevention and Control, Deputy Director of Infection Prevention & Control

Louise Fox,
Clinical Lead Nurse Infection Prevention and Control

Dr Aiden Plant,
Consultant Microbiologist

Infection Prevention & Control Annual Report 2021-22

Contents

Appendix 1	Terms of Reference for Infection Prevention and Control Committee
Appendix 2	Antimicrobial Stewardship Team Strategy Work Plan
Appendix 3	Reporting Structure for Infection Prevention and Control Committee
Appendix 4	Annual plan of work 2022/23

1.0. Executive Summary

- The Annual Infection Prevention and Control (IPC) Report reports on infection prevention and control activities within Walsall Healthcare NHS Trust for April 2021 to March 2022. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability.

- The following organisms are subject to mandatory reporting. These are MRSA, MSSA, Clostridiodes difficile and Gram-negative bloodstream infections (Escherichia coli, Klebsiella species, Pseudomonas aeruginosa).

- The Trust has achieved the planned infection prevention and control activities outlined in the annual programme 2021/22 including planned audits, teaching sessions and undertook additional duties to support the Trust in response to the COVID-19 pandemic.

- The Trust experienced 3 cases of MRSA bacteraemia during 2021-22 against a target of zero.

- There were 31 toxin positive reportable cases of Clostridium *Difficile* (C. diff) against a trajectory of no more than 33 cases

- Mandatory surgical site surveillance was completed in elective orthopaedic hip and knee replacements for 1 quarter; no infections were identified.

- During 2021/22 the COVID-19 pandemic was a challenging year for the IPC team and Trust wide services, posing additional demand in the prevention and control of infection within healthcare premises.

- The Trust is currently rated amber by NHS England and Improvement for Infection Prevention and Control. The Trust received very positive feedback for progress in standards of IPC and plan to revisit the Trust in August 2022.

2.0. Introduction

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

3.0. Reporting arrangements

The Infection Prevention & Control Team (IPCT) is based at the Manor Hospital site.
The team works closely with all Trust colleagues and external contractors to support a vision of no person being harmed by an avoidable infection. The service provides IPC support to the

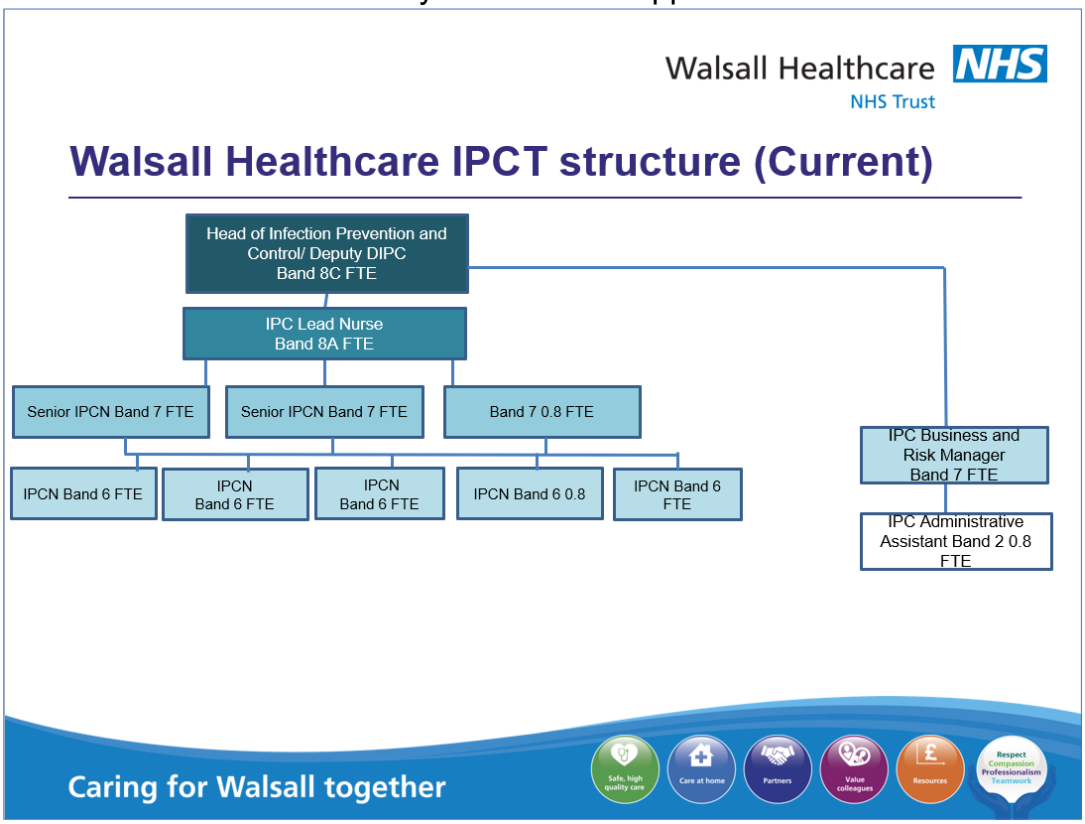
Manor Hospital site and the community services provided by the Trust.. In addition, they work closely with Walsall Council's Health Protection team to deliver a health economy approach to infection prevention strategies.

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

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC or Deputy DIPC and met monthly during 2021-2022.

4.0. IPC team structure

The IPC team structure for 2022 is detailed below. New IPCNs joined the IPC service during 2021 and 3 Senior IPCNs have been in post from December 2021 since the new structure was developed in 2021. This has supported developing working relationships with the divisions across the Trust and continuity in divisional support.



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

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

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

6.0. Infection Prevention and Control Committee (IPCC)

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

Compliance with The Health and Social Care Act is measured using the hygiene code. This is routinely assessed at Infection Prevention and Control Committee via the IPC Board Assurance Framework (BAF) updates.

6.1. Decontamination Group

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

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

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

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

6.2. Antimicrobial Stewardship

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

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

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

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

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

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

- Halve healthcare associated Gram-negative blood stream infections
- Reduce the number of specific drug-resistant infections in people by 10% by 2025
- Reduce UK antimicrobial use in humans by 15% by 2024
- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

Antimicrobial Stewardship Team (AMST); governance and reporting

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

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

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

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

The Trusts Antimicrobial priorities for 2021/2022 and continuing into 2022/2023 include:

- MicroGuide was completely revised in August 2020; since then, there have been numerous updates – the most recent updates include
  - bespoke, evidence based and peer reviewed obstetric antimicrobial prescribing.
  - prescribing for dual infections.
  - management of malaria.
  - low-risk neutropenic sepsis pathway.
  - management of victims of penetrating injuries including bomb blasts.
  - prophylaxis of open fractures.

  The next update will include comprehensively reviewed surgical prophylaxis guidance.
- Improve recording of allergy, including nature of allergy
- Improve documentation of antimicrobial indication and intended duration
- Improve evidence of antimicrobial review within 72 hours
- Reduce consumption of high-profile antimicrobials

In addition, in 2021/22 Patient Group Directions (PGDs) for antimicrobial treatment of neutropenic sepsis including the low-risk neutropenic sepsis pathway, management of sexually-transmitted infections, and diabetic foot infections were peer-reviewed and ratified by the AMST.

An SOP for the use of Procalcitonin to facilitate early de-escalation of antibiotics in medical inpatients was approved. Procalcitonin testing was extended beyond ICU, to helps clinicians feel supported in stopping/optimising antimicrobial for patients treated with viral RTI, including COVID-19.

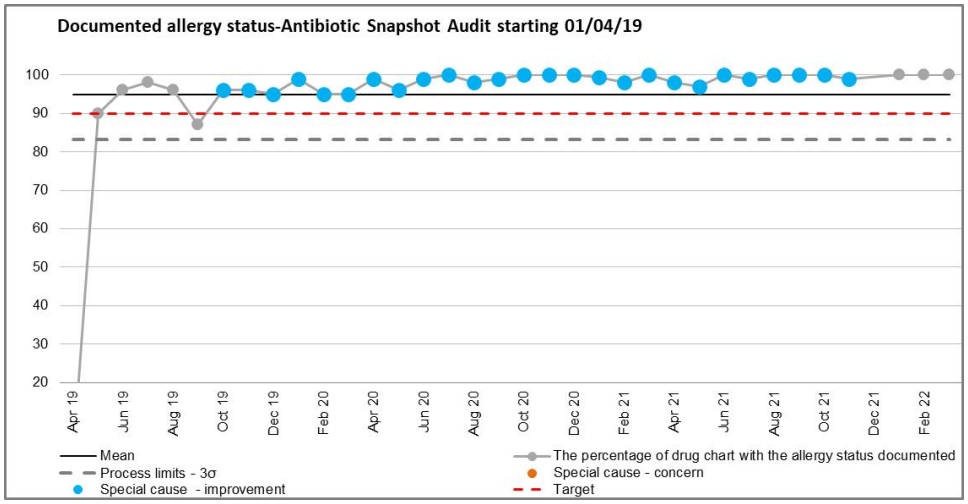
The Antimicrobial Prescribing policy and OPAT policy was revised and ratified. OPAT MDT's were resumed on a weekly basis, the table below, recorded by the clinical intervention team, highlights key figures relating to referrals, hospital days saved, and cost avoidance derived (Jan 2021-Dec 2021).

Month	SPA	CIT self referral	Allied Health care professional	Acute WMH	Acute	GP	A&E Ucare	Days saved	Money saved	Total
January	0	0	2		15	4	1	196	88,200	26
February	3		2		5	2		188	84,600	24
March	0	2	3		1	3	1	109	49,050	14
April	0	3	0	8	1	1	0	131	58,950	15
May	2	1	0	6	2	2	2	138	62,100	19
June	1	2	2	8	3	6	1	217	97,650	26
July	0	2	0	15	1	4	1	183	82,350	25
August	0	6	2	10	1	1	0	178	80,100	25
September	0	1	5	9	3	4	0	159	71,550	23

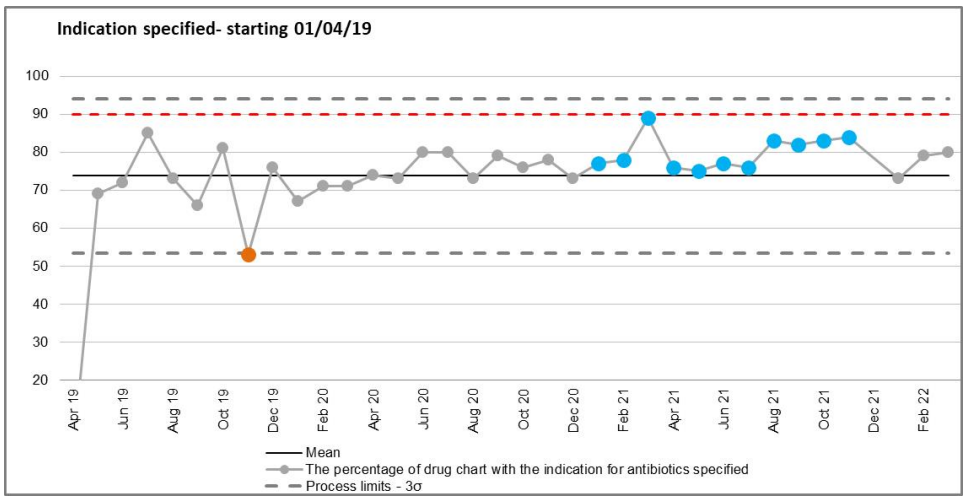
October	3	3	2	8	1	0	0	136	61,200	17
November	2	0	2	9	2	2	0	193	86,850	19
December	3	1	3	10	3	6	0	319	143,550	30
Total	**14**	**21**	**23**	**83**	**38**	**35**	**6**	**2147**	**966,150**	**263**

Performance measures are reported monthly and our progress to date is as follows:

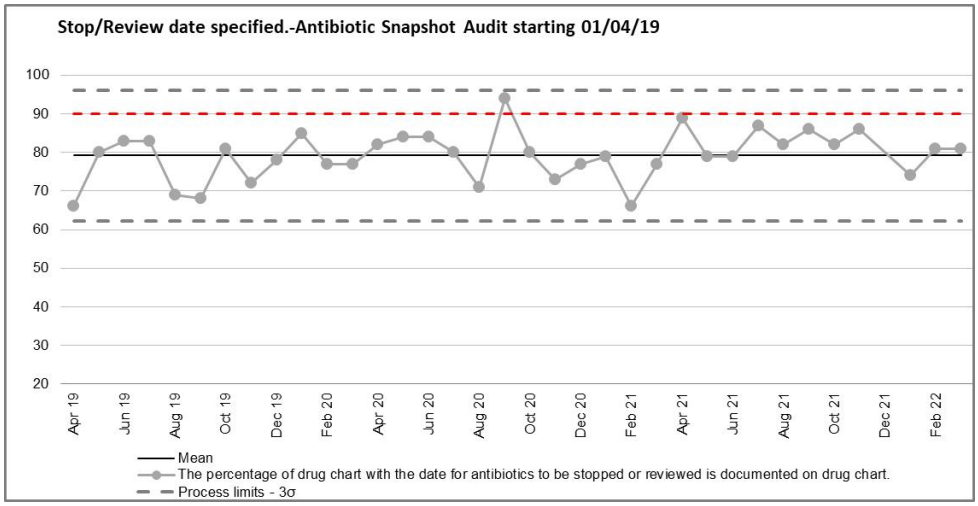
- **Charted allergy; including nature**:



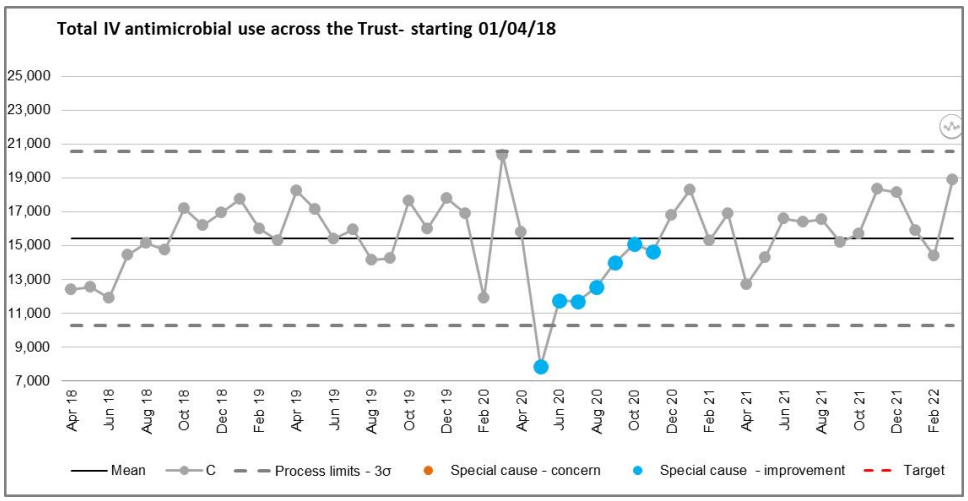
- **Charted indication:**

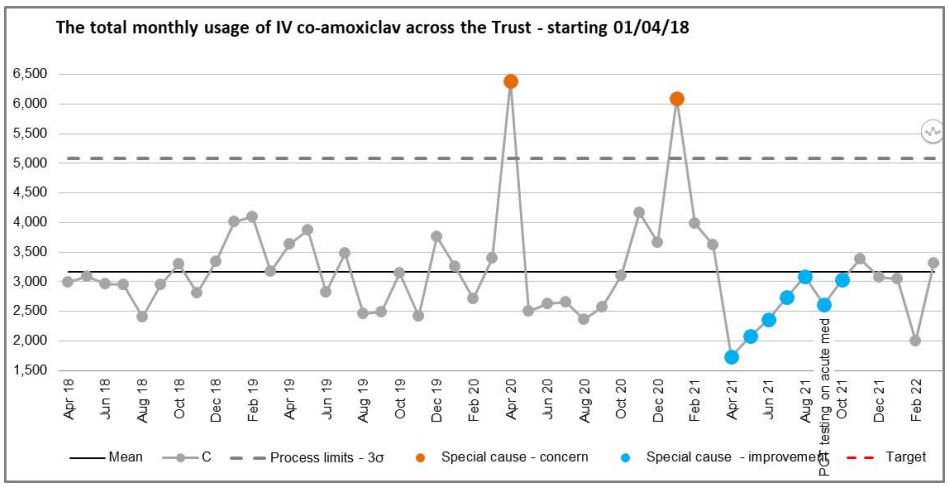


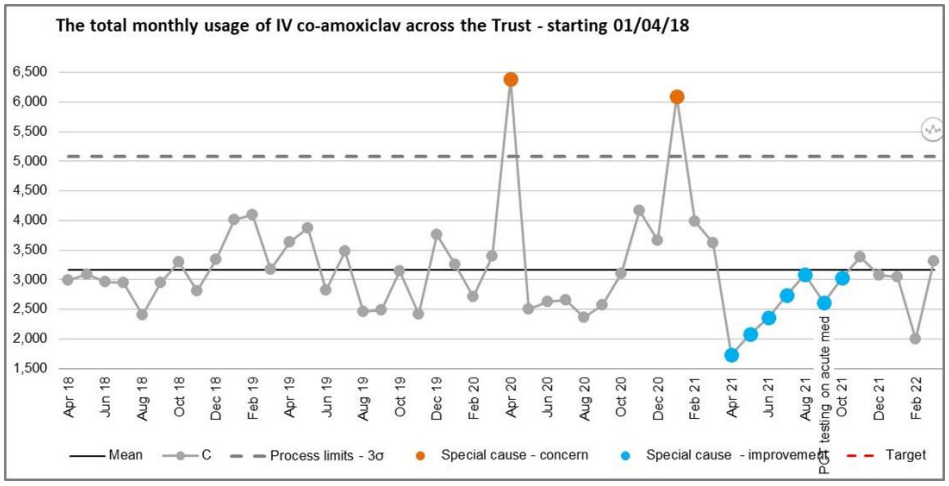
- **Evidence of review within 72hrs:**

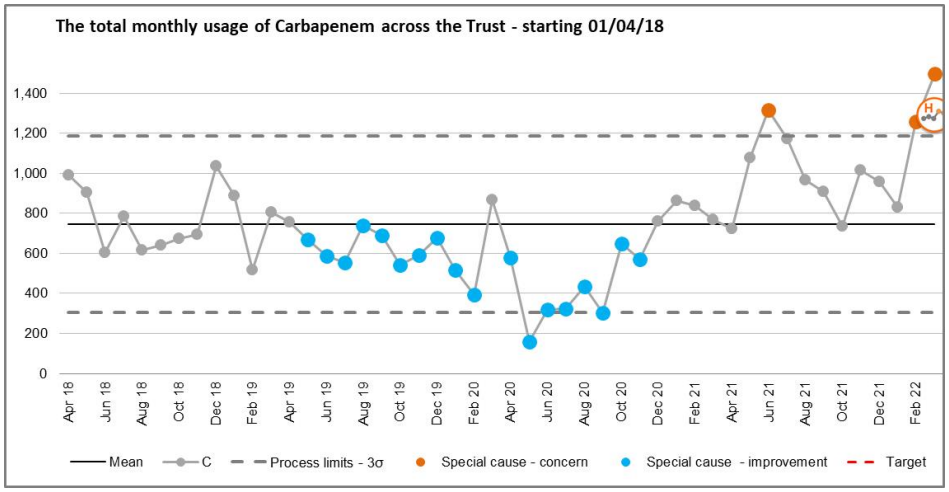


- **Consumption of intravenous and high-profile antibiotics:**



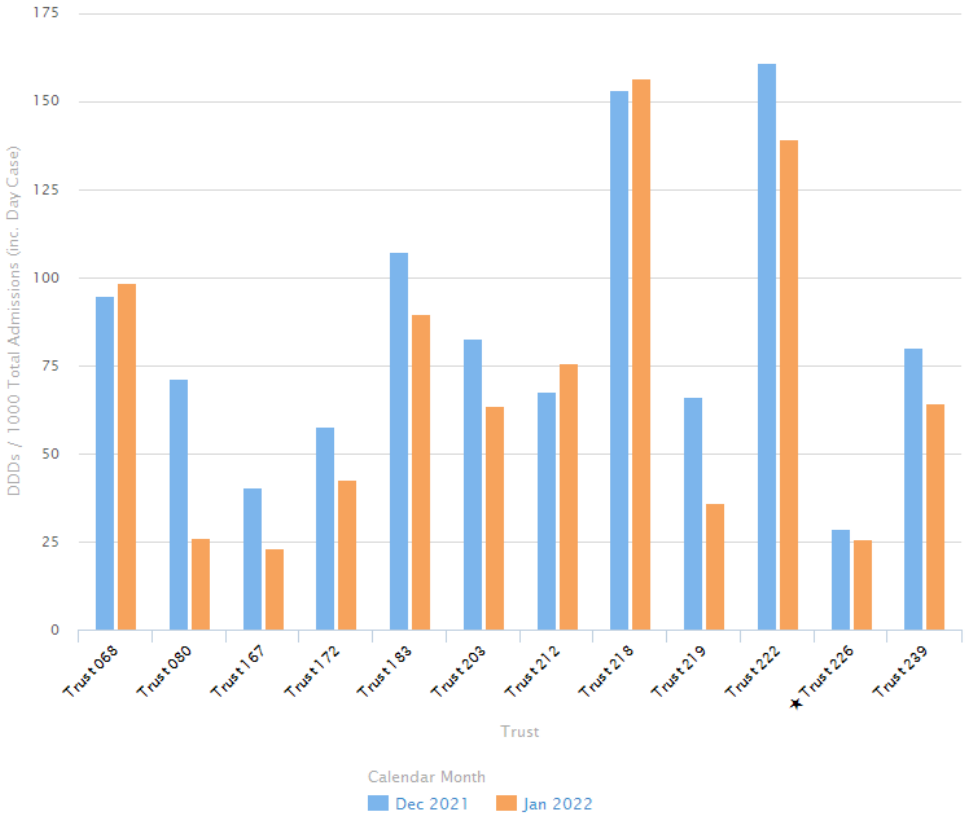



The total monthly usage of IV co-amoxiclav across the Trust - starting 01/04/18
6,500
6,000
5,500
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
PCT testing on acute med
Mean
C
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


The total monthly usage of Carbapenem across the Trust - starting 01/04/18
1,400
1,200
1,000
800
600
400
200
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Mean
C
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Filter Summary

Date Range: Dec 2021 - Jan 2022. **Trusts**: SHA - Similar Type. **Drugs**: ATC: J01DH - Carbapenems. **Specialties**: CQUIN Preset (243 of 249). **Prescription Types**: Day Case, Discharge/TTA, Homecare, Inpatient, Inpatient - Service, Mix of In and Outpatient, Outpatient, -Unknown-. **Other Filters**: Include transactions with '0' Cost



The Trust consistently featured amongst the lowest users of carbapenems (DDDs/1000 admissions incl. Day Case) in the region throughout 2021/2022.

The AMST priorities for 2022/2023 are outlined in the current annual strategy (Appendix 2).

6.3. Water Safety group

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

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

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

- Ensure the Water Safety Plan is reviewed.
- Review and action risk assessments and other associated documentation.

- Review new builds, refurbishments, modifications and equipment and ensure they are designed, installed, commissioned and maintained to the required standards.
- Ensure maintenance and monitoring procedures are in place.
- Surveillance of environmental monitoring, specifically in respect of determining water sampling requirements and agreeing location of augmented areas.
- Ensure augmented units within the Trust are tested monthly and results are reviewed and actioned as required. The remit will include all elements as per Section 6.9 of Health Technical Memorandum 04-01 Part B 2016.

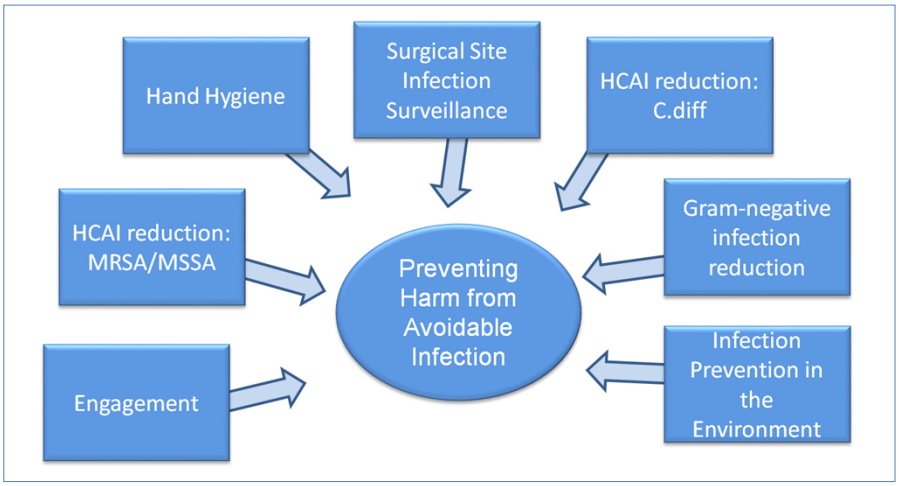
6.4. Assurance Framework for Infection Prevention and Control

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

7.0 Annual work plan 2021-2022

An annual work plan runs throughout the financial year; it is prepared by the IPCT, agreed each year by the IPCC and approved by the Board. The programme for 2022-2023 can be found in appendix 4.

The annual programme for 2021-2022 had a set of strategic objectives which linked to the Hygiene Code:



Each strategic objective and actions has been reviewed to assess progress and objectives for the 2022-2023 programme.

7.1 Annual Programme 2021-2022 Strategic Objective: Hand Hygiene

Most health care associated infections are preventable through good hand hygiene practices. The IPCT continue to promote hand hygiene standards throughout their programme of work and delivered an updated hand hygiene campaign during May 2021 to coincide with the World Health Organisation Hand Hygiene Day. This was combined with promotion of personal protective equipment with a particular focus on the Glove Aware campaign. This was delivered in collaboration with the Occupational Health Team to ensure the messages promoting reduction of glove use

included the importance of skin health in health care workers in addition to messages of sustainability in preventing transmission of infection.

Hand hygiene audits are completed by the IPC team every quarter and reported to the IPCC. The observations last between 5 and 20 minutes and ward staff are not made aware the observations are being completed. These observations are a snapshot of practice and may vary depending on workload, staffing levels, staff present in the department and number of staff observed. It can be difficult in some areas to observe whether hand hygiene takes place prior to or during some procedures and therefore observations are based on easily observed practice.

Audits throughout the financial year demonstrated sustained standards of hand hygiene amongst staff groups following educational campaigns from the IPC team and departmental level support provided. For the last three quarters, continuous improvement has been observed during hand hygiene audits.

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

Comparison of Compliance scores from IPCT audits

	Mar 2021	June 2021	Sept 2021	Dec 2021	Mar 2022
All Doctors	72%	86%	82%	86%	93%
Registered nurses	84%	90%	88%	88%	91%
Clinical support workers	85%	87%	91%	95%	95%
Students and cadets	69%	82%	84%	100%	93%
Other Staff	87%	99%	93%	94%	97%
Overall Trust score	**81%**	**89%**	**87%**	**91%**	**94%**

7.2 Annual Programme 2021-2022 Strategic Objective: MSSA/MRSA Reduction

The IPC team provided education across clinical areas during quarter two to prevent infections associated with indwelling devices. This included developing newsletters to teach staff on aseptic technique and best practice with indwelling devices and working with the Trust's FORCE team to build on existing training packages. Further information on MRSA/MSSA HCAIs is detailed in section 8 of the report.

7.3 Annual Programme 2021-2022 Strategic Objective: Surgical Site Infection Surveillance

During Quarter three, a surgical site infection improvement group was commenced for the Trust, being chaired by a trauma and orthopaedic consultant. This

demonstrates a comprehensive review of NICE guidance and the One Together Framework by the IPC team and leads to quality improvement projects to improve patient outcomes. Outcomes of the group are presented to the IPCC. The surgical division also introduced a surgical site infection surveillance nurse to support with their improvement projects, supported by the IPC team. Further details on surgical site infection can be found in section 8 of the report.

7.4 Annual Programme 2021-2022 Strategic Objective: C.diff reduction

Themes from C.difficile post infection reviews are articulated from divisions at IPCC to share learning. Antimicrobial stewardship reports are shared monthly at IPCC, demonstrating improvements in all elements throughout the financial year.

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

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

Since focus work on improving identification of patients presenting with potential infectious diarrhoea, there has been an increased trend of PCR cases identified, highlighting the great progress made in rapid identification and patients receiving prompt, optimum treatment to prevent toxin cases. All C.diff toxin cases have not been linked and therefore not representative of transmission within the healthcare setting. A significant theme on reviews is justified antibiotics which will lead to a more in depth review by IPCT to look into further syndromic interventions to prevent infections leading to antibiotic use.

The post infection review tool and educational resources have been shared at the IPC National shared decision making council as an example of best practice.

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

7.5 Annual Programme 2021-2022 Strategic Objective: Gram-negative infection reduction

Focussed work is being undertaken by the IPC team to support reduction of syndromic infections following the point prevalence study in June 2021. The highest priority is producing a business case for a mouth care matters team to prevent the incidence of hospital acquired pneumonia, the largest system infection identified in the study. Progress with this has been delayed due to the IPC team responding to the Omicron variant of COVID-19 during quarter three-four.

A Senior IPCN for the community division is currently undertaking quality improvement work with community services to reduce the incidence of urinary tract infections (UTI), including effective diagnosis of UTI and projects to reduce the

incidence of catheter associated UTIs. A procurement project is due to be commenced on the use of new catheterisation packs, aiming to maintain asepsis and prevent breaches in asepsis through contamination of key parts. Further details of Gram-negative infections can be found in section 8 of the report.

7.5 Annual Programme 2021-2022 Strategic Objective: Infection Prevention in the Environment

Refurbishment plans of the West Wing commenced in June 2021 to improve standards of the health care environment. Four wards have been completed and four more are due to commence in spring 2022. An NHSEI visit was undertaken at the Trust in December 2021; the overall rating for the Trust has changed from "Red" to "Amber" recognising the significant environmental improvements as part of the refurbishments.

In September 2021, the Trust Environmental Control Group was launched, chaired by Head of Facilities and with representation from estates, facilities, matrons, patient experience and IPC. This group strives for high standards of cleanliness and environmental IPC management and papers from the group are shared with the Infection Prevention and Control Committee. Since commencement of the group, escalation of logged jobs and prompt responses have improved.

The procurement of segregation pods for the Manor Hospital was successful during this financial year, with plans of installation of nine pods during the new financial year. This will improve opportunities to safely segregate patients with different infections.

The IPC team have provided education and support to clinical areas in improving standards of ventilation as a strategy to prevent nosocomial transmission of COVID-19 and other respiratory pathogens. This includes monitoring of window opening for 10 minutes every hour and the use of air disinfector units in areas without formal mechanical ventilation. IPC have developed a proposal with estates for the purchase of HEPA filtration units as part of a long term plan to improve air quality and ventilation improvements have been incorporated into the refurbishment plans. 134 units were approved for installation in the new financial year. The IPC team have also been providing resources for every patient bed space to promote the precautions in place to keep them safe from COVID-19 and includes how ventilation has an important role in this.

7.5 Annual Programme 2021-2022 Strategic Objective: Engagement

Members of the IPCT fit into the Trust divisional structure to provide support and continuity in improvement cycles, developing key working relationships to support improvement. The IPC nurses were recently praised during the NHSEI infection prevention review, highlighting that for every hour, the IPC team were spoken highly of for their support and leadership.

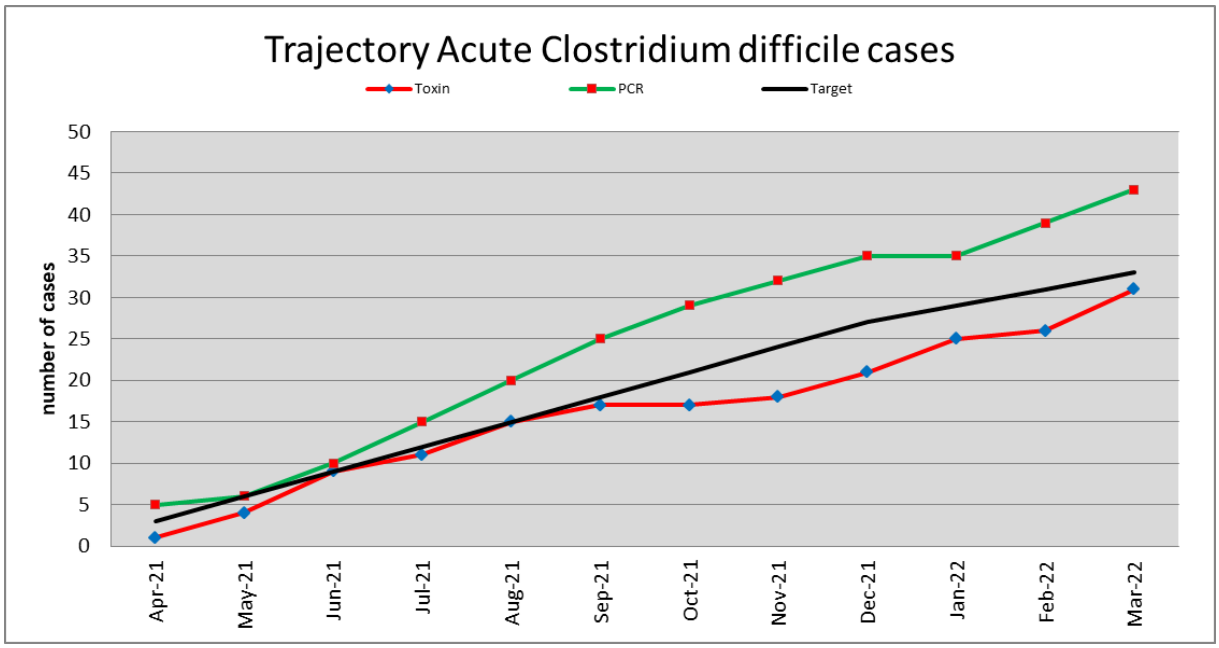
In June 2021, the IPCT launched "IPC Heroes of the month" to celebrate individuals who had been recognised for excellence with infection prevention practices.

8.0. Hospital acquired infections

Each year, the Trust is set objectives from NHS England and Improvement for health care associated infections. The financial year 2021-2022 introduced for the first time a target on Gram-negative bacteraemias, including Klebsiella, Pseudomonas and E.coli. Details of the Trusts performance against the targets set and further local surveillance data for HCAIs can be found in the following section of the report.

8.1. *Clostridioides difficile*

The graphs below identify *Clostridioides difficile* hospital attributed toxin positive specimens at Walsall Healthcare NHS Trust between April 2021 and March 2022.



The Trust carries out reviews of all Trust apportioned *C.difficile* cases and a multidisciplinary review is undertaken to investigate cases where new lessons can be learnt. These are reported to the divisional quality meetings and at IPCC.

Between April 2021 and March 2022 there have been 31 cases confirmed of acute *C.difficile* Toxins against annual trajectory of 33.

Total Acute Toxin cases	31
Avoidable	5
Unavoidable	26

Avoidable cases

- 2 inappropriate acute prescribing of antibiotics with failure to review therapy
- 2 community onsets with delay in obtaining specimen, leading to meeting acute acquired criteria

- 1 case community prescribed antibiotics

Common Trends in Risk Factors

- Multiple antibiotics in last 6 weeks
- Over 65 years of age
- Prescribed Proton Pump Inhibitor (PPI)
- Previous history of *C.difficile*

Trend issues and learning in the Trust from avoidable cases

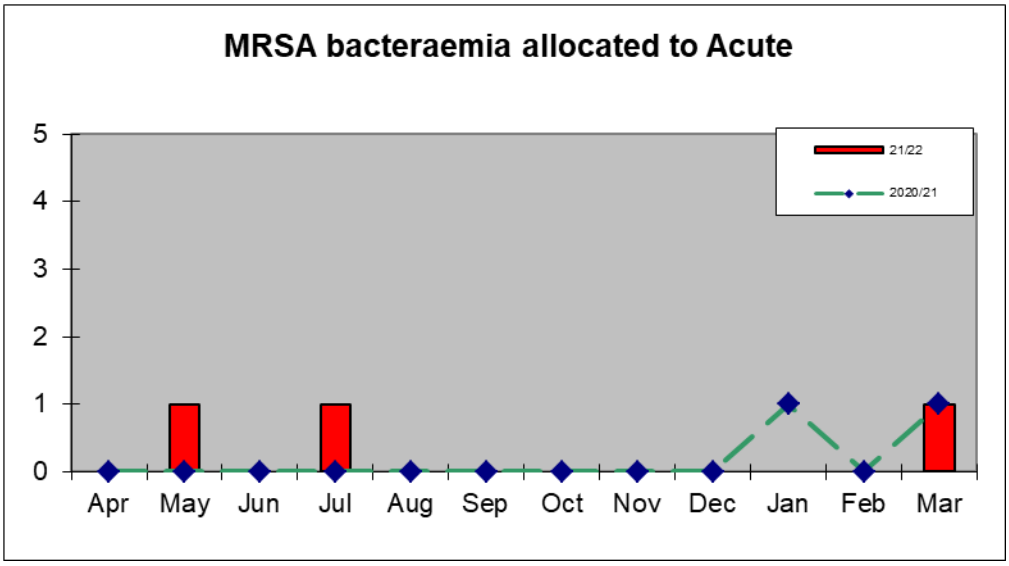
- Delay in sending specimens for *C.difficile* testing
- Failure to isolate patient when specimen was obtained (due to unavailable isolation facilities, these are captured in incident reports).
- Failure or delay in sending clinical specimens to confirm correct antibiotic therapy / confirmation of infective organism
- Inconsistent review of antibiotic therapy

Actions that have been taken to address the issues have included:

- Feedback of learning to divisions
- Ward based education
- Antimicrobial Stewardship promotion
- Daily side room reviews by IPCT and clinical areas
- Capacity team access to ICNet isolation reports
- Planned increase in side room availability using installation of segregation pods

8.2. Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

There were 3 cases of MRSA bacteraemia (blood-stream infection) attributed to the Trust during 2021-22 against a National target of 0.



Root causes

Case 1 – Infected Peripherally Inserted Central Catheter (PICC) line
Case 2 – Contaminated blood culture
Case 3- Delay in obtaining blood cultures on presentation of sepsis

Case 1 identified a health care associated infection acquired as a result of indwelling device care. Cases 2 and 3 whilst meeting definition for reporting on review were not hospital acquired infections but with key learning identified to prevent future incidents.

Learning points

- Need to reduce incidence of blood culture contamination through education, retraining, competencies (undertaken in 2021-2022 annual programme of work).
- Improve care and monitoring of intravenous devices.
- Need for review of vascular access policy
- Improvement work on requirement to obtain blood cultures urgently when sepsis is suspected to support optimum treatment for the patient.

Actions taken

- Education provided across clinical areas including "focus of the month" campaign on MRSA.
- Blood culture task and finish group including competency framework for obtaining blood cultures and updated educational package.
- Collaborative working with the Trust's new sepsis team and communications cascaded on best practice with blood cultures.

8.3. Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

A total of 6 hospital associated cases were reported in 2021-2022 compared to 11 reported in 2020-2021.

This represents a reduction of hospital cases by 5 in this financial year

There were no local or national mandatory reporting trajectories for MSSA during 2021/2022 and the Trust set its own internal target.

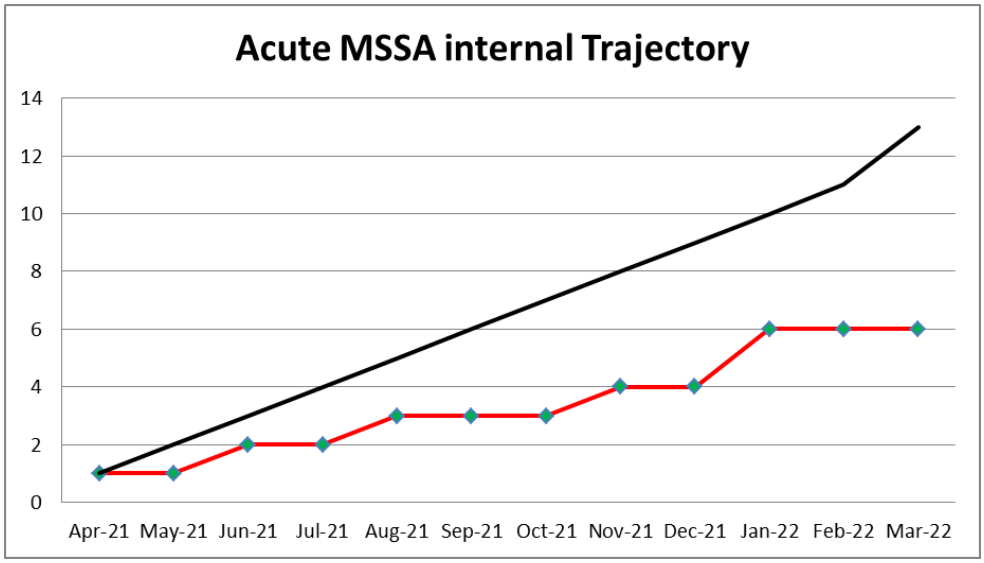
The Infection Prevention & Control Team aims to maintain low rates of MSSA and investigate all cases to ascertain if there are further actions that can be taken. Performance of MSSA bacteraemia continues to be monitored at the Infection Prevention and Control Committee.

All cases are reviewed on an individual basis to identify the cause and if there are any lessons to be learnt.

2 of the reported cases in 2021-2022 were reported as avoidable and 4 unavoidable.

Root cause of avoidable cases:

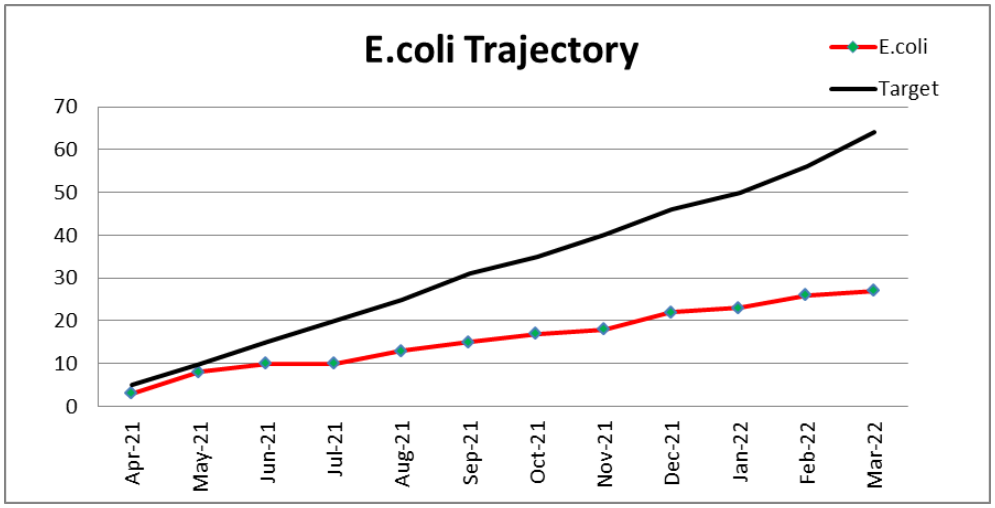
- 1 infected peripheral vascular device
- 1 related to urinary catheter



8.4. E.coli bacteraemia

Reporting of E.coli bacteraemia has been mandatory since June 2011. All cases are reviewed and a table top review completed if the patient dies and E.coli is indicated as a cause of death or areas of concern are identified during the review.
The national Target for the Trust was 64 for 2021-2022

There were a total of 27 hospital attributed cases of *E.coli* bacteraemia in 2021-2022 compared to 31 in 2020-2021; a reduction of 4 cases. All cases are reviewed on an individual basis regarding cause. If there are any lessons to be learnt including whether these could have been avoided, these are shared across the Trust.

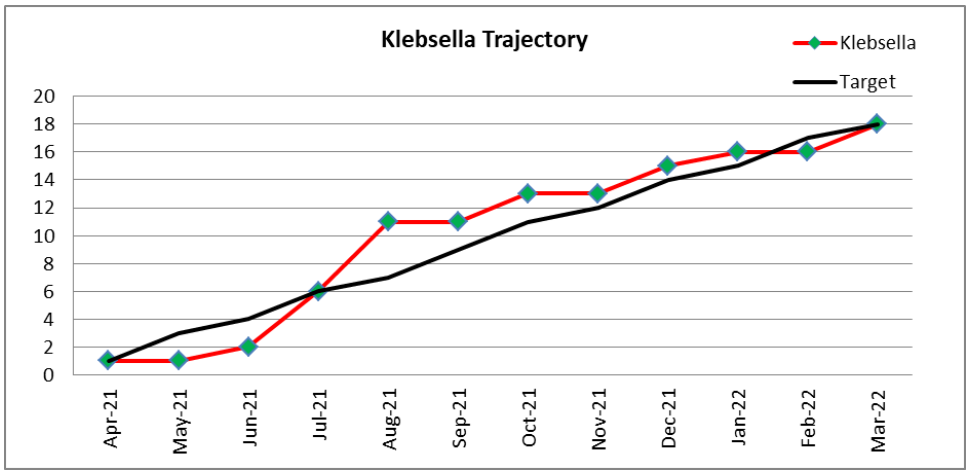


8.5. Klebsiella species

Reporting of Klebsiella Species bacteraemia has been mandatory since April 2017 a national target for the Trust in 2021/2022 was 18.

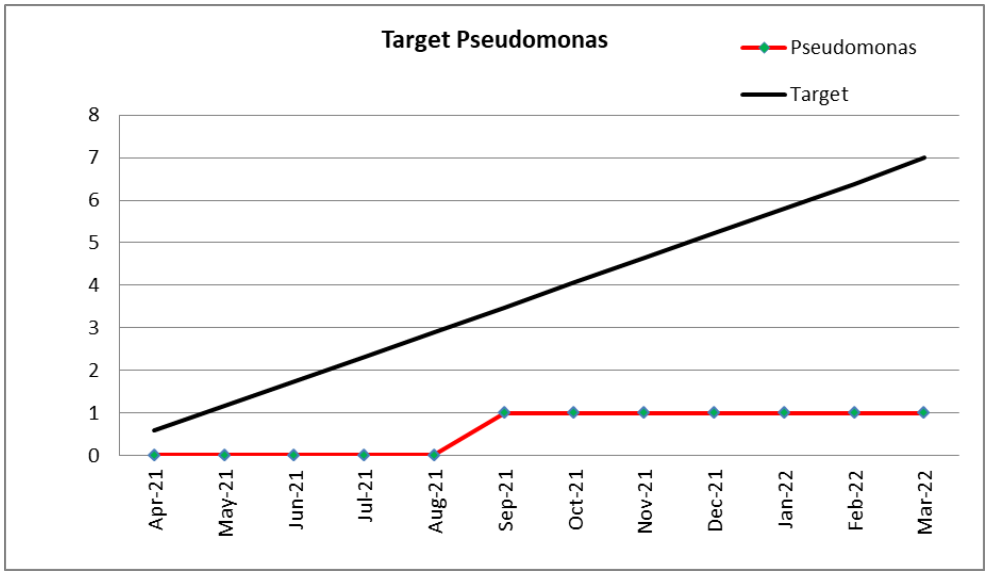
During 2021/2022 the Trust reported 18 acute cases compared to 2020/2021 when 15 cases were reported

All cases are reviewed and a table top review completed if the patient dies and this organism is indicated as a cause of death or areas of concern are identified during the review.
The increase in July and August was investigated to check for any links between cases, outcome of investigation was that cases were not linked.



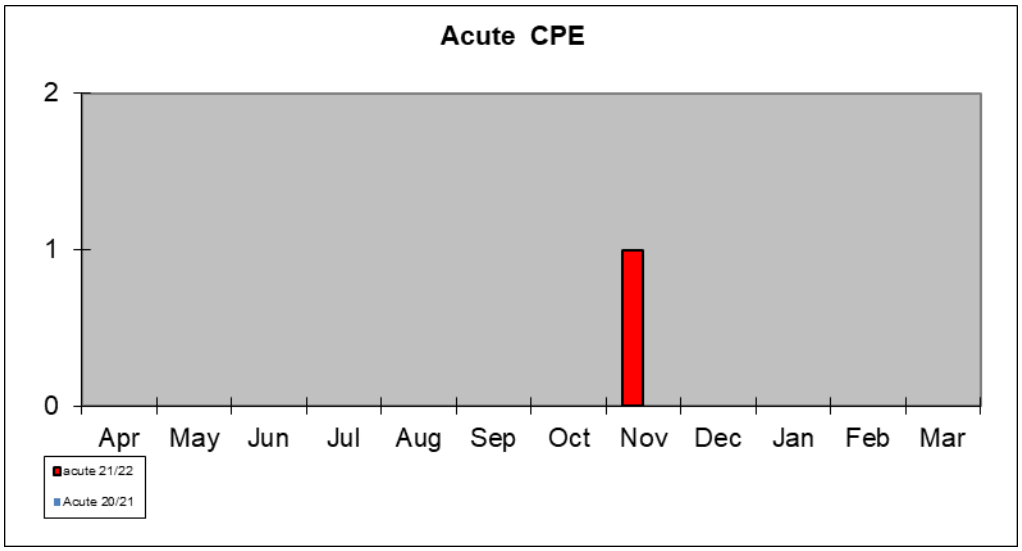
8.6. Pseudomonas

Reporting of Pseudomonas aeruginosa bacteraemia has been mandatory since April 2017 and the national target for 2021/2022 was 7.
A total of 1 case was reported in 2021/2022 compared to 8 cases reported in 2020/2021. The proactive work of the Water Safety Group helps to support prevention of Pseudomonas bacteraemias.



8.7. Carbapenemase-producing Enterobacterales (CPE)

CPE can spread rapidly in healthcare settings and lead to poor clinical outcomes due to limited therapeutic options. Increased incidence of CPE has significant cost and operational implications for healthcare providers. The Trust closely monitors for CPE by undertaking screening based on risk factors to promptly identify and isolate patients who are colonised with the organism.
There was 1 acute CPE case reported during 2021/2022 compared to 0 cases in the previous year. The IPC team introduced an updated CPE policy this year to reflect changes in national guidance, increasing screening requirements for at risk patients.



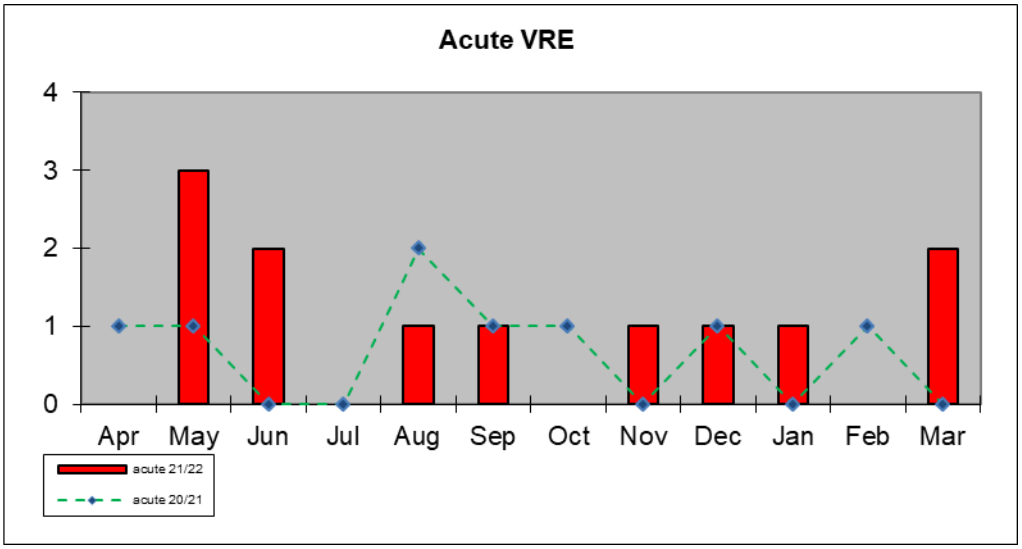
8.8. Vancomycin Resistant Enterococcus (VRE)

Enterococci are intrinsically resistant to many antibiotics and treatment options are always limited, usually being sensitive to Amoxicillin, Teicoplanin and Vancomycin and a few other reserve antibiotics.

Sometimes Enterococci develop resistance to these first line antibiotics. VRE stands for Vancomycin Resistant Enterococcus and this usually denotes that the organism isolated has developed resistance to Amoxicillin, Teicoplanin and Vancomycin. Glycopeptide Resistant Enterococcus (GRE) is another term used as Teicoplanin and Vancomycin are classed as Glycopeptide antibiotics. With subtle technical differences, the two terms amount to the same thing and are often used interchangeably.

As infections caused by these organisms are difficult to treat requiring 2nd or 3rd line antibiotics, and because of the potential for environmental contamination and nosocomial transmission they are regarded as an Infection Control priority. Rapid identification of patients carrying VRE within the Trust and imposition of comprehensive infection control barriers/ precautions is therefore essential. The

Trust monitors patients with a previous history by screening and isolating on a new admission to hospital.
There were 12 acute VRE cases reported during 2021/2022 compared to 8 cases in the previous year



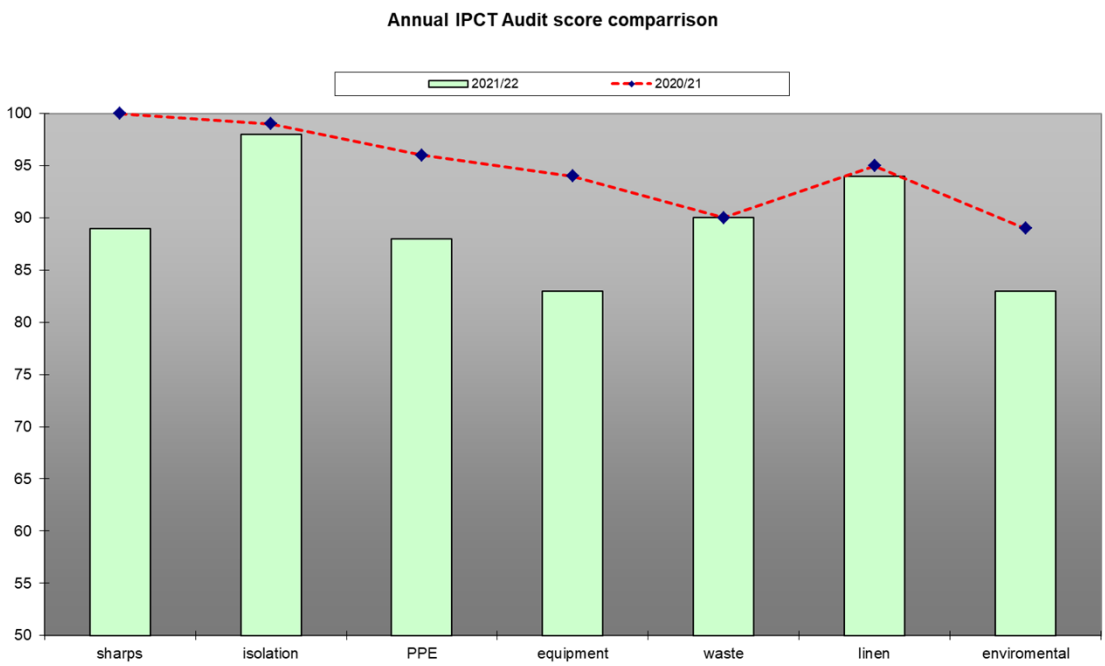
9.0 Acute Services Infection Prevention audits

The following infection prevention environmental audits were undertaken during quarter one of 2021/2022 covering the Manor Hospital site. A comparison to similar audits undertaken during the previous year is provided in the table below.

Audit results are shared with Heads of Service and are reported to and discussed at Infection Prevention and Control Committee and Divisional Quality team meetings.

Any non-compliance is fed back to the area at the time of audit. These annual audits are in addition to the monthly observational audits for all ward areas which were undertaken by the Infection Prevention & Control Team throughout the year in conjunction with Matrons.

Audit	2021/2022	2020/2021	Trajectory
Sharps	89	100	↓
Isolation	98	99	↓
PPE	88	96	↓
Patient Equipment	83	94	↓
Waste	90	90	→
Linen	94	95	↓
Environmental	83	89	↓



Since completion of these audits, escalation occurred through IPCC and captured in reports to the Trust board through the IPC BAF to improve environmental issues identified in the audit. Since this, four ward refurbishments have been completed with a plan for further refurbishment in 2022-2023 financial year. Senior Nursing staff have also undertaken a robust action plan to improve standards of IPC in their clinical areas. The NHSEI visit undertaken in December 2021 had highlighted improvements in the environment, changing the Trust from a "red" rating to an "amber" rating, with plans to revisit the Trust in summer 2022. The IPC team will undertake full environmental audits in spring 2022 and share feedback through divisional teams, divisional meetings, the Trust environmental control group and IPCC.

10. Viral outbreaks of Infection

The IPCT recognises and responds to any significant episode, incident or outbreak of infection. Incidents and outbreaks may be reported in several different ways: by the clinical areas, through microbiology results and IPC visits to the ward. All outbreaks and incidents are included in the IPCT monthly reports and reported via the Infection Prevention and Control Committee.

Outbreaks of Healthcare Associated Infection are reported via the Trust's incident reporting arrangements as serious incidents. An outbreak report is also prepared for the Infection Prevention and Control Committee for significant outbreaks to ensure any relevant lessons are learnt. An outbreak committee is convened to manage and monitor the situation.

Outbreaks of infection, for example Norovirus, influenza or periods of increased incidence of *Clostridium difficile* are classified as serious incidents and reported on the serious incident reporting system STEIS. A full investigation and 50 day report is subsequently submitted.

Norovirus
5 ward closures and 12 bay closures due to Norovirus.

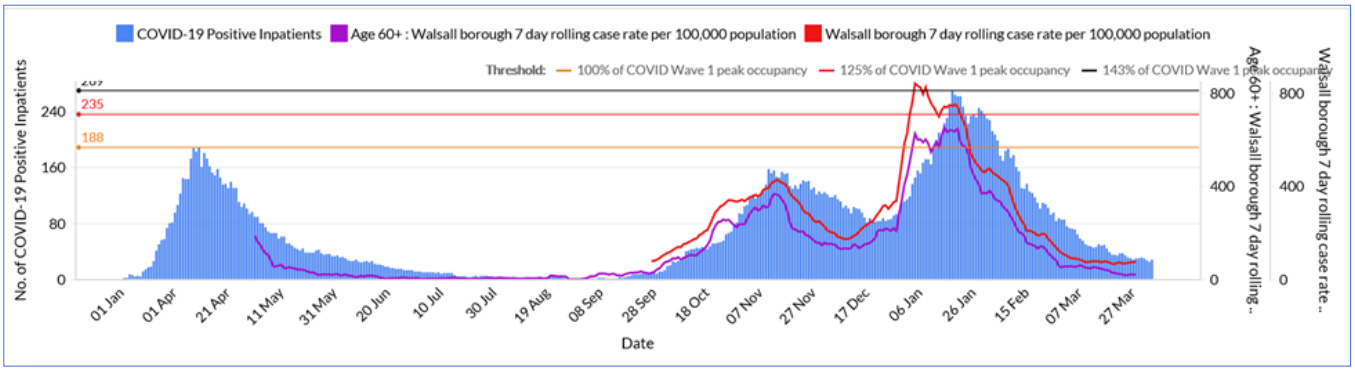
Learning from Norovirus outbreaks included:

- A reinvigoration of public messaging due to a focus on COVID-19 precautions and vigilance with symptom checking but not for potential symptoms of Norovirus.
- Education to clinical staff to reiterate measures required to prevent transmission of Norovirus and to consider Norovirus in testing when a patient presents with symptoms.

Influenza
No closures due to influenza.

COVID-19
12 ward closures due to outbreaks and 190 bay closures for contact monitoring

The Trust followed National guidance regarding precautions that needed to be taken to prevent the spread of the virus. The infection prevention and control team increased the service by providing additional cover over weekends. The IPC team supported the Trust and clinical areas with management of patients, providing data required for the National Sitrep and attending tactical meetings (both in the acute and the Community), responding to actions required accordingly.



Compliance with standards to prevent transmission of COVID-19 is monitored by the Infection Prevention and Control Team by undertaking assurance audits of practice in different Walsall Healthcare settings based on the standards set out in updated National guidance. A full review of COVID-19 precautions is undertaken through the IPC BAF and this is presented monthly to IPCC. Items for escalation from the BAF are reported to QPES.

11.0. Surgical Site Surveillance

In 2004 it became a mandatory requirement for all Trusts undertaking orthopaedic surgery to conduct surveillance of surgical site infections, using the Surgical Site Infection (SSI) Surveillance Service of Public health England, (PHE). The data set

collected as part of the surveillance is forwarded to Public Health England (PHE) for analysis and reporting. Surveillance is divided into reporting quarters (Jan-Mar, Apr-Jun, July-Sept and Oct-Dec) and each site is required to participate in at least one surveillance period every 12 Months in at least one orthopaedic category.

In 2021/2022 the Trust completed one quarter mandatory SSI surveillance.

Reporting Period: October 2021 – December 2021
Modules completed: Total Hip Replacements and Total Knee Replacements.

Operation	**Total no of cases**	**Surgical Site infections**
Total knee replacement	26	0
Total hip replacement	28	0
Total	**54**	**0**

12.0 Education

Education remains a core element of the work of the Infection Prevention & Control Team in both hospital and community settings.

2021-2022 continued to be a challenging year for training provisions due to COVID 19: induction and mandatory training continued via e-learning modules as face to face teaching sessions were reduced to support social distancing measures.

The IPCT contribute to the Trust Induction and mandatory updates and a range of planned and bespoke education sessions whenever a specific need arises. These included junior medical staff inductions, sessions for medical and nursing students and intravenous line care.

The team delivered a “Focus of the month” campaign of part of the annual programme of work which includes educational sessions face to face in clinical departments. The following topics were covered:

- Hand Hygiene
- Glove Awareness
- Norovirus awareness
- Water safety
- “Bell for Clinell”- a campaign to promote routine cleaning of surfaces in clinical areas in addition to existing decontamination standards
- Fundamentals of IPC
- Aseptic technique
- C.difficile
- MRSA
- Peripheral vascular device care
- Outbreak management

Appendix 1

INFECTION PREVENTION AND CONTROL GROUP

TERMS OF REFERENCE: Version 2 – Reviewed June 2021

RATIFIED BY THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE ON: July 2021

NEXT REVIEW DUE: June 2022

1. CONSTITUTION

1.1 The Quality, Patient Experience and Safety Committee hereby resolve to establish a sub group of the Committee to be known as the Infection Prevention and Control Group (The Group). The Group is an executive group of the Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. PURPOSE

2.1 The purpose of this group is to provide strategic direction for the prevention and control of Healthcare Acquired Infections in Walsall Healthcare Trust. It will performance manage the organisation against the Trust's Infection Prevention and Control Strategy and will ensure that there is a strategic response to new legislation and national guidelines. In addition the committee will seek assurance from the divisions and ensure compliance with the Health and Social Care act.

3. MEMBERSHIP

3.1 The Group will comprise:

- Medical Director / Director of Infection Prevention and Control (DIPC) (Chair)
- Director of Nursing or Deputy
- Head of Infection Prevention (Deputy Director of Infection Prevention)
- Infection Prevention Team Members
- Consultant Microbiologists
- Divisional Directors of Nursing
- Allied Health Professional Representative
- CCG Lead for Quality
- Public Health England representative
- Director of Public Health or Deputy
- One representative from Local Authority
    - Health Protection Nurse
    - Public Health Consultant
- Divisional Directors of Nursing & Midwifery (Acute & Community) – Walsall Healthcare NHS Trust

- Antimicrobial Pharmacist
- Occupational Health Service Manager
- Divisional Director Estates & Facilities
- Health and Safety Officer
- Decontamination Lead

4. ATTENDEES

4.1 The Group Chair may extend invitations to attend Group meetings to any individual considered appropriate to progress the work plan of the Group.

5. ATTENDANCE

5.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy must be identified for core members of the Group and must attend when a member is unable to be present. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.

6. QUORUM

6.1 A quorum will be a minimum of seven representatives of which one will be an Executive Director from the Trust, one a member of the Infection Prevention and Control Team and a Consultant Microbiologist.

7. FREQUENCY OF MEETINGS

7.1 The Group will meet formally on monthly basis. Meetings will be expected to last no more than 2 hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Group may be called by any member of the Group, with the consent of the Chair.

8. CHANGES TO TERMS OF REFERENCE

8.1 Changes to the terms of reference including changes to the Chair or membership of the Group are a matter reserved to the Trust board.

9. ESTABLISHMENT OF SUB GROUPS

9.1 The Group may establish sub groups made up wholly or partly of members of the Group to support its work. The terms of reference of such sub group will be approved by the Group and reviewed at least annually. The Group may delegate work to the sub group in accordance with the agreed terms of reference. The Chair of each sub group will be expected to provide a Chairs report to the Group and review its effectiveness on an annual basis.

10. ADMINISTRATIVE ARRANGEMENTS

10.1 The Chair of the Group will agree the agenda for each meeting. The Group shall be supported administratively by the EA to the Director of Nursing who's duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the action notes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Group on pertinent issues / areas
- Enabling the development and training of Group members

All papers presented to the Group should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Group.

11. ANNUAL CYCLE OF BUSINESS

11.1 The Group will develop an annual cycle of business for approval by the Committee meeting at its first meeting of the financial year. The Group work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.

12. REPORTING TO THE COMMITTEE

12.1 The Chair of the Group will provide a highlight report monthly to the Committee outlining key actions taken with regard to the patient safety issues, key risks identified and key levels of assurance given.

13. STATUS OF THE MEETING

13.1 All Groups of the Committee will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Group.

14. MONITORING

14.1 The annual report on assurance will provide a statement that enables the Group to monitor the effectiveness of the Group. This will include levels of attendance, delivery against the forward looking work programme and the management of identified risk.

15. DUTIES

- To develop an Annual Work Plan in the agreed Trust format, denoting the objectives of the Group for approval by the Committee ensuring these are aligned with the Trust's vision, strategy and values and the relevant risks contained in the Board Assurance Framework.
- To identify any risks and issues that may prevent the achievement of the Work Plan and ensure that they are assessed and placed on the Trust's Risk Register and the action plan is monitored and mitigating actions are undertaken to ensure progress is made.

- Strategic responsibilities include the development of a strategic plan for the reduction of healthcare acquired infections and will performance manage the delivery of that strategic plan.
- Approve, review and monitor the Infection Prevention and Control Team's annual programme of work/Code of Practice for Healthcare Associated Infection Action Plan.
- Receive and approve the Infection Prevention and Control Annual Report in the first quarter of the following year prior to submission to the Committee and Trust Board.
- Receive advice from the Infection Prevention and Control Team on new national policy and guidance and its implementation within the organisation, highlighting potential areas of non-compliance.
- Address outstanding areas of non-compliance with national standards and requirements (e.g. CQC/Hygiene Code) and advise the Committee and Trust Board/Executive Team as appropriate.
- Drive improvements through teaching and education to uphold standards in reducing HCAI, monitor SSIs and will have oversight of mandatory reporting
- Review and ensure adequacy of the Trust's Uniform policy.
- Ratify Infection Prevention and Control and Occupational Health policies prior to submission to the TMB.
- Seek assurance from quarterly and annual reports from each division on progress with the Infection Prevention and Control Annual Programme of Work/Code of Practice for Healthcare Associated Infection Action Plan and will monitor progress in implementing these plans.
- Seek assurance from reports from each division on performance against HCAI Key Performance Indicators (KPIs), and will monitor progress in achieving targets and delivering agreed actions.
- Seek assurance from reports from the Director of Infection Prevention and Control (DIPC) on the outcome of discussions following all HCAI Root Cause Analyses (RCAs) including receipt of the RCA Action Plan(s).
- Receive a monthly report from the Antimicrobial pharmacist, regarding antibiotic prescribing audits and performance.
- Receive exception reports on compliance with the National Specifications for Cleanliness (2004, revised in 2014). The Group will also receive the quarterly reports to QPES from the Matrons.
- Seek assurance reports from the Infection Prevention and Control Team against national and local HCAI targets, use of isolation facilities, trends of infectious diseases reported from CCDC and review the work plan of the IPC.
- Receive a highlight report and minutes of the Decontamination Group and reports by exception from the Chair of that Group in order to ensure that decontamination risks are appropriately escalated and managed.
- Receive the minutes of the Accidental Inoculation/Exposure Group and reports by exception from the Chair of that Group in order to ensure that inoculation / exposure incidents and risks are appropriately escalated and managed.
- Receive the minutes of the Water Safety Group and reports by exception from the Chair of that Group in order to ensure that issues are dealt with or escalated as appropriate.
- Receive and review analysis reports on Infection Prevention and Control incidents and make recommendations for further action as necessary and appropriate.

Version Control:

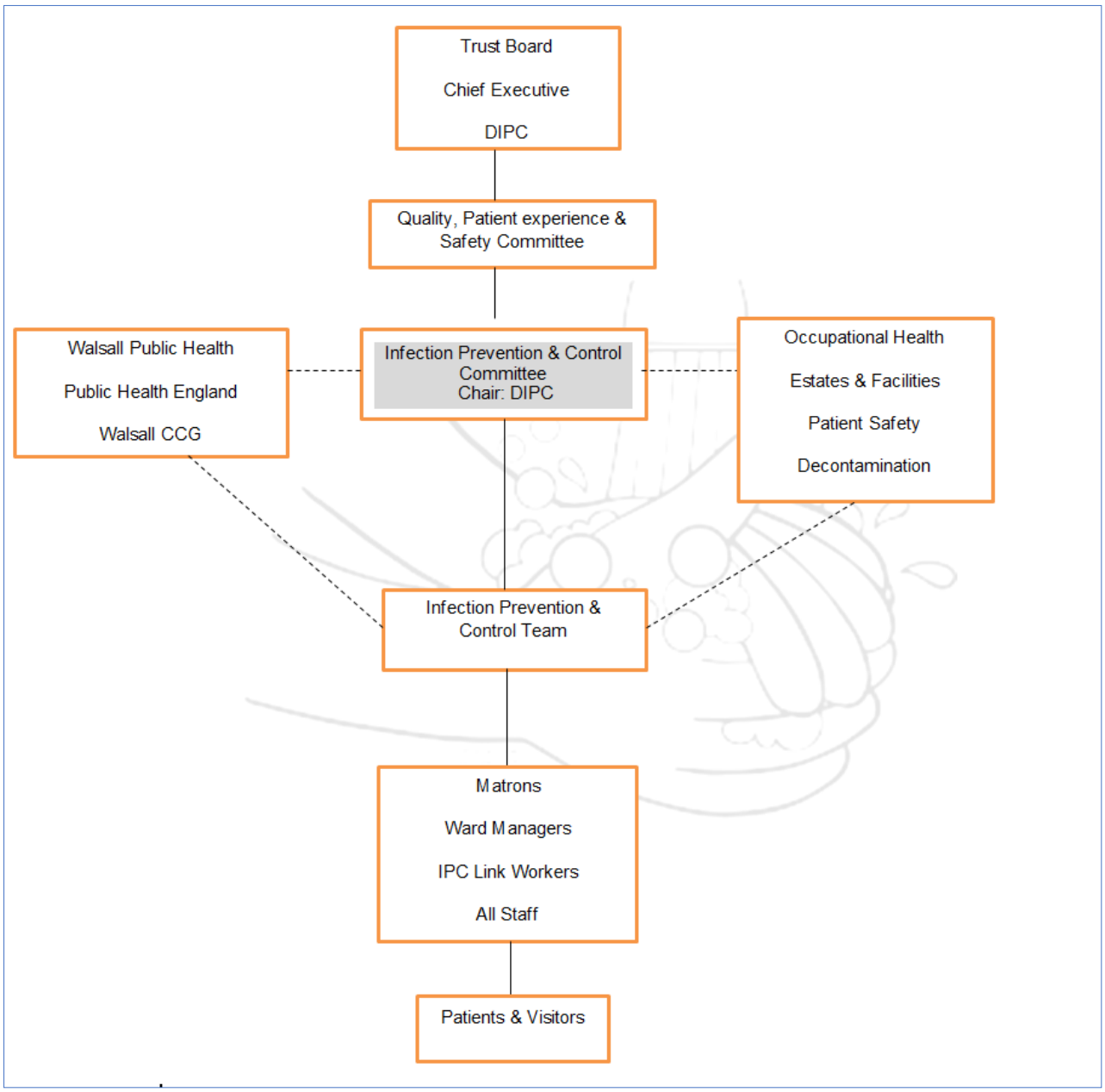
Version 2.0

Reviewed by QPES and approved July 2021.

Appendix 2

Antimicrobial Stewardship team 2022-23 strategy work plan	
Strategy	**Actions**
Recognition of responsible antimicrobial use	• Certificate of appreciation
Improved audit, feedback and benchmarking of antimicrobial use to clinical team	• Monthly point-prevalence audit
	• Feedback to clinical teams via monthly Medicines Management Group
	• Benchmarking via Antimicrobial Update presented to Infection Control Committee + Medicines Management Group • To achieve successful achievement of the UTI CQUIN
Teaching & training; Public engagement	• Regular rota of teaching to doctors in training
	• Grand Round presentations
	• Public campaign during Antibiotic Awareness Week
User-friendly antimicrobial formulary; Updated surgical prophylaxis guidance	• New revision to current antimicrobial formulary to be published
	• New revision to current surgical antimicrobial prophylaxis guidelines to be published
New evidence-based dose + duration recommendations	• Standard meropenem dosage: 500 mg IV q6h
	• Weight-based dosing instructions to be incorporated into antimicrobial formulary
	• Durations for antimicrobials to be limited to shortest possible duration on antimicrobial formulary
Better antimicrobial dosing for the sickest patients on ITU	• Introduce prolonged infusions of Tazocin, meropenem and temocillin for patients with septic shock on ITU
Quality improvement project: gentamicin use	• Review use of gentamicin dosing calculator
Empowered pharmacists, ready to make a change	• Educational update of pharmacists on improving antimicrobial prescribing, including IV-to-oral switch and avoiding unnecessary dual therapy
	• Resumption of Antimicrobial Pharmacist role following completion of secondment, due to maternity leave
An engaged & visible antimicrobial team	• Daily-to-weekly antimicrobial team ward-rounds for trouble shooting, audit, spot checks, education, etc.
A safe + reliable OPAT service	• Advance the service by launching Complex Outpatient Antibiotic Therapy (COpAT)
	• Maintain a safe OPAT service with adequate governance
New ‘discharge enabling’ antimicrobials	• Formulary application and laboratory testing of fosfomycin oral salts
Spotlight on ‘high risk’ antimicrobials: cephalosporins, quinolones, carbapenems, clindamycin, Tazocin	• Audit, feedback and restriction of cephalosporin use

Appendix 3 – Reporting Structure for IPCC



Walsall Healthcare NHS
NHS Trust

Infection Prevention and Control (IPC) Service

Annual Programme of Work April 2022 – March 2023

Introduction

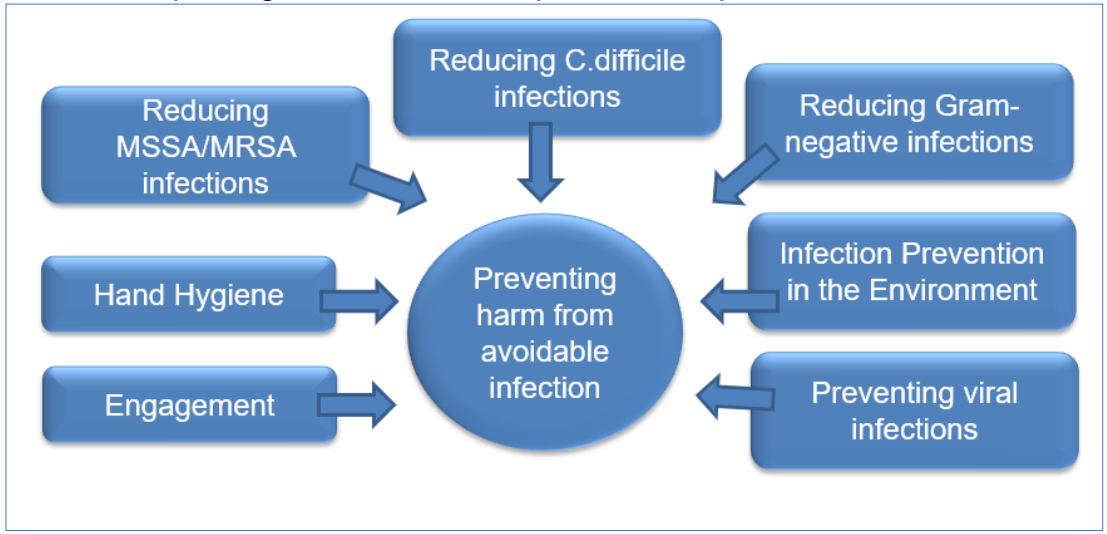
Infection prevention and control is a top priority for Walsall Healthcare NHS Trust. Keeping our patients safe from avoidable harm is everyone's responsibility. In this summary document we set out our programme for the year to keep our patients, staff and the public informed of our planned activity at Walsall Healthcare.
Each year the Infection Prevention & Control Team undertakes a review of the Trust's compliance with the Health & Social Care Act 2008 Code of Practice on the Prevention and Control of Infections (2015). The team's aim is to provide an infection prevention & control service that supports our clinical teams to deliver safe care. This annual plan covers strategic themes we have identified as areas of focus for the financial year 2022/2023. This annual programme of work for the year includes the annual plan, audit plan and our monthly themed focus plan. The programme also takes into consideration flexibility in approach whilst continuing to manage the COVID-19 Pandemic and related local actions required.

Vision

Our vision is to prevent harm from avoidable infection

Strategic themes

Our strategic themes in 2022/2023 focus on improving outcomes for our patients and provide a framework for our operational work plan.



Compliance with the Health and Social Care Act 2008 (updated 2015)

This programme will refer each operational objective to related compliance criterion within the Health and Social Care Act Hygiene Code.
The programme will be reviewed on a monthly basis by the Infection Prevention and Control Team and feedback on progress shared at the monthly Infection Prevention and Control Committee.

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Hand hygiene	**Produce and implement a multimodal hand hygiene improvement strategy.**	Develop a revitalised hand hygiene campaign in line with the World Health Organisation Hand Hygiene day and reduction of glove use as part of the Glove Aware Campaign.	**2, 6, 9**
		Collaborative work between Infection Prevention and Control and Occupational Health on reducing glove use in clinical practice to promote hand hygiene in the prevention of infection, supporting staff skin health and improving sustainability.	**6,9,10**
		Engage with colleagues in the organisation to understand perceived barriers towards hand hygiene to influence education of communication materials.	**6**
		Involve patients in improving hand hygiene whilst receiving care, utilising patient experience volunteers in encouraging use of hand wipes prior to meal times and encouraging to ask health care workers to clean their hands prior to contact with them.	**4**
		Infection Prevention and Control Team to undertake quarterly hand hygiene audits submitted to Infection Prevention and Control Committee.	**1, 6**

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: MRSA/MSSA	**Strong governance processes to embed learning from incidents of MRSA/MSSA bacteraemias**	IPCT to lead comprehensive post infection reviews for any MRSA bacteraemia and in the event of an MSSA bacteraemia associated with indwelling devices. Lessons learnt articulated through IPCC, divisional quality meetings and as a snap shot learning please for IPCT to educate clinical areas.	1, 6, 9
	Ensure patients are screened and effectively decolonised for MRSA when admitted to the Trust	Educating team to sustain standard for full MRSA screening (including additional specimen sites) for patients admitted on an emergency care pathway. Provide updated education on decolonisation and screening processes. Development of a SOP led by IPCT to ensure decolonisation regime is promptly prescribed and commenced.	1, 9 3 6
	Safe delivery of IV care	Review devices used within the Trust and standardise products based on current evidence base through the Trust's Clinical Product Evaluation Group. IPCT to continue to deliver a Trust education package on aseptic technique, incorporating IV access in the bundle. IPCT to continue support in delivery of IV training. Education and monitoring of standards of line care to prevent line infections, including clear indication for continued use of IV access, VIP scoring to frequency of 3 times a day and strong supportive evidence of aseptic technique in all aspects of insertion and ongoing care. Develop a business case to align service delivery of an IV Team with Royal Wolverhampton NHS Trust.	5 6, 9 1, 6, 9
Strategic Theme	Operational Objective	Action	Related Compliance Criterion

HCAI Reduction: C.difficile	**Strong governance and MDT processes to embed learning from incidents of C.difficile infections**	Review the process for ensuring that themes identified as part of the infection review process for C.difficile infections are shared at Infection Prevention and Control Committee and Divisional Quality Meetings. Deliver bespoke C.difficile education package in clinical areas for areas on an audit cycle.	**1, 6, 9**
	Monitor the treatment and IPC management of inpatients with a C.difficile infection	Undertake an MDT weekly C.difficile ward round, consisting of Consultant Microbiologist, Infection Prevention and Control Nurse, Antimicrobial Pharmacist and clinical team to review and advise on current patient treatment and infection prevention management within the setting. Review treatment options to prevent relapse cases of C.difficile and reduce risk of transmission. Explore options of Fidaxomicin as a first line treatment and faecal microbiota transplant for relapse cases. Expand competencies with the IPC nurses to support treatment pathways for C.difficile infection within the Trust.	**1, 3, 5, 6**
	Provide robust environmental controls to reduce risk of transmission associated with contaminated environment/equipment.	Explore environmental decontamination options for emergency portal areas to minimise environmental burden of pathogens (e.g. enhanced side room cleaning for all AMU discharges regardless of prior occupant infectious status). Any positive case of C.difficile in a clinical area (acute or community acquired) to be placed on an audit cycle by the IPCT to ensure immediate controls are in place to minimise risk of transmission.	**1, 2, 6, 9**

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: Gram negatives	**Reduce the incidence of Hospital Acquired Pneumonia (HAP) across health care setings.**	Present a business case for the development of a mouth care team across the Trusts, incorporating a clinical lead, specialist dental nurses and clinical support workers, providing comprehensive education, promotion of oral health and providing expertise for more complex oral health needs.	**1** **5, 6**
	Water safety measures to reduce inpatient acquisition of Pseudomonas/Legionella.	Continuation of water safety groups with reports circulated to Infection Prevention and Control Committee. Follow up process from Estates to review clinical area for any water interventions following a positive Pseudomonas case. Water safety captured and reported in the Trust environmental control group and Infection Prevention and Control Reports. Embedding the L8 Guard system across the Trust for assurance on water flushing measures.	**1** **2** **1, 6** **2**
	Strengthen the identification of CPE colonised patients to prevent nosocomial transmission.	Review the current microbiology laboratory process with BCPS for identification of CPEs, with a view to a more sensitive and quicker detection Monitoring use of updated CPE policy to include increase in screening criteria for at risk patient groups as per updated National Guidance. Conduct the UKHSA CPE point prevalence study to support National work to improve identification and management of CPE across all sectors.	**8** **5, 9**
	Deliver a strategy to reduce the incidence of Catheter Associated Urinary Tract Infection (CAUTI) across the health economy.	Input from Infection Prevention and Control in the Continence Steering Group to incorporate reduction of infection associated with catheters. Incorporate focus of the month in IPC education programme on UTI awareness and reduction strategies. Introduce catheter packs to support a closed system approach, improving standards of aseptic technique to prevent CAUTI.	**1, 6** **6** **5,6**

	Work across the health economy to strengthen Gram negative reduction	IPCT to work with collaborative Midlands IPC group to align approaches to Gram-negative infection workstreams.	**1, 5, 6**

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Infection Prevention in the Environment	**Monitor cleaning standards across Walsall Healthcare**	Monitor use of cleaning matrix and process at Walsall Manor Hospital through the Environmental Control Group to deliver effective decontamination of clinical environments following discharge/transfer of patients with different infections, including implementation of UV technology. Increase availability of UV and HPV technology to meet demand for higher level cleans. Work with facilities to develop a deep clean programme across the acute hospital. Estates and Facilities reports to continue to be submitted for review by the Infection Prevention and Control Committee. Develop and deliver an education campaign on the importance of cleaning in the prevention of HCAI as part of Focus of the Month campaigns. Infection Prevention audit programme for assurance of maintaining a clean, safe environment at Walsall Healthcare. Themes shared at Infection Prevention and Control Committee.	**2** **1** **2, 6, 9** **1, 2, 9**

	Improvement of the healthcare environment in Trust premises	Infection Prevention Environment Group feed into Infection Prevention and Control Committee to ensure a robust process of managing Infection Prevention in the built environment. Continue IPC representation for the Trust Water Safety Group. Infection Prevention team input through all stages of Trust refurbishment plans and purchasing of new equipment. Improve standards of indoor air quality for environments with sub-optimal mechanical ventilation with the installation of air disinfectors.	**1, 2** **2** **2**
	Increase isolation facilities to support increased demand for circulating infections	Infection Prevention involvement in refurbishment plans to incorporate increase permanent isolation facilities. Installation of 9 segregation pods across AMU and the modular block of the acute hospital.	**2, 7**

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Surgical Site Surveillance	Embed updated process for identification and surveillance of SSI	Utilisation of ICNet, Infection Prevention Team and surgical division SSI nurse to support identification and review of SSI cases. Increase ability to undertake SSI surveillance through the development of a business case for an SSI team within the IPC structure.	1, 5
	Standardise approaches to reducing SSIs through Trust wide SSI group	IPCT attendance and participation at the Trust SSI group. Collaborative working with the MDT to improve practice where learning has been identified. Implementation of antimicrobial sutures and temperature monitoring systems to improve patient outcomes following surgical interventions.	1, 6 2, 3, 6 1, 6, 9

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Engagement	Engage with divisions to support continuity in delivering infection prevention	Members of the Infection Prevention team to support a divisional structure to provide continuity of support to clinical area and build strong working relationships. Continue to attend bed bureau/capacity meetings regularly Engage with Departments and Divisions – working together as one IPCN to be a facilities link, providing updates to domestic services on a routine basis Deliver an awards programme to positively recognise contributions individuals make to infection prevention and control agenda	1,2,6,9
		IPCT to deliver the Infection Prevention Champion programme, with	1, 3, 5, 6, 9

	Strengthen the link practitioner/IPC champion programme	different methods for champions to access materials. Incorporate adaptable and flexible methods to support attendance to link meetings/updates. Report participation of Champions to IPCC.	
	Delivering an IPC service from highly skilled specialist nurses.	Develop close working relationship within the IPC team, with team educational lead to develop a robust "Thinking Thursdays" programme for IPC practitioners across the Trusts. IPC team to deliver nursing team development programme, supporting and developing new and existing members of the IPC team, creating a supportive environment for continuing professional development. Explore expanding competencies of IPCNs including non-medical prescribing.	**1,3,5,6,9**
	Engage the workforce in the infection prevention and control agenda	Ensure medical staff attend and engage in table top review meetings and antimicrobial stewardship Identify and attend medical forums to update on the IPC agenda and share learning Identify and engage IPC leaders across different medical specialities Deliver an IPC syndromic approach to engage the workforce, considering alternative options in education delivery including Webinar functions.	**6** **6** **6** **6**
	Engage patients in the infection prevention and control agenda	Participate in patient engagement forums to enable patient inclusion in the hand hygiene improvement strategy. Work with the "Ewe" volunteers to support patient engagement in clinical areas to encourage patient hand hygiene and increase patient awareness of standards to expect	**4**
Preventing viral	Embed lessons from the COVID-19 pandemic to prevent the incidence of nosocomial transmission of respiratory viruses.	Present a business case in collaboration with Occupational Health to strengthen support to Trust staff; including providing advice, supporting outbreak management staff screening, delivery of fit test training and delivering Influenza and COVID-19 vaccinations for Trust colleagues. Deliver debrief sessions following the incident of any viral outbreak.	**1,5,6,10**

infections		Robustly undertake reviews of the IPC BAF for assurance on controls to prevent risk of transmitting respiratory tract infections.	
	Deliver a preparedness strategy for other viral infections that could pose a risk to the healthcare setting.	Incorporate in IPC education preparedness sessions for Norovirus/viral infections depending on community prevalence of circulating organisms. Work collaboratively with EPRR for preparedness of other threats (e.g. presentation of viral haemorrhagic fever)	**1,5,6,10**

Annual audit plan

The table below shows audit plan for 2022/2023. In addition to this, the Infection Prevention and Control Team will undertake audits based on incidents or obtaining assurances on updated infection prevention guidance/policy.

Audit	Location	Plan	Related Compliance Criterion	Related Strategic Theme
Full ward audit	All inpatient wards	To be completed by August 2022	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene
Community audits	Community clinics and units	To be completed by October 2022	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene
Full departmental audits	Acute site departments	To be completed January 2023	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene
Ward kitchens	Inpatient wards	To be completed by March 2023	1,2,9	Infection Prevention in the Environment, Hand Hygiene
Support services cupboards	Inpatient wards	To be completed by March 2023	1,2,9	Infection Prevention in the Environment, Hand Hygiene
Hand hygiene	Acute site	Quarterly: June 2022 September 2022 December 2022 March 2023	6,9	Hand Hygiene, Invasive Devices
Compliance to wearing personal protective equipment (PPE)	Acute site	Quarterly: June 2022 September 2022 December 2022 March 2023	6,9,10	Hand Hygiene, Invasive Devices

Infection Prevention Focus of the Month

The below schedule highlights educational campaigns the Infection Prevention and Control Team plan to deliver across Walsall Healthcare. This is based on seasonal activity, local learning and existing recognised National campaigns.

IPC activity can be found on Trust communications including Daily Dose, Intranet pages and followed on Twitter by searching for @IPCWalsall.

Month	Focus	Month	Focus
April	Improving Indoor Air Quality	**October**	International Infection Control Week
May	Hand Hygiene and Glove Aware	**November**	Antimicrobial Resistance and Stewardship
June	Urinary Tract Infections	**December**	Winter Preparedness
July	MRSA	**January**	Winter Preparedness
August	IV Devices	**February**	Surgical Site Infections and Wound Care
September	Sepsis- HCAI Prevention	**March**	Spring into Cleaning

MEETING OF THE TRUST BOARD – 8th June 2022			
Audit Committee Annual Review of Activities Report			
Report Author and Job Title:	Mary Martin Chair, Audit Committee	**Responsible Director:**	Mary Martin, Chair, Audit Committee
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• The aims of the Committee are to provide an objective review of governance within the Trust, to include financial systems, financial information, risk management and compliance with laws and guidance. This ensures regulations governing the NHS and statutory obligations in regards to annual filings have been and continue to be met.		
Advise	• At each Committee meeting updates on any new risks or assurance concerns from the Chairs of the Quality, Patient and Safety Committee (QPES), the Finance, Performance and Investment Committee (PFIC), People and Organisational Committee (PODC) and the Trust Management Committee (TMC) are received. • Representatives from Internal and External Audit commissioned services are in attendance at Committee, reviewing and reporting on systems and processes in operation within the Trust, members receiving recommendations to strengthen systems as appropriate.		
Alert	• The Audit Committee has alerted the Trust Board when Internal Audit reports have shown high or medium risk recommendations requiring management attention.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	The report provides assurance to the Board on matters of governance, oversight and risk. Assuring Board members risks quantified within the BAF and Risk Registers have been recorded accurately alongside mitigations to support achievement of plans.		
Resource implications	There are no resource implications.		
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 ☐		

Audit Committee Annual Review of Activities Report

1. PURPOSE OF REPORT

To provide the Trust Board with an overview of the Audit Committee's annual review of it's activities for 2021/22.

2. BACKGROUND

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

3. DETAILS

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

The Committee received and discussed reports on the:

- Annual Report for Trust Charitable Funds 2021-22
- Trust Annual Report and accounts 2021-22
- Board Assurance Framework, Strategic Risk Register and related governance processes
- Core financial controls
- Data security and Protection Toolkit
- Buildings and staff security and protection
- Infection prevention
- Staff survey
- Improvement programme

Most of the audits and reviews were completed to plan against the constraints caused by the Covid 19 pandemic. Where not completed they were planned for completion early in 2022-23.

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

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

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

The Chair of the Quality, Patient Experience and Safety Committee (QPES) is a member of the Audit Committee, which helps to maintain the flow of information between the two committees, particularly on clinical audit matters. Two of the Committee members have recent and relevant financial experience.

Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

4. RECOMMENDATIONS

To receive the report for information and assurance.

MEETING OF THE TRUST BOARD – Wednesday 8th June 2022			
Medicines Management Report			
Report Author and Job Title:	Gary Fletcher Director of Pharmacy	**Responsible Director:**	Manjeet Shehmar Medical Director
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• It is through the Medicine Management Group that audit compliance is being monitored and escalated to Divisions where necessary • Measures have been put in place to strengthen the effectiveness of medicines management through Divisional and Care Group engagement. • Risks supporting the corporate risk 2737 are being managed and updated by Pharmacy and the respective Divisions through the Divisional Governance Advisors • There are now clear improvements in medicines management compliance and this has been achieved through a collaborative effort between pharmacy the Divisions and Care Groups.		
Advise	• The known risks regarding medicines storage and CD record keeping compliance is being monitored. There are some tentative signs of improvement in some areas. • Purchase orders for electronic drug storage units have been raised for AMU, Wards 14-17, Maternity & Ward 24/25.The installation of electronic drug storage units will largely resolve the compliance issues. Pharmacy are also purchasing a new controlled drug storage unit for the main dispensary. • Controlled Drug record keeping is also being monitored closely and electronic solutions to replace the current paper systems is being considered.		
Alert	• There are no new issues which require escalation.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The main risks identified are concerned with the level of compliance with the Medicine Policy which is managed through Corporate risk 2737 and associated Divisional and Care Group risks.		
Resource implications	Resources will be required for purchase of electronic drug storage units and Controlled Drug management software, if supported in principle by TMC. Business cases to follow if supported.		
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 ☐		

Medicines Management Report

1. PURPOSE OF REPORT

The purpose of this report is to inform and assure the Committee on the management of medicines within the Trust. This is achieved through the activity of the Medicines Management Group and its sub-groups.

2. PHARMACY AND MEDICINES MANAGEMENT

The responsibility for medicines management within the Trust rests with the Medical Director with delegated responsibility to the Director of Pharmacy, who is also the Controlled Drugs Accountable Officer (CDAO) for the Trust.

The Medicines Management Group (MMG) is the group which has oversight of medicines management and usage. The MMG is chaired by the Medical Director or by the Director of Pharmacy in the absence of the Medical Director. The MMG meets on a monthly basis with the exception of August and December.
The MMG met on:

- 17th January 2022
- 16th February 2022
- 21st March 2022

The MMG reports directly into the Clinical Effectiveness Group on a quarterly basis.
The MMG receives reports from a number of sub-groups.

Since the previous report in January 2022 there have been a number of developments with regard to improving medicines management across the Trust and to evidence compliance with the Medicines Policy.

Controlled drugs

There is evidenced improvement across the division of MLTC on the management of controlled drugs. This has been achieved by clinical/ward areas adopting the local ownership of the medicines management issues.

In 2020 a serious incident in Accident and Emergency highlighted poor compliance to controlled drugs management therefore, a Quality Improvement Project for Controlled Drugs (CD) commenced in April 2021.

This quality improvement project involved:

- Initial CD medicines management daily review and feedback on compliance by band 7 pharmacist to staff in Accident and Emergency including one to one training where possible at the commencement of the Quality Improvement Project.

- CD medicines management risk assessment accepted by Accident and Emergency matron with actions to be implemented.
- More regular CD audit standard review carried out by pharmacist and Medicines Management band 7 link nurse/senior sister and results fed back to the latter and matron copied in so that the areas of non-compliance could be followed up with staff.
- Compliance with CD standards discussed at staff safety huddles.
- Band 7 nurses checking CD register documentation at each shift change to ensure compliance.
- Change to theatre style CD register to capture documentation on Supply, Administration and Disposal and CD poster updated illustrating correct documentation updated and supplied to matron for dissemination.

MLTC

The results have shown an improvement from 40% compliant in April 2021 (A&E main) to the Controlled drugs audit standards, to 78% in Feb 2022 and increase from 73% in Jan 22. Whilst the 78% is lower than the threshold of 90% this work undertaken by pharmacy and the ward areas is showing an improvement in the management of controlled drugs. However, A and E Resus is showing a decline in compliance from February to March 2022, this will therefore, be re-audited.
This is an ongoing project.
Similar improvements have been seen across ward 15.
Other areas in the MLTC division are averaging around 75-91%. The area of concern for March 22 is Ward 7 mainly around crossing out, missing twice daily checks – this shall be re audited in April 22.

Surgery

In March 2022 there are two areas of concern within the Division of Surgery- Wards 10 and 11;

- CD keys not on the nurse in charge
- Missing receipt signatures
- Missing second signature on the CD check
- Crossings out

These have been fed back to the respective teams and shall be re audited in April 22.
Wards 20a and 22 have shown 100% compliant upon re audit.

WCCSS

Ward 27 has shown improvement from 58% compliance in June 2021 to 83% compliant with the CD audit standards in March 22.
This has been a result of the ongoing work between pharmacy and midwifery.

Areas of continued monitoring wards 25, ward 27 and Mat theatre around the following standards:

- Crossings out

- Signatures for the destruction of controlled drugs.

These areas are being monitored monthly with the support of the midwifery team.

Community

IPU Walsall is not meeting the standard around daily CD checks. This will be monitored on a monthly basis.

Areas of support

There is the need for funding for a pharmacist to be present in Accident and Emergency. This will allow for a more sustained level of support to the Accident and Emergency department to maintain the continued improvements.

Risk Register

Risk 2737 has been placed on all Divisional and Care Group risk registers around the non-compliances to the Safe and Secure Handling of Medicines and Controlled drugs Audit. This has shown to improve local ownership of this the management of medicines at a ward level which is evidenced by some improvement in the management of controlled drugs which has been presented in the above section. The care groups are currently reviewing their evidences with a view to downgrading the risk scores. This will have an overall effect on the scoring of the Divisional and Corporate risks.

Ward storage

As with controlled drugs, in 2021 it was identified that were a number of non-compliances around the safe and secure handling of medicines.

Actions taken:

- Appointment of a Pharmacy Governance Advisor (nurse by background)- this post holder has linked in with matrons and ward manager to identified the human factors that may affect ward storage and has supported the individual areas in the management of the medicine management risk on their pertaining risk registers.
- Twice monthly spot checks undertaken by the pharmacy governance advisor and Medication safety officer- this consistent approach has allowed pharmacy to benchmark each of the ward areas to establish a baseline for the audits.
- There is now a process for immediate escalation to the ward manager and/or nurse in charge to allow them to act on any deficiencies identified from the ward storage audits and to rectify these in a timely manager.
- Escalation of noncompliance by Lead Pharmacist representation at each Divisional Quality Board- regular representation at each of the Divisional Boards by the Lead Pharmacist has allowed for timely escalation for any areas of concern.

The main standard of noncompliance includes the ward medicine cupboard being unlocked. This is a legal requisite for the safe and secure handling of medicines.

Further actions taken include:

- Funding secured to purchase automated ward storage cabinets across 14-17 and AMU, this will allow for the above standard to be achieved consistently across these ward areas.
- WCCCSS are purchasing automated ward storage cabinets for 21, PAU and wards 24-25, this will help to ensure that there is a robust process for the handling of To Take Out pre packed medication which has been an area of concern for this division.

Further projects and work

Missed or omitted doses

The most frequently reported medicine error at WHT is around missed and omitted doses. As this is also a common theme to RWT, pharmacy is working closely with the Head of Nursing of Quality to disseminate some of the improvement RWT have made across to WHT.

Pharmacy Quality Improvements

Pharmacy has their own Quality Improvement group some of the projects that are currently being undertaken include:

- Controlled drugs management- aim to improve controlled drugs compliance across ward 27 and accident and emergency
- Oxygen prescribing- to improve oxygen prescribing in AMU, once this has been achieve the work will be disseminated to other clinical areas.
- Discharge medication management- to improve the communication to the GP on the electronic discharge summary around medication changes. This is the foundation work to the CQUIN target of 1.5% that has been set for 22-23.
- Waste management- to reduce the amount of waste being received in pharmacy, currently there are a number of dispensed medicines being received in pharmacy for destruction. This project involves scoping to identify what the reasons are for this and to identify of minimising the number of wasted medicines.
- Ward based services improvements- to improve the number of items dispensed for patients at ward level.
- Environmental sustainability

Medical Gases

- Medical Gases Groups Terms of reference were accepted by the MMG.

- The next Medical Gas Group meeting is on the 30th June 2022.

Policies and procedures

Medicines policy has been approved by TMC.

Upcoming policies due at the next trust PPG.

April 2022

- Self-administration policy
- Defective medicines Policy
- To take out medicine pre pack policy

May 2022

- Antimicrobial policy

In May 2022- that will leave the trust at 75% compliant with Medicines Management related Polices

Non Medical Prescribing (NMP)

Audits and self-declarations have been received from nom medical prescribers. Ten non-medical prescribers have been removed from the trust NMP register due to failing to submit their audit and self-declaration in line with the NMP Policy and governance process for NMP's.

CQUIN Update

There are two CQUIN relating to medicines.

- Appropriate antibiotic prescribing for UTI in adults aged 16+
- Timely communication of changes to medicines to community pharmacists via the discharge medicines service

Progress on these shall be reported on a monthly basis to the Medicines Management Group.

3. REGULATORY

- General Pharmaceutical Council pharmacy premises – renewed annually in October, no inspection due.
- Wholesale Dealers Licence [WDA(H)] – last inspection July 2019. No inspection due.
- Home Office Controlled Drug Licence – no inspection due. Renewal in March 2023.

4. RECOMMENDATIONS

TMC to note that there remain some areas of concern regarding compliance to the Medicines Policy with regard to drug storage and CD record keeping, measures have been put in place will give much more visibility of the issues locally and through risk 2737 and associated risks will provide greater accountability through the care groups and Divisions with regard to compliance.

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 8th June 2022**			
WHT Safeguarding Update Report Q4 (Jan-March 2022)			
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	• The Safeguarding Business Case was agreed in February 2022, allowing for the expansion of the Safeguarding Team. • Substantial work has been undertaken regarding the completion of actions outlined in the WHT Safeguarding Development Plan. • Progress has continued to be noted in the completion of outstanding actions in respect of WHT Safeguarding Case Review 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. The feedback from the partnership in Q4 was that WHT had good governance arrangements overall. • The learning disability agenda within the Trust is being scoped via collaboration work across RWT and WHT. • DBS compliance reporting has commenced as part of the requirements of the safeguarding dashboard.		
Advise	• Significant staff shortages (in the safeguarding children and maternity team) have had an impact on contributing to Walsall Partnership work during Q4. This has been included on the risk register. To note this is now resolving in Q1. • The expansion to the safeguarding team is being progressed, and posts are expected to be recruited to by August 2022. • The staff groups aligned to DBS is under review in Q1. • Safeguarding Children activity is buoyant. The number of domestic violence cases for MARAC has increased by 50% • 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. Additional Training sessions have been provided during May, June and July.		
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 Q4 (Jan – March 2022]

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 following scrutiny at the Trust Safeguarding Group.
- The Safeguarding Midwife has commenced in post during April 2022.
- It is noted that from January to March, safeguarding training compliance has deviated in Children Level 3 and Adult Level 1 and 3. This has been escalated to Divisions for their attention. Additional training sessions have since been provided over May, June and July.
- Safeguarding supervision compliance has increased across the health visiting service but reduced in community maternity services. Compliance will be monitored at the Trust SG Group.
- The safeguarding team have continued to provide a visible presence across the Trust to support staff and teams.
- 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 commence in Q1/Q2.
- 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. Many outstanding actions have now been addressed.
- The number of MASH checks completed by the safeguarding children team has remained consistently high and complex in nature. It is noted that there has been more than 20% increase in activity overall.
- The number of DoLS applications submitted during Q4 was 91. To note, this is a slight decrease on the 93 submitted during Q3 and could be attributed to staff shortages.
- 27 concerns were received via an external source during Q4. The key themes cited were poor discharge (12), care and treatment issues (6), pressure ulcer damage (5), bruising (3) and a cannula left in a patient arm on discharge. 21 met the criteria for S42 enquiry.
- 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 during Q4 was that WHT had good governance arrangements overall.
- WHT and RWT are working in collaboration to respond to the LPS consultation

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

This Q4 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

Q4 Update

- There will be a review of safeguarding policies undertaken in Q1/Q2. Full data to be provided in the Safeguarding Department Annual Report (November 22).
- A safeguarding business case was submitted to the Trust at the end of Q3 for additional staff to complement the team. This has subsequently been approved in Q4. It is expected that the new posts will be recruited into the Trust by August 2022.
- During Q3/Q4, there was 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 is planned in Q1 to review the staff groups aligned to the standard and enhanced element of this work.

Actions:

- During Q1, Head of Safeguarding to meet with HR/Workforce to review staff groups aligned to the DBS process.

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

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

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

Q4 Update

- The current training programme content for safeguarding has been reviewed and competencies required for healthcare staff remain in line with the Intercollegiate Document for Children and Adults. The staff groups will be reviewed again every six months.
- All safeguarding training compliance is reported monthly at the Trust Safeguarding Group (for each Division) and via the Safeguarding Dashboard (attached). It is noted that from January to March, compliance has deviated in Children Level 3 and Adult Level 1 and 3. The poor compliance for both Children and Adults (across those Levels) was raised with the Divisions for their attention and support.
- During Q4 it is noted that two training sessions were cancelled due to significant staff shortages in the safeguarding team. To support the Divisions with attendance opportunities, further training sessions have now been created during May, June, and July.
- Attendance at the Mental Capacity Act training has increased slightly (end of March). This training remains on an electronic platform.
- The Safeguarding Team has continued to provide bespoke training for ward and community staff as required.
- WHT Board training is currently being scoped for delivery purposes in Q1/Q2

Actions:

- Safeguarding Training compliance will continue to be monitored during Q1 and additional training dates will be provided as necessary to meet the needs of the Trust

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 Q4, the Safeguarding Team specialists, including Named Doctors have been offered or have had access to safeguarding supervision (except for the Named Safeguarding Midwife as this post was vacant). It is noted that for most safeguarding professionals this supervision is provided externally by the CCG or other external experts.

Total number of children community Staff/midwives identified to receive supervision within Q4	**Total number of staff who received supervision within Q4 period**	**Q4 Compliance**
Health Visitors: 37 School Nurses: 14 Community Midwives 37	Health Visitors: 35 School Nurses: 14 Community Midwives (37 staff – 10 off sick, 15 completed supervision, 10 booked, 2 not compliant)	**95%** **100%** **56%**

Health Visitor and School Nurse supervision compliance had previously varied (during Q2 and Q3) but increase significantly to 95% in Q4. All outstanding supervision was automatically provided the following month (April).

Due to significant staff sickness, 10 community midwives were unable to attend supervision during this period. The outstanding supervision will be monitored during Q1.

In Quarter 4 the Safeguarding Children Team commenced undertaking School Nurse Supervision, this was previously delivered by their own service team.

Throughout Quarter 4 ED and acute paediatrics have had access to Monthly Drop-In safeguarding supervision sessions. The Safeguarding Children Team have also undertaken floor walks which provides opportunistic case reflection and discussions.

General support is also provided to all key areas within the Trust including Maternity, Children Ward, Sexual Health, and community services. The Safeguarding Team plan to provide safeguarding children supervision to Sexual Health Services and allied professionals in the future.

Supervision training has been completed in Q4 by WHT staff as part of a commissioned training event by Richard Swann (National Safeguarding Supervision Expert). A further training event has been organised for staff outstanding in this area during Q3 2022.

Actions:

- To monitor supervision compliance and ensure outstanding supervision is completed.

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 Q4, WHT have attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR).

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.

Two new referrals to Walsall 'Practice Review Group' were made by WHT during Q3/Q4. Both referrals resulted in the decision that the Trust would complete single agency reviews and upon completion, the cases would be re-presented to the PRG to examine if further work was required regarding a multiagency response. One review has now concluded, the other is in progress. ***(see Appendix 1 Internal PRG action report)***

A CSPR referral was made to Walsall Practice Review Group during Q3, however after an in-depth review this was accepted 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 was agreed at One Panel (Wolverhampton) and PRG (Walsall) in Q4.

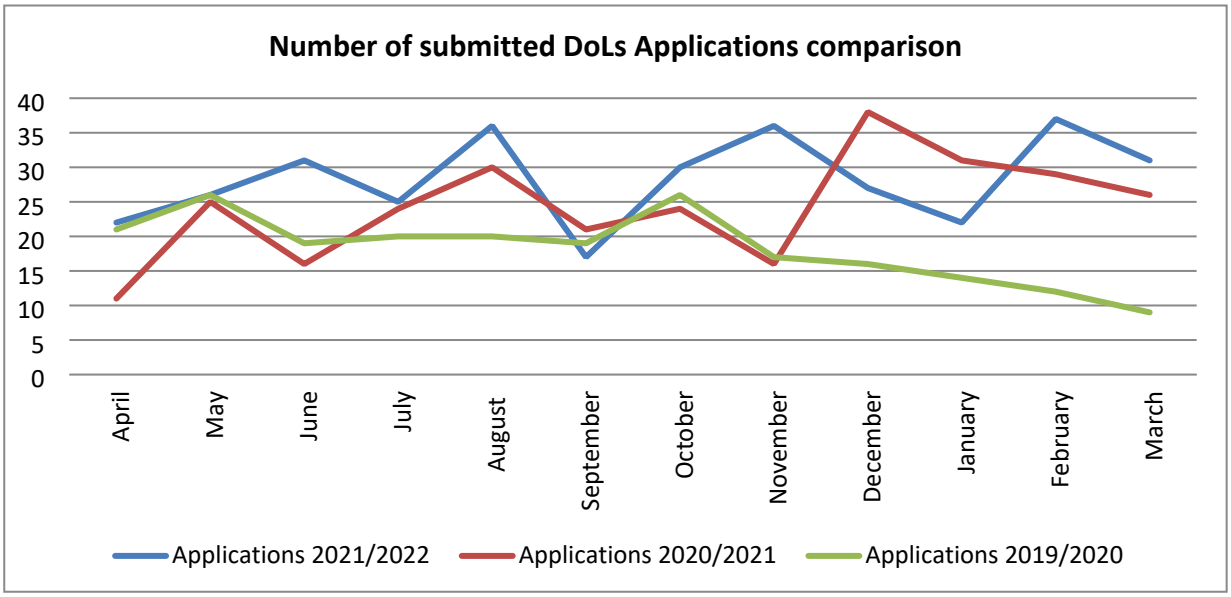
The Learning Disability Team have continued to participate in the 'Learning from lives and deaths' programme. 7 notifications were made by the Trust during Q4 as part of the

'Learning from the lives and deaths' programme. There are no outstanding actions for the Trust, but work continues to ensure the sustainability of previous actions.
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 Q4 WHT has ensured that learning from all types of reviews has been disseminated Trust wide via: • Trust brief • Daily Dose • 7 Minute briefings • Bespoke/Training • Specific targeting of professionals/wards 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). These will be monthly from June 2022 • The Trust Safeguarding 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 (see 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

- 91 DoLS applications were submitted during Q4 which is a decrease on the 93 submitted during Q3. However to note that for the same period during 2020/21 there were only 86 applications made.



- No Prevent referrals have been made during Q4. This is not unexpected, as Walsall has a low level of activity.
- All Prevent returns (to NHSE) have been completed in required reporting timeframe.
- 27 concerns were received via an external source during Q4, (2 concerns were subsequently withdrawn). The key themes cited were in relation to poor discharge (12), care and treatment (6), pressure ulcer anomalies (5), bruising (3) and a cannula left in a patient arm on discharge (1).
- Of the 27 external concerns received, 20 related to the Division of Medicine and Long-Term Conditions, 3 related to Community and 4 related to Surgery.
- 21 (out of the 27) concerns raised met the requirements for a S42 enquiry.
- At the end of Q4, 18 reports have been submitted by respective Divisions and the outstanding 3 are in the process of being concluded.

- During Q4, 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 attended the NHSE Leads meeting during Q4 and disseminated the recommendations regarding preparation and organisation readiness for LPS. There is a joint plan in place across WHT and RWT to address the response.
- The safeguarding team continue to offer support, training, and guidance on the Mental Capacity Act, assessing mental capacity, and completing DoLS. During Q2 WHT have planned an MCA seminar.
- During Q4, it was agreed that RWT would provide the Trust with a LD specialist (for 2 days per week) to scope the current service and work with service areas to identify any future requirements.

Safeguarding Children Activity

- During Q3, it was noted that there continued to be a significant staffing shortage due to sickness, maternity leave, and vacancy factors. This prompted the service to be placed on the Trust Risk Register. To note subsequently 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.
- The Safeguarding Children Team have provided support via face to face 'floor walks' to Ward 21, ED, Maternity and Fracture Clinic.
- 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. (**See Appendix 3 attached Safeguarding Children report)**
- Group Supervision has been offered to Ward 21 and ED. Attendance has been difficult due to operational pressures.
- During Q4 the MASH checks and Strategy Meetings remained consistently high. There was a total of 1179 health information requests made by Walsall MASH compared to 945 in Q3 (an increase of 20%) and 147 MARAC check requests made compared to 99 in Q3 (an increase of 50%).
- It is also noted that advice calls received into the team increased by 22% from 84 (during Q3) to 107 (in Q4).
- Virtual Safeguarding Children Level 3 training and face to face training has been delivered to all staff.
- During Quarter 4 the Safeguarding Children Team supported staff with 40 statements for court. 35% of the statements completed were from the health visiting service.

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.
• WHT participated in Walsall Partnership assurance audits in respect of Section 11 of the Children Act 2004, and Care Act 2004. The feedback during Q3/Q4 from the Walsall Partnership was that WHT had good governance arrangements overall. Positive feedback referred to effective governance, training, service engagement and working within the 'Think Family' model. • During Q4 WHT participated in a multi-agency audit in regard to people in a position of Trust. The feedback session is to be conducted in Q1. • During Q4 WHT participated in the audit to assess if practice was in keeping with the Protocol for Injuries in Non-Mobile Children presenting in the Emergency Department. The findings are yet to be published and the feedback sessions will be held during Q1/Q2. • Throughout Q4, 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 these concerns (raised during 2021) and most of the actions completed. (Attached). The safeguarding development plan now forms part of the normal reporting process through the Safeguarding Group and continues to provide assurance to the CCG and Local Authority. • An audit (planned for Q4) of compliance with the Child Protection Information Sharing System (CP-IS) has been delayed until July 2022. • The safeguarding team continued to undertake the Trust audit around RESECT and MCA completion for those adults deemed to lack capacity in relation to the decision. Results have been disseminated to the Divisional teams for review and reported corporately through PBI reports. Action: • Conclude outstanding CP-IS audit.

8. Health providers are required to provide evidence and assurance that they are responding to National Reports and Inquiries.
During Q4, the WHT Safeguarding Team commenced collaborative work with RWT regarding the response to the LPS national report. There are no outstanding CQC actions.

	During Q1/Q2, 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 subgroups (including Channel, MAPPA, MARAC, CSP, CJB and Modern Slavery Partnerships)
	During Q4 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. ***(see appendix 4 – Safeguarding Dashboard)***

3. RECOMMENDATIONS

The committee is asked to receive the report for assurance.

Appendix 1 – Walsall Practice Review Group

Appendix 2 – Safeguarding Development Plan

Appendix 3 – Safeguarding Children's Update Report

Appendix 4 – Safeguarding Dashboard

Walsall Healthcare NHS Trust

Trust Safeguarding Group

Meeting Date:	29.04.2022
Title:	Summary Report for Walsall Safeguarding Partnership, Practice Review Group.
Executive Summary:	This report provides an update to the group regarding the activity and input by WHT into the Walsall Safeguarding Partnership, Practice Review Group.
Action Requested:	For the group to receive the summary report for information.
Report of:	Clare Hope Deputy Head of Safeguarding.
Author: **Contact Details:**	Clare Hope Tel 01902 695163 Clare.hope@nhs.net
Links to Trust Strategic Objectives	Safeguarding is linked to all Trust Strategic Objectives
Resource Implications:	N/A
Equality and Diversity Assessment	Overarching safeguarding agenda is considered in relation to age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion and belief, sex, and sexual orientation.
Risks: BAF/ TRR **(describe risk and current risk score)**	NA
Public or Private: **(with reasons if private)**	Public
References: **(e.g. from/to other committees)**	To be presented at the Trust Safeguarding Committee
Appendices/ References/ Background Reading	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details	
1	This meeting was held virtually using Microsoft Team due to current COVID-19 restrictions and was chaired by Maria Kilcoyne.
2	**Action Log** No open actions for WHT.
3	**TB SAR referral – Consideration** Initial work has been completed for some time. Coroners inquiry completed - cause of death unascertained, open verdict. WHT issue around sharing statements has not been resolved and PRG continue to request information. This was stated by the chair to be a serious concern regarding statutory information sharing and will be escalated to the Ops group. TB to remain open until issue resolved. **WHT Action: CH to meet with FP to confirm actions to resolve this issue. CH to feedback the outcome of discussion to PRG.**
4	**CSPR W13** Case to be published this afternoon. Actions to be added to main PRG action tracker. Training event to be held in July 2022. **WHT Action: WHT actions to be added to the internal tracker and progress discussed at internal case review meeting and shared with PRG.**
5	**Quality Markers** New updated information from SCIE published that describes the SAR process in detail. This is currently being review by the regional SAR group. SAR Quality Markers
6	**CSPR flowchart** Agreed by the group
7	**SAR 5** Final report presented to PRG for sign off. Due to ongoing disagreement around a learning point, further clarity is to be sought by the CCG and author. The amended report will then be circulated for final approval. To go to Executive Committee June 2022.
8	**Case updates:** AS - Recommendation considered at Operations and Scrutiny on 6th January 2022 – agreed it does not meet SAR criteria CA - Recommendation considered by Exec on 22nd Dec 2021 – agreed that the case does not meet CSPR criteria GH - Recommendation considered at Operations and Scrutiny Group in February 2022 – agreed not for review

	SAR 6 - Final version of report due week commencing 9th May. Extraordinary PRG to be arranged for mid-June SAR 7 - Chronology reports due 6th May 2022. Practitioner event scheduled for 27th May 2022 SAR 8 - Chronology reports due 4th May 2022. Practitioner event scheduled for 6th June 2022 SAR 9 – Lead reviewer commissioned. First panel meeting to be held on 13th May 2022 (delayed start due to lead reviewer availability and number of reviews currently underway) CSPR W14 - First draft of report due to be reviewed at a panel meeting on 6th May 2022
14	**Next Meeting** 10 June 2022, 1pm – 2pm: SAR6 sign off 11 July 2022, 9:30am – 12:30pm 10 October 2022, 9:30am – 12:30pm

Walsall Healthcare NHS
NHS Trust

Safeguarding Development Plan – May 2022

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
1	**Safeguarding Service & Team Resource**	To carry out a review of the current resources within the Safeguarding Team (Adults, Children and LAC) to ensure there is the capacity to promote good professional practice, support the local safeguarding system and processes, provide advice and expertise for fellow professionals, and ensure safeguarding supervision and training is in place.	**Dec 21** (for business case approval) **August 22** (To conclude recruitment process) Head of Safeguarding	**06.05.22 Update:** **Band 8b (Deputy Head of Safeguarding) post interview set for 26.5.22.** **Band 6 (Safeguarding Adult Nurse x 2) post interview set for 13.5.22** **Band 7 (Named Nurse) post in recruitment stage** **Band 5 (Safeguarding Business Manager) awaiting job matching** **Band 4 (Admin Team Lead) recruited to and will commence in post on 16.5.22.** **Named Midwife for Safeguarding commenced in post 25.4.22** **11.04.22 Update**: Posts out on Trac and recruitment expected from August onwards following expected notice periods. Additional space to be sought at Walsall Manor Hospital. **2.3.22 Update:** Business case concluded and full funding agreed. Plan to commence recruitment week commencing 7.3.22 **1.2.22 Update:** Awaiting outcome of business case which has been sent to WHT Senior Team for their consideration in February 2022. **29.12.21 Update:**	Amber Evidence: (*Minutes with Outcome of finance meeting January 2022*) Staff in post

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				Outcome of business case as evidence for completing action **23.12.21 Update:** Business case to be presented in January (to new WHT finance group). Additional room space to be sourced c/o Space Utilisation Meeting in January too. **17.11.21 Update;** Business case completed. Funding in review. Decision date to be confirmed. **29.10.21 Update:** In process**.** **12.10.21 Update:** In process, meeting with finance 14.10.21 **10.09.21 Update:** In process – Awaiting confirmation of current service budgets to provide the immediate funding of posts. **31.08.21 Update**: Business Case to be progressed via WHT C&C processes. **19.08.21 Update**: HOS Meeting with accountant on Friday 27th August. **05.08.21 Update:** Initial Business Case (part 1) for SG Team in progress. Meeting to be confirmed (requested) with WHT Corporate Accountant and AMC to consider initial funding for 4 posts (1 x Band 8b, 2 x Band 6's and 1 x Band 5). Part 2 of Business Case to be drafted in Q3/Q4.	
2	**Safeguarding Supervision Process (Adults & Children)**	**a)** Safeguarding Team to develop a Specific Safeguarding Supervision Policy (Children and Adult Policy)	**August 2022** Head of Safeguarding	**06.04.22 Update:** **Supervision policy to be tabled at new WHT Policy Group during Q1. Safeguarding children**	Amber Evidence:

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
		b) Safeguarding Adult and Children Supervision Training to be delivered during August/September. *(Safeguarding champions to attend training)* Safeguarding Adult Supervision Policy to be developed during Q3.	and Team Leads	**supervision in place. Reported monthly/quarterly** **29.12.21** Update from Group In process during Q4 **23.12.21 Update:** WHT Policy Group (new process) to receive the updated policy Feb. Additional EIA paperwork to be completed. *Wendy James contacted by FP for review of process*. **17.11.21 Update:** Discussion with Community Division (Kelly Geffin) to potentially adopt this (base) as a pilot site in Q4. **Update 29.10.21** Safeguarding adults' team currently reviewing the policy and will forward to Head of safeguarding. Scoping also being undertaken with other Trusts to benchmark what their process is for delivery of adult safeguarding supervision. **12.10.21 Update:** Policy to be presented to WHT Group end of October. Training delivered (safeguarding supervision). **20/08/21 Update:** Policy is in draft and has been forwarded to the safeguarding children and adult leads for comments. Comments to be completed by 23/08/21. Thereafter the policy will be forwarded to WHT Policy Group for ratification. **05/08/21 Update**: Policy is in draft	(*Copy of Supervision Policy*)
3.	**Safeguarding and SUI Processes within WHT**	**Further work required during 2022 to understand the process with regard**	**Dec 21**	**11.4.22 Update:**	Amber

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
		to the development of the terms of reference to ensure that any safeguarding elements are identified and addressed. Attendance at SUI – Falls, PU meeting Provide safeguarding oversight on safeguarding incidents as appropriate.	Director of Nursing	**Meetings commenced (with governance) to review the process within these service areas via respective (Falls/PU meetings) and how reporting up through to safeguarding is robust. Further work to be progressed with (RWT inclusion) during Q1** **2.3.22 Update:** Meeting convened to discuss this work with MA end of March 22 **1.2.22 Update:** Raised by HOS to Deputy Director of Governance (MA) about establishing a process going forward. 'Consider SG as part of the SI/STEIS process. Construction of enquiry and Safeguarding Sign off'. **23.12.21 Update:** SG Team have oversight of SI on a weekly basis. Further work regarding review of referral/form to be considered in 2022**.** **22.10.21 update** The Safeguarding Service Team are supporting the falls team with the 'falls 'cluster review- safeguarding over sight has been provided. Membership at the SI, falls and PU meetings. Head of Safeguarding and Safeguarding Adult Lead have met with CCG to discuss and review SI process. **12.10.21 Update:** Safeguarding Team are now in attendance at SUI meetings. (Cluster meetings). **05.08.21 Update:** Internal WHT process to be confirmed.	

2.3.22 Update

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
4	**Safeguarding Audit:** **Child Protection Information System (**CPIS) To ensure that this process is embedded across the Trust.	• Current CP-IS SOP requires improvement • Current SG Children Policy needs to be updated to reflect CP-IS. • Audit to be undertaken to ensure practitioners are using CP-IS during Q4.	Dec 21 **May 22** Head of Safeguarding	**11.4.22 Update:** **FP and RV to progress CP-IS audit. For update at Trust Group in June as joint work with ED and Named Nurses halted in April due to unforeseen staff sickness.** **23.12.21 Update**: To commence audit in Q4. Discussion with SG and ED leads in February to review as part of wider support to ED service. **17.11.21 Update:** Audit outstanding. To commence in Q4. **12.10.21 Update**: Work to commence to review process in Q3. All respective staff (ED) will have access to NHS smartcard (to access system) and have received training on CP-IS process. All midwives will have access to CP-IS as well.	Amber Evidence: *Audit findings & action plan.*
5	**Safeguarding Risk: HV and School Nurse Records** *Current HV Records are not a formal Trust commissioned patient information system (PIS). The system being used is 'informal' due to delay in introduction of electronic records. Currently using Microsoft Word documents which record all HV contacts and interactions. HVs send their typed record to the team administrator who converts it to*	• To add to the Corporate Risk Register • For Trust to progress with development of new IT platform for records in 2022.	**Nov 21** *changed to* **June 22** Head of Safeguarding & 0-19 Lead	**11.4.22 Update:** **Continues to be progressed and completion date expected June 2022 (tbc).** 2.3.22 Update: Update from service requested by HOS. Advised it is in process still. **17.11.21 Update:** Work in process – timescales for completion extended. This group to receive confirmation of progress from service division. **12.10.21 Update:** In process **10.09.21 Update:**	Amber

2.3.22 Update

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
	a PDF and uploads onto a secure electronic drive. Main issues are: lack of chronology of events, MASH health information is not complete, Records have no care plan, and practitioners are responsible for uploading their own word document.			Work in progress across the Trust to complete the transfer of 'paper records' to electronic platform. Timescale within 12 weeks. **28.08.21 Update:** Significant work in place to resolve issue. Placed on TRR. Plan to resolve within 12 weeks. 05.08.21 Update: Head of safeguarding and Children Lead to meet 11.8.21 Added to CRR. Work commenced to transfer records from paper to electronic platform. Estimated time 12 weeks.	
6	**Learning Disability Service Within WHT** confirmation of role of LD service within Trust, and review of LD Strategy/Standards**.**	To review the current model of service provided by LD team (via BCHT) to include posts, training, autism & LD Strategy. • Additional resource required during scoping of service (from May 2022)	**May 22** Head of Safeguarding	**06.05.22 Update:** **EW (LD Team Lead Band 7 from RWT) working at WHT from May 22 for 2 days per week on site to scope service with LD nurses from BCPFT. Focus will be on standards, strategy, team & flagging. Role to support the LeDeR process.** **11.4.22 Update** Service discussion in progress. For update to Trust Group in May 1.2.22 Update: HOS to meet with BCPFT LD Community Lead to clarify KPI's and service spec. **23.12.21 update:** HoS to meet with the LD nursing team to discuss the service and achievements towards any identified KPi's. WHT have enrolled on NHSI Improvement Standards with an end date for Feb 2022. Data regarding processes currently being collated by service leads within the Trust. LD nurses supporting with service user feedback	Amber

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				questionnaires (requirement is 100), link for staff to complete on line staff version has been circulated. **22.10.21 update** BCHCT have appointed into the 0.5wte vacancy. Current provision therefore 1.0WTE Trust has supported BCHCT re- 'changing our lives 'audit. Will await final report. Audit was commissioned by Black Country and west Birmingham CCG. Trust has enrolled on NHSI LD and autism improvement standards self-assessment process. Communication plan to be developed to ensure staff aware of the Trust participation. Audit supporting the process **12.10.21 Update:** LD service provision discussed at WHT Board 7.10.21. Service to be scoped and paper to go to Board in March 2022. **10.09.21 Update:** Initial scope of current LD provision for WHT (from BCHFT) has identified gaps – (limited resourcing and subsequent oversight of LD patients within the Trust). For further review with WHT Chief Nurse in Q3. **05.08.21 Update**: Full review of LD service and provision to commence September 2021. Initial meeting with LD lead from BCHFT arranged 31.8.21.	
7	**Children placed on Adult Ward areas for scheduled or unscheduled care.** WHT to have awareness of children placed in adult areas for training and oversight purposes.	To commence recording number of children placed in adult ward areas to consider paediatric oversight, training and legal/documentation position.	**March 22** Head of Safeguarding	**06.05.22 Update:** **Data is now available and will be included in the children report to Trust Group each month. Numbers per month, and ward area data to be shared.**	?Green

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				12.04.22 Update: Monthly data now available. Trust SG Group to discuss at April meeting. 2.3.22 Update: Data requested from business support service. **23.12.21 Update:** Data collection to commence from February 22	
8	**May 2022** **Safeguarding Policy Work** A review of Safeguarding Policies to be undertaken during Q1.	Review of all related WHT safeguarding policies to ensure: • Updated • Relevant • That any outstanding policies are written	**July 2022** Head of Safeguarding	**06.05.2022 Update:** **SG Policy tracker to be drafted and presented at Trust Group in June 2022. Policy leads to be confirmed for updating respective documents that are outstanding. Support from RWT and WHT staff to ensure this work is completed.**	
9	**May 2022** **Liberty Protection Safeguards known as LPS (from Oct 2023 tbc)** WHT to be fully prepared for the forthcoming changes within legislation and implications for practice	Review of national (and local) documentation around the intended introduction of LPS and the impact and implications for WHT. • There should be WHT attendance at relevant national and local LPS events. • WHT to attend the Black Country STP LPS Group and feedback to SG Group • Identify a Trust 'Lead' for LPS • Set up a Trust Group with relevant stakeholders to support this work	**Dec 2022**	**06.05.2022 Update:** **Work has commenced. National report/paper released in April. (paper presented at Trust Group in April 22).** **NHSE National Group is meeting (WHT in attendance) and Black Country STP Group meeting to be attended in May.** **RWT/WHT Safeguarding Adult Team LPS 'away day' organised.** **Further updates will be prepared for TSG.**	

Rag RATE	Description

2.3.22 Update

Walsall Healthcare NHS
NHS Trust

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

2.3.22 Update

Walsall Healthcare Trust
Safeguarding Children's Monthly Activity Data
April 2021– March 2022

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Advice:												
Advice calls	31	38	38	42	30	37	26	28	30	45 includes queries via email	34	28
Narrative/themes	The advice calls taken have been varied. They include - practitioners requiring support with escalation of cases to CSC. Poor parental engagement; statements for court and MARF completion.			Advice, Support and Guidance varied throughout the quarter. It is noted 26 calls related to Midwifery/unborn child SG concerns There were 9 concerns raised due to Domestic Abuse disclosure from patients 5 practitioners sought advice Re: suspected NAI's The team answered external calls from Out of Area Children's services requesting supporting health information 14 staff members received support Re: MARF submission			The advice calls taken have been varied. They include -practitioners requiring support with escalation of cases to CSC. Poor parental engagement; statements for court and court attendance.			Advice, Support and Guidance varied throughout the quarter. It is noted that the Team received calls from Out of Area Children Services/ HV/SN/Maternity Services and Education. The callers requested health information and also shared concerns regarding mothers and their unborn child. The Team also received calls from Partner Agencies in Walsall. i.e. Police and Walsall Children Services – requesting supporting health information.		

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
				It is noted during the quarter ➢ 4 Children disclosed historical sexual abuse ➢ Ward 21 followed up calls from the NNSC floor-walk to the SG Children team There were 21 calls which did not meet the criteria for Safeguarding						8 practitioners received advice regarding MARF submission. 4 practitioners requested advice regarding Neglect In addition other advice and guidance calls taken related to: ➢ Domestic abuse disclosure. ➢ Consent for surgery ➢ Information sharing ➢ Children not being bought to follow up appointments ➢ Child over dose ➢ Parental overdose ➢ Legal advice ➢ Parenting capacity ➢ Unable to locate child ➢ All categories of child abuse including 1 concern re: FGM It is noted that in this quarter the Team received 2 calls from non paediatric		

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
										areas regarding in patient children with mental health concerns. The Team also received a call from a member of the public who was verbally abusive to the Named Nurse who took the call.		
Supervision:												
Health Visitors Recorded quarterly	23 out of 33 required – 70% compliance			22 seen out of 32 required – 69% compliance 1 Long Term Sick			35 out of 37 completed in Quarter 3 which is 95% compliance			35 out of 37 required supervision (9 received late – attended in April) Plus – 2 non-compliant)		
School Nurses (Group and recorded quarterly)	0	0	14	0	0	12 (12 out of 14 staff received) The 2 staff were on leave.	100% compliance (excluding staff absences)			100% compliance (excluding staff absences)		

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Community Midwives Group session	4	8	7	0	0	0	0	0	0	0	0	0
Community Midwives -1:1	0	1	2	36 completed + 83% compliance			93%. (1 x sick leave, 1x isolating x 1 recent return off long term sickness, 2 x mat leave, 1 no case load and 1 still outstanding			56% (37 staff – 10 off sick, 15 completed supervision, 10 booked, 2 not compliant)		
Others ED/PAU/CCN	1	3	5	Group safeguarding Supervision recommenced for ED September 2021			5	5 (10 compliant)	0	0	0	0
Group	10 (HV, 21 NNU)	2 (Ward 21)	6	No group safeguarding supervision took place due to capacity within the safeguarding team			0	0	0 (1 session offered, no one attended)	1 (ED) None turned up Ward 21	0	0
Court Statements:												
Health Visitors	8	2	3	0	1	4	4	1	4	2	6	6
School Nurses	2	0	0	0	0	0	0	0	0	0	2	0
NNU	1	0	0	1	0	1	0	1	1	0	1	0
Midwives	0	6	3	6	3	5	3	6	5	4	3	3
Others	2	1	1	0	1	0	19	4	3	9	3	1
MARAC:												
Cases	38	26	46	30	43	32	26	39	34	73	39	35
children	56	53	87	72	59	56	49	84	50	100	62	48
MASH:												
Checks completed	267	269	293	302	294	306	343	217	385	356	427	496
Amber Checks	158	164	193	188	167	192	191	105	205	245	224	268
Red Checks	51	23	33	53	45	62	72	35	76	37	97	159
Information Checks	58	82	73	61	82	52	80	77	104	74	106	67
Strategy Meetings	25	13	19	14	12	13	11	16	21	8	15	27

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Discussed at DA Triage	NR	NR	NR	329	347	320	358 Some data missing	412	476	271	248	392
MARFS												
Total MARF Referrals:	**77**	**86**	**86**	**45**	**44**	**54**	**44**	**36**	**34**	**21**	**23**	**14**
Health Visitor	0	0	1	0	2	1	0	0	1	0	0	0
School Nursing	2	0	0	0	0	2	1	1	1	2	0	0
Ward 21	1	0	0	0	2	0	0	1	1	0	0	1
Themes	**April themes** - young people presenting with mental health concerns. **May themes -** young people with mental ill health concerns. Also young people being assaulted by other children and adults. **June themes** -young people presenting with mental health concerns. Also parental poor engagement and parents with mental health concerns. In April/May/June –There was a proportion of MARF's whereby MARF not appropriate-threshold EH.			**July themes –** Children/Young people presenting with Emotional & Mental Health concerns Concerns raised for Unborn **August –** Children/Young people presenting with Emotional & Mental Health concerns Concerns raised for Unborn/new born child Parental Non engagement ➢ Appointments ➢ Leaving ED without treatment ➢ HV appointments DNA/child not bought to clinic **September -** Children/Young people presenting with			**October themes - Over 60% of MARF referrals submitted.** Children/Young people presenting with Emotional & Mental Health concerns. Concerns also raised for parental substance use and mental health concerns. Concerns raised by maternity included - domestic abuse; poor engagement with the maternity and maternal mental health. **November themes -** Children/Young people presenting with Emotional & Mental Health and wellbeing concerns. Parents presenting to ED following an assault and parents not taking child to their appointments.			**January themes** Young people presenting with mental health concerns/suicidal ideations/self-harming behaviours. Domestic abuse including physical assault on the unborn child. Adult with mental health concerns which included threats to end life. Child exploitation Substance use Delayed presentation of a fracture.		

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
				Emotional & Mental Health and wellbeing concerns Parents presenting with Emotional & Mental Health concerns Non engagement from parents Re Child's presenting health needs / Not bought to appointments / Leaving ED prior to assessment and non-disclosure of previous children service involvement			**December themes –** As above. Concerns also included physical assault of a child 2x NAI and neglect			**February themes** Children exposed to Domestic abuse Children/Young people presenting with Emotional & Mental Health concerns Concerns for Unborn and Mother. Neglect of child Physical abuse of preschool children **March themes** –as above		
Categories	Emotional –child and parental ill health/mental ill health/Domestic abuse/Substance use Neglect-poor engagement Physical			Emotional –predominately child but not excluding parental ill health/mental ill health/Domestic abuse/Substance use Neglect-poor engagement by parents Physical – X 5 Suspected NAI's			Emotional child and parental Neglect-parents non engagement with services			Emotional-Children exposed to DA. Mental health of child Neglect-delayed presentation and cannabis and alcohol use. Child not brought to appointments Sexual-child exploitation		
Number of Rejections	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Rejection Themes												
Training (delivered by team):												
Level 3 Core	2	2	2	2	2	2	2	2	2	2	2	1
Level 3 Specialist	0	0	0	0	1	0	0	0	0	0	0	0
Child Protection:												

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
CP Medicals undertaken	8	5	13	5	5	10	10 (3.12.2021 this figure has changed)	13	13	12	15	Awaiting info

Summary:

Team Achievements

Quarter One

- Successfully recruited 2 experienced named nurses for the Safeguarding children Team -1 x 1.0 wte and 1 x 0.8 wte.
- The safeguarding children team have continued floor walks and support to paediatric areas.
- We have also maintained the delivery of safeguarding level 3 training despite staff shortages, training is both well attended and evaluated.

Quarter Two

- Advice provided to Ward 21 by the NNSC via the Ward daily Floor-walk was followed up with a call to the Duty NNSC, clear concise advise provided, excellent joint working evident between the NNSC Team and the Acute team
- 21 Advice, Support and Consultation calls did not meet the criteria for Safeguarding MARF submission, it is noted and documented the expertise and knowledge of the duty NNSC reassured the practitioner Re: use of policies, accessing Universal services (HV/SHA) and GP support
- Safeguarding Level 3 training appears to support the practitioner to complete a MARF autonomously, with 14 staff requesting support from 143 MARF's regarding completion during the quarter.

Quarter Three

- Safeguarding level 3 training continue despite staff shortages, training is both well attended and evaluated.
- Successfully appointed part time Named Nurse (fixed term 12 secondment from the HV Service) due to commence 02/22.

Quarter Four

- Successfully appointed full time Named Midwife for Safeguarding , the successful candidate is due to commence in role late April 2022
- Due to staff shortages in the team (sickness) Level 3 Safeguarding Children training was cancelled on 1 occasion.
- There has been a reduction in the inappropriate MARF being completed for Children presenting at ED with mental health concerns. Practitioners appear to be utilising Walsall Safeguarding Partnership Right Help Right Time Threshold document to aid their risk assessment and decision

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**

making. The Floor walks and the advice and guidance provided by the named nurses have provided staff with the opportunity to reflect on case and the thresholds.

- Safeguarding Children Supervision Supervisors joined the SGCT in December and commenced supervision for the school health service

Exceptions:

Quarter One

- Named midwife for safeguarding children left the Trust July 2021. Post currently vacant, awaiting to go back out to advert again. Although there is a plan in place to mitigate the risks, the vacancy does pose a risk to the Trust. Recommendation-Corporate Risk Register to reflect the vacant post/risks.

- Other vacant posts include Named Nurse for Safeguarding Children 0.5wte substantive post; 0.41wte fixed term for 12-month post and 1.0 x wte Band Team Administrator. All vacant posts to be recruited to.

Quarter Two

- Quarter One exceptions are still applicable for Quarter 2. In addition, during September 2021 there were 0.8 WTE Named Nurse absences within the Team. Request made for staffing shortages within Safeguarding Children Team to be placed on the Trust Risk Register.

- Due to reduced staffing within Named Nurse for Safeguarding Children work has had to be prioritised which had resulted in reduction in floor walks, delay in MASH health checks (Amber) being completed within the agreed timescales, Paediatric Clinical Update (x1) and Group Safeguarding Supervision was not delivered in this Quarter by the Team.

Quarter Three

- Named nurse absences -1.0wte for month of November and December

- Named midwife for safeguarding children remains vacant, interviews are scheduled to take place 18/01/22. There is a plan in place to mitigate the risks, the vacancy does pose a risk to the Trust, the risks and mitigations are reflected on Trust Risk Register.

- Other vacant posts include Named Nurse for Safeguarding Children 0.5wte substantive post and 1.0 x wte Band 4 Team Administrator.

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**

- Child Death x 1-SUDIC process commenced.

- CSPR x 2-

1-Rapid Review held - death will not progress to a CSPR, as the criteria were not met.

It was agreed that there was local learning, which will include:
1. CSC to consider how they assesses the accumulative impact of low level concerns (CSC received 9 referrals for this family between 02/016 -07/2021).
2. Black Country Healthcare Foundation Trust to embed 'Think Family approach to safeguarding children/adults in to practice-Maternal Grandmother is known to their Service (diagnosed mental illness which includes auditory hallucinations), BCHCFT were not aware that Maternal Grandmother has her grand-children residing with her.

2-Rapid review held –Maternity case identified by RWT, CSPR criteria not meet, criteria meet for an Adult Safeguarding Review

Quarter Four
January

- 2 x child deaths (one to progress to a JAR) concerns raised that SUDIC process not followed. In addition an internal SI has commenced.

February

- MASH data detailing number of S47 enquiries following a MASH Strategy Discussion not recorded on spreadsheet due to the lack of MASH Admin within the service to support the Named Nurses. The Local Authority has been approached for this data and discussions are underway with commissioners regarding MASH funding.
- Group Safeguarding Children Supervision remains poorly attended in the acute due to clinical duties and staff absences. There is a plan in place to for staff to be rostered to attend sessions. Staff still has the opportunity to reflect on children during floor walks and at the Mandatory Paediatric Update Session.
- Safeguarding Children Policy requires updating
- Due to reduced staffing Safeguarding Children Team have not completed any single agency audits (participated in Multi Agency Audits).

	Q1			Q2			Q3			Q4		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**

March

- As above and also there was one child death, the death did not meet the for a CSPR referral.
- One Safeguarding Children Level 3 training cancelled due to staff sickness.
- The percentage of HV Safeguarding Children Supervision compliant for safeguarding children supervision has decreased when figures compared to quarter 3. The reason for this is staff have cancelled due to ill health and competing workload priorities. All staff that are non-compliant have been booked and are scheduled to be seen in April.

- MASH & DA triage remains a key part of the named nurse's work and is increasing, which is reflected when the February and March data is compared. There has been the following increase:

- Checks: 16%
- Amber checks 20%
- Red checks 63%
- Nurse attending strategy meetings: 80%
- DA Triage 58%

The increase is also present when Quarter 3 and 4 data are compared i.e.: Checks 35%; Amber: 47% and Red checks 60% and a slight increase of 4% for the named nurses attending strategy meetings. However when quarter 3 and 4 figures are compared for DA triage there is a decrease of 26% for DA triage. This is usual and the reason for this is unknown, it may be due to not all the data is captured and a review will be undertaken with the Team.

Safeguarding Dashboard

Populated by P&I | Populated by Service

Ref	Area	Quality Requirement	Target	Frequency		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Narrative
LQSG01	SG	Level 1 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence (YTD per month)**	95%	Recorded Monthly Reported Quarterly	N	1245	1084	1056	1087	1070	1079	1075	1089	1088	1107	1095	1116	
					D	1283	1111	1118	1126	1102	1104	1104	1120	1123	1145	1141	1163	
					%	97.04%	97.57%	94.45%	96.54%	97.10%	97.74%	97.37%	97.23%	96.88%	96.68%	95.97%	95.96%	
LQSG02	SG	Level 2 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 2 Safeguarding Children competence (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	1664	1665	1654	1658	1682	1694	1704	1783	1787	1816	1821	1891	
					D	1791	1802	1818	1809	1834	1846	1837	1927	1940	1976	1988	2041	
					%	92.91%	92.40%	90.98%	91.65%	91.71%	91.77%	92.76%	92.53%	92.11%	91.90%	91.60%	92.65%	
LQSG03	SG	Level 3 training for Safeguarding Children. As set out in Safeguarding Children & Young. People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date. Level 3 Safeguarding Children competence. (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	855	875	880	911	885	909	920	955	943	922	903	927	
					D	949	1077	1057	1062	1041	1042	1052	1083	1068	1078	1063	1108	
					%	90.09%	81.24%	83.25%	85.78%	85.01%	87.24%	87.45%	88.18%	88.30%	85.53%	84.95%	83.66%	
LQSG04	SG	Level 4 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 4 Safeguarding Children competence**	100%	Recorded Monthly Reported Quarterly	N													
					D													
					%													
LQSG05	SG	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members. **As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document.**	100%	Reported Annually														Some board members attended Safguarding Training in June 21 delivered by the RWT Safeguarding Team under the new collaberative working. A second session will be deliverd by RWT for those outstanding - date ageed and board training was delivered 06.10.21
LQSG06	SG	Level 1 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence (YTD per month)**	95%	Recorded Monthly Reported Quarterly	N	1091	1071	1050	1061	1054	1061	1056	1078	1066	1084	1068	1083	
					D	1131	1113	1118	1123	1102	1103	1102	1119	1119	1138	1135	1153	
					%	96.46%	96.23%	93.92%	94.48%	95.64%	96.19%	95.83%	96.34%	95.26%	95.25%	94.10%	93.93%	
LQSG07	SG	Level 2 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	971	969	969	951	945	923	929	929	928	945	952	979	
					D	1044	1020	1014	1002	989	966	973	964	970	1000	1008	1026	
					%	93.01%	95.00%	95.56%	94.91%	95.55%	95.55%	95.48%	96.37%	95.67%	94.50%	94.44%	95.42%	
LQSG08	SG	Level 3 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	1561	1584	1622	1653	1613	1625	1653	1692	1684	1699	1732	1764	
					D	1846	1857	1842	1856	1883	1918	1921	2049	2044	2062	2051	2134	30 sessions has been delivered via MST during 2021/22. 28 sessions have been scheduled to take place for 2022/23
					%	84.56%	85.30%	88.06%	89.06%	85.66%	84.72%	86.05%	82.58%	82.39%	82.40%	84.45%	82.66%	

Safeguarding Dashboard

Populated by P&I | Populated by Service

Ref	Area	Quality Requirement	Target	Frequency		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Narrative
LQSG09	SG	Level 4 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 4 Safeguarding Adults competence**	100%	Recorded Monthly Reported Quarterly	N													30 Hours of safeguarding related training/ activity has been undertaken by the safeguarding adults lead . Training has been mapped against the competencies 32 hours of safeguarding related training / activuity has been undertaken by the named nurse for safeguarding Adults
					D													
					%													
LQSG10	SG	Safeguarding Adults training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members. **As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document.**	100%	Reported Annually														
LQSG11	SG	Basic Prevent Awareness Training (level 1&2) as defined in NHS England – Prevent Training and Competencies Framework (2015). **Percentage of staff with up to date PREVENT competence. (YTD per month)**	95%	Recorded Monthly Reported Quarterly	N	1766	1815	1845	1853	1854	1844	1834	1857	1852	1892	1901	1940	
					D	2025	1987	1988	1968	1954	1941	1933	1942	1948	1994	2004	2039	
					%	87.21%	91.34%	92.81%	94.16%	94.88%	95.00%	94.88%	95.62%	95.07%	94.88%	94.86%	95.14%	
LQSG12	SG	Prevent Awareness Training (level 3,4 & 5) WRAP training as defined in NHS England – **Prevent Training and Competencies Framework (2015). Percentage of staff with up to date competencies. (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	1883	1893	1846	1833	1853	1903	1922	2029	2012	2036	2019	2091	
					D	1993	2000	1983	1980	1999	2055	2061	2188	2182	2204	2188	2272	
					%	94.48%	94.65%	93.09%	92.58%	92.70%	92.60%	93.26%	92.73%	92.21%	92.38%	92.28%	92.03%	

Safeguarding Dashboard

Populated by P&I | Populated by Service

Ref	Area	Quality Requirement	Target	Frequency		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Narrative
LQSG13	SG	Statutory Organisational Prevent Leads to demonstrate criteria met to achieve competency levels as defined in NHS England – **Prevent Training and Competencies Framework (2015).. • Attendance at a minimum of 2 NHSE regional Prevent forums each financial year (4 take place). • Evidence of face to face meetings with the channel coordinator and CTU officers. • Participate in local or regional multi-agency Prevent forums/Boards when required**	100%	Recorded Monthly Reported Quarterly	N													
					D													
					%													
LQSG14	SG	**Learning Disabilities Awareness Training**	95% (Trajectory to be agreed)	Recorded Monthly Reported Quarterly	N	1561	1584	1622	1653	1613	1625	1653	1692	1684	1699	1732	1764	
					D	1846	1857	1842	1856	1883	1918	1921	2049	2044	2062	2051	2134	
					%	84.56%	85.30%	88.06%	89.06%	85.66%	84.72%	86.05%	82.58%	82.39%	82.40%	84.45%	82.66%	
					Traj.													
LQSG15	SG	**Domestic Abuse Awareness Training**	95% (Trajectory to be agreed)	Recorded Monthly Reported Quarterly	N	1561	1584	1622	1653	885	1625	1653	1692	1684	1699	1732	1764	
					D	1846	1857	1842	1856	1883	1918	1921	2049	2044	2062	2051	2134	
					%	84.56%	85.30%	88.06%	89.06%	47.00%	84.72%	86.05%	82.58%	82.39%	82.40%	84.45%	82.66%	
					Traj.													

Safeguarding Dashboard

Populated by P&I | Populated by Service

Ref	Area	Quality Requirement	Target	Frequency		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Narrative
LQSG16	SG	Mental Capacity Act/DoLS (LPS) Training	95%	Recorded Monthly Reported Quarterly	N	5083	5139	5068	4981	4963	5023	5104	5359	5251	5321	5393	5595	
					D	5409	5415	5318	5254	5282	5349	5392	5706	5617	5709	5762	5909	
					%	93.97%	94.90%	95.30%	94.80%	93.96%	93.91%	94.66%	93.92%	93.48%	93.20%	93.60%	94.69%	
LQSG17	SG	DBS Compliance – new staff	100%	Recorded Monthly Reported 6 monthly	N													
					D													
					%													
LQSG18	SG	DBS Compliance – existing staff	100%	Recorded Monthly Reported 6 monthly	N	2435	2468	2484	2495	2576	2621	2688	2751	2783	2869	2946	2932	
					D	3565	3625	3658	3693	3760	3810	3891	3992	4015	4134	4229	3727	
					%	68.30%	68.08%	67.91%	67.56%	68.51%	68.79%	69.08%	68.91%	69.32%	69.40%	69.66%	78.67%	
IRSG01	SG	Percentage compliance with provider protocol for child protection supervision for frontline staff (individual or group)		Monthly – Reported Quarterly	Health Visiting	72.50%	60.00%	45.00%	Q2 - 69%			Q3 - 95%						
					CNN	27.50%	22.20%	33.30%	Under review			Under review						
					SHA	35.00%	54.00%	43.20%	Q2 - 86%			Q3 - 100%						
					Paeds Nurse	19.00%	14.00%	17.80%	Under review			Under review						
					TPT	75.00%	0.00%	100.00%	100.00%			100.00%						
					NNSG	28.50%	42.80%	85.70%	Q2 - 75%			Q3 - 50%						
					NNLAC	100.00%	100.00%	100.00%	100.00%			100.00%						
					CMW	25.70%	14.30%	14.28%	Q2 - 83%			Q3 - 93%						
IRSG02	SG	Percentage compliance with provider protocol for adult protection supervision for frontline staff (individual or group)		Monthly – Reported Quarterly	N													
					D													
					%													

Safeguarding Dashboard

Populated by P&I | Populated by Service

Ref	Area	Quality Requirement	Target	Frequency		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Narrative
IRSG03	SG	Percentage compliance for safeguarding supervision for Named Professionals/Specialist roles within Safeguarding		Monthly – Reported Quarterly	N	28.50%	42.80%	85.70%	Q2 - 75%			Q3 - 50%						
					D													
					%													
IRSG04	SG	Number of referrals made for PREVENT		Monthly – Reported Quarterly	N	0	0	1	0	0	0	0	0	0	0	0	0	
IRSG05	SG	Compliance with quarterly CCG/provider meetings, either 1:1 or Safeguarding Forum -		Monthly – Reported Quarterly	N				Yes									
					D													
					%							#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
IRSG	SG	100% Compliance with Submitting Safeguarding Reporting Framework to CCG	100%	Monthly	N	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
IRSG07	SG	100% Compliance with Prevent Returns (NHS Digital – Strategic Data Collection Service)	100%	Quarterly	N	Yes			Yes			Yes						On target for submission on 07/04/2022
IRSG07	SG	Numbers of DoL's/LPS referrals.		Monthly – Reported Quarterly	N	22	26	31	25	36	17	30	36	27	22	37	31	
IRSG07	SG	Number of DoL's/LPS authorised. Number of LPS completed under the Vital Act. Number of DoL's/LPS which have objections		Monthly – Reported Quarterly	N	0	0	0	0	0	0	0	0	0	0	0	0	

MEETING OF THE PUBLIC TRUST BOARD – 8TH June 2022			
Biannual skill mix review			
Report Author and Job Title:	Gaynor Farmer -Lead Nurse Workforce Lisa Carroll 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	• The Trust completed a biannual skill mix reviewing in January 2022. • The Director of Nursing is advising no change to current establishments at this time as the next review will take place in June 2022 (this month)		
Advise	• The next planned skill mix review will take place in June 2022. This will enable comparison between the data collected in January 2022 during the peak of a COVID-19 wave and at a point when we are living with COVID. • The June 2022 SNCT data and Nurse Sensitive Indicators will be reviewed with Divisions to ensure professional judgement is included in recommendations • An updated paper will be presented to Trust board in August 2022 with recommendations for all wards.		
Alert	• Nothing to alert		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	**Corporate 2066** – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15).		
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 ☒		

WALSALL HEALTHCARE NHS TRUST BIANNUAL SKILL MIX REVIEW

PHASE 2 – January 2022 data

Gaynor Farmer

Gaynor.farmer@walsallhealthcare.nhs.uk

V2-Report completed- 12th May 2022

INTRODUCTION

To deliver safe quality patient care it is essential wards have optimal Nurse staffing levels. It has been acknowledged that one of the contributory factors linking failures in care and patient safety were inadequate staffing levels (Francis 2013). In July 2016 the National Quality Board published 'Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time: Safe, sustainable and productive staffing'. This safe staffing improvement resource provided updated expectations for nursing and midwifery care staffing**.** The Developing Workforce Safeguards published by *NHS Improvement* in October 2018 will assess Trusts compliance with a more triangulated approach to Nurse staffing planning in accordance with the National Quality Board guidance for all clinical staff. This document recommends a combination of evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

To demonstrate the Trust's commitment to the above requirement a twice-yearly Adult Inpatient, Acute Assessment units and Paediatric inpatient skill mix review is completed.

Walsall Healthcare NHS Trust (WHT) uses the 'Safer Nursing Care Tool' (SNCT). The SNCT is a simple-to-use, evidence based digital tool that calculates nurse staffing requirements based on the acuity and dependency of the patients on a ward and it is linked to nurse sensitive outcome indicators.

The SNCT, which was developed by Professor Dame Hilary Chapman and Katherine Fenton OBE, has been validated using a substantial database over a number of years and is now widely used by NHS trusts. The development of the SNCT has been supported and endorsed for use by NHS England and NHS Improvement. The SNCT now includes different staff multipliers for Acute Assessment Units, Acute Inpatient and Children and Young People's Wards, and very recently released one for Emergency Departments.

This tool enables the measurement of both acuity and dependency which can be applied to patients whose care can be delivered within acute adult, paediatric or acute assessment settings (appendix 1). A multiplier for calculating establishments will suggest nursing whole time equivalents (WTE) required to provide a safe and appropriate standard of care for each of the five levels of acuity and dependency identified by SNCT. Also measured are Nurse Sensitive Indicators (NSIs); these are quality indicators, which can be influenced by nursing establishments and skill mix (appendix 2).

Acuity and dependency data was collected in January 2022 for one month from:

- Fifteen adult inpatient ward areas
- One Community area

This review has taken place during January 2022 whilst within the omicron variant peak of the covid pandemic.

You will note that the review does not provide data for the following areas where these are areas of additional capacity that are not open for the entire year:

- Ward 14 Medical Winter Ward (maximum 28 beds) and Ward 9 Surgical Winter Ward (maximum 26 beds) – these two areas opened to support the Trust through winter demands. Some of the staffing has been redeployed from other areas and there has been reliance upon Temporary Staffing for the remaining shifts.

The review does not include Ward 21 (Paediatric ward) and the Paediatric Assessment Unit. Paediatrics are developing a business case separate to this process as currently the budget is combined across inpatient and assessment areas.

In undertaking a skill mix review it is essential that the acuity/dependency data is triangulated against professional judgement and Nurse Sensitive Indicators (Falls, Pressure Ulcers, Medication Incidents, Complaints and Healthcare Associated Infections).

- Ward layout/facilities: the configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, wards with a high proportion of single rooms might make adequate surveillance of vulnerable patients more difficult. This is particularly pertinent around covid with donning and doffing requirements and where isolation has reduced staff-patient visibility.
- Escort duties: consideration needs to be given if this role is likely to affect the numbers of staff required. A local data collection and analysis exercise is undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care needs if this is considered to have a significant impact on the ward activity.
- Shift patterns: the type of shift patterns (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These are monitored to understand the impact and effect on staff and patients.

RESULTS

OCCUPANCY, ACUITY AND DEPENDENCY

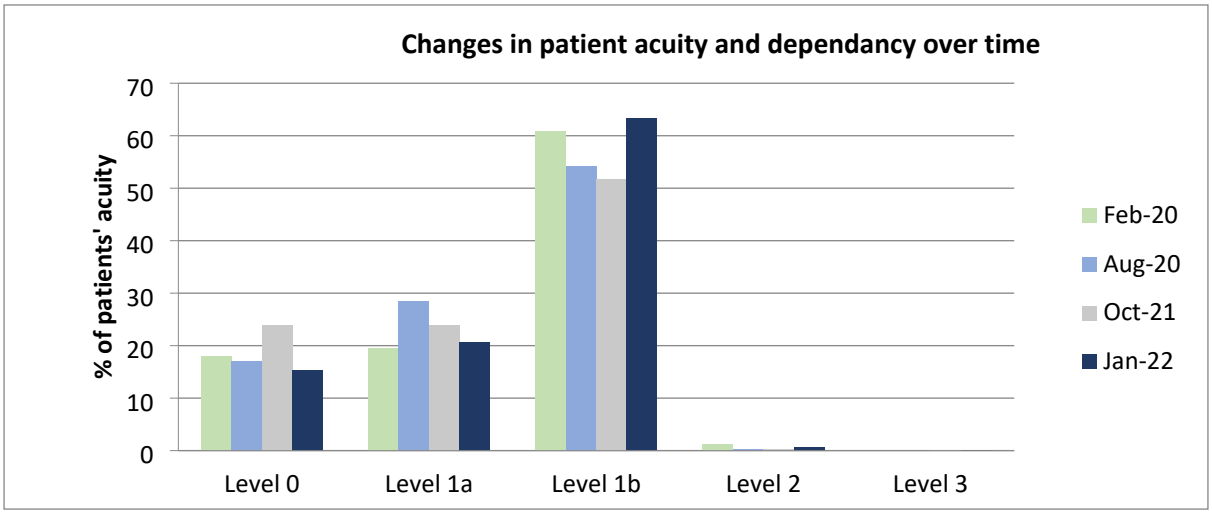
The data in Table 1 below summarises that 7351 acuity scores were collected using the SNCT daily in January 2022. 15.3% of patients were scored at level 0, 20.6% at 1a and 63.2% of patients were scored as level 1b (stable but have a higher dependency on nursing support). Level 2 totalled 0.6% and represent patients on acute medical wards and one surgical ward. There were no recorded level 3 patients on wards prior to transfer to an ICCU or another Level 3 facility.

Table 1 (Acuity Scores collected by Level)

		Feb-20	Aug- 20	June-21	Jan-22
No of Scores	Multiplier	8494	6781	7447	7351
Level 0 (requires hospitalisation)	0.99	18.1%	17.1%	23.9%	15.3%
Level 1a (acutely ill patients who unstable)	1.38	19.5%	28.4%	23.9%	20.6%
Level 1b (stable patients who are heavily dependent on nursing care)	1.72	60.9%	54.2%	51.6%	63.2%
Level 2 (require expertise provided in designated beds or Level 2 facility)	1.97	1.3%	0.2%	0.3%	0.6%
Level 3 (require advanced respiratory support or therapeutic support of multiple organs).	5.96	0	0	0	0

Chart 1 below shows that acuity score at 1b is predominantly the highest proportion of scores and that level 0 has the least number of patients in each data collection. Since the June 2021 data collection there has been an elevation in level 1b patients', but it is worth recognising the data collection for January 2022 is within the winter period where typically more patients are in hospital with higher acuity and dependency as a result of chronic illness and was also during the height of the Omicron variant of COVID-19.

Chart 1 – changes in acuity (last 4 SNCT reviews)



From September 2021 there was an E-learning Tool available that had been designed to enhance knowledge around acuity recording. A competency assessment was attached to that. There have been 170 responses to the E-learning, staff can attempt multiple times. The number of Band 6 and above staff that are fully competent is 64 across our in-patient areas. A recommendation for education following this report is that the E-learning will be mandated for band 6, 7 and 8 for the in-patient areas and further work will be undertaken to ensure a wider understanding amongst all registered nurses and midwives.

NURSE SENSITIVE INDICATORS (NSI) BY AREA

Table 2 demonstrates rates of falls, pressure ulcers, medicine related incidents, number of complaints and infections during January 2022 (the month in review). For falls, the 5 areas highlighted as amber had a falls incident rate in month greater than the national average (6.68)

Within Table 2 wards with an Asterix highlight where data indicates an establishment uplift of greater than 10% is required. There is limited correlation between the indicated uplift and NSI by area. 2 areas' show a high NSI score and a 10% or greater change to establishment.

- Ward 1- SNCT 52.4 WTE, Professional Judgement 52.87, current establishment 47.5
- Ward 4- SNCT 53.6 WTE, Professional Judgement 49.21, current establishment 30.91. The data collection is based on 34 beds. Since the January 2022 SNCT data collection the medical division has had a business case approved resulting in ward 4 being established to 28 beds with the agreement that should there be a requirement to increase capacity this will be established using winter monies. At the time of writing this report the division have not closed the winter capacity beds and ward 4 remains open to 34 beds. The additional 6 beds will be closed in June 2022 and therefore ward 4s substantive staffing is being predicated on 28 beds
- Ward 7- SNCT 29.9 WTE, Professional Judgement 40.78, current establishment 33.43
- Ward 17-SNCT 38 WTE, Professional Judgement 46.61, current establishment 34.90
- Ward 10- SNCT 31.1 WTE, Professional Judgement 38.81, current establishment 33.43
- Ward 11- SNCT 32.5 WTE, Professional Judgement 41.41, current establishment 34.51

- Ward 12- SNCT 36.7 WTE, Professional judgement 38.81, current establishment 22.01
- Wards 11 and 12 were historically managed as one ward (ASU) with a single budget. Following a reconfiguration over a year ago ward 11 became a complex surgical ward and ward 12 the emergency surgical ward. At the point of this change being made the budgets and establishments were split. The decision on allocation of the budget between the two wards was not based on the acuity or dependency of patients or any other nurse sensitive indicators.

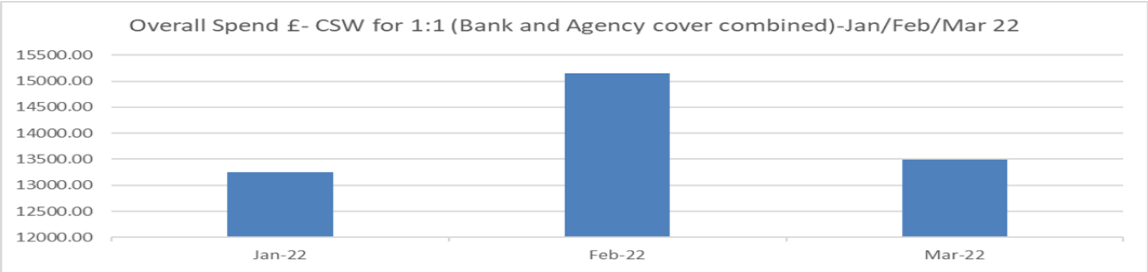
Table 2 – Nurse Sensitive Indicators by Area – January 2022

Jan-22	Ward	Falls per 1000 occupied bed days	Pressure Ulcers	Medication Errors	Complaints	C-Diff	MRSA
MLTC	1*	7.74	0	2	0	0	0
	2	1.15	0	1	0	0	0
	3	5.78	0	3	0	0	0
	4*	9.51	2.85	2	1	0	0
	AMU	2.86	0	9	3	0	0
	7*	3.14	1.57	1	0	0	0
	15	12.69	2.82	0	0	0	0
	16	1.44	1.44	0	1	1	0
	17*	9.51	0	0	0	1	0
	29	11.46	1.91	4	0	0	0
SURGERY	10*	2.71	1.36	0	1	1	0
	11*	1.33	0	10	2	0	0
	12*	1.37	0	1	0	0	0
	20A	5.48	0	0	1	0	0
WCCCS	23	0	0	0	0	0	0
	21	0	0	1	0	0	0
COMMUNITY	Hollybank	0	0	0	0	0	0

AMBER= high falls rate/ *= 10% or higher professional judgement requested change

Chart 2 demonstrates the current cost of 1:1 cover via Bank and Agency CSW to help mitigate some of the falls and care issues for those patient's requiring supervision. Total 3-month cost is £41,897

Chart 2- Cost of CSW cover for 1:1's



ESTABLISHMENTS

Applying the SNCT multipliers (described in Table 1) to the data collected, the differential between funded establishments and required establishments are calculated inclusive of 21% uplift (to provide direct comparison). This model is based on establishment and not actual nursing staff in post (contracted).

The previous establishment and skill mix review was undertaken in June 2021. At this point in time the country was out of the lockdown period of the COVID-19 pandemic. The skill mix review undertaken in January 2022 was at the height of the Omicron variant of COVID-19 and this had a

significant impact on the number of unwell patients with COVID-19 within the hospital. The next review will take place in June 2022.

Data collected in January 2022 indicates the need for an increase in RN and CSWs of more than 10% in 6 wards.

Table 3 provides the full suite of data calculated.

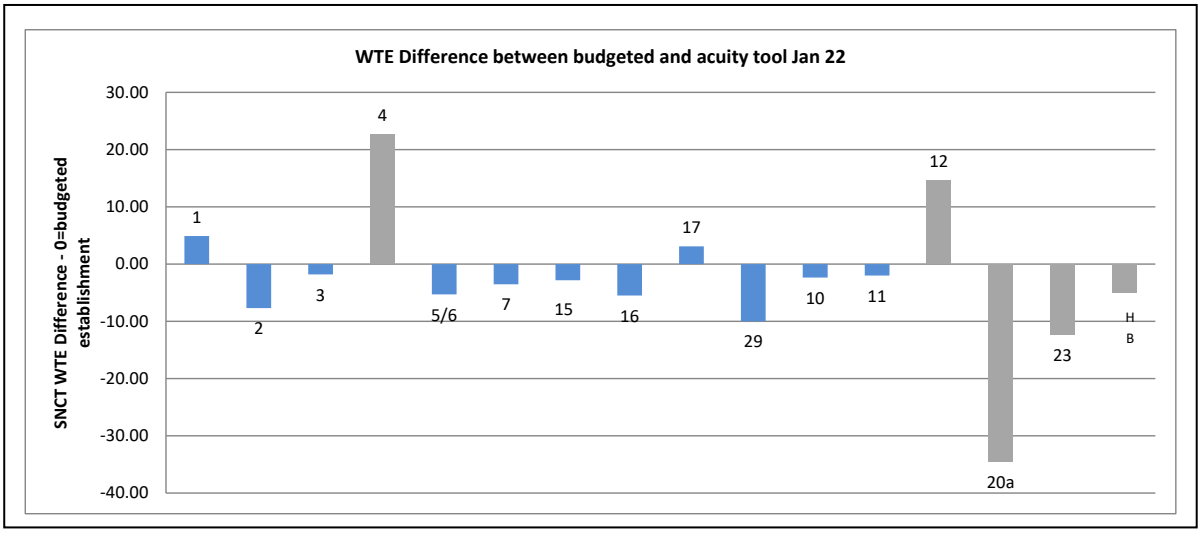
Division	Ward	WTE- Professional Judgement Jan22	WTE- SNCT Acuity Tool Jan 22	Areas that breach 10% SNCT threshold	WTE- Total Budgeted 21/22		WTE-Total budgeted required post skill mix review	% change from current budget	REG- Difference required from Current to Required budget (%)	CSW- Difference required from Current to Required budget (%)	Total difference required from Current to Required budget (WTE)
MLTC	Ward 1	52.87	52.4		47.50		52.87	10.16	0.00	5.37	5.37
	Ward 2	47.5	39.8		47.50		47.50	0.00	0.00	0.00	0.00
	Ward 3	49.21	45.7		47.50		49.21	3.47	-1.07	2.78	1.71
	Ward 4	49.21	53.6		30.91		44.01	29.77	7.40	5.70	13.10
	Ward 5/6	74.7	69.4		74.70		74.70	0.00	0.00	0.00	0.00
	Ward 7	36.22	29.9		33.43		36.22	7.70	2.43	0.36	2.79
	Ward 15	40	37.2		40.00		40.00	0.00	0.00	0.00	0.00
	Ward 16	39.1	33.6		39.10		39.10	0.00	0.00	0.00	0.00
	Ward 17	41.41	38		34.90		41.41	15.72	1.23	5.28	6.51
	Ward 29	50.3	40.3		50.30		50.30	0.00	0.00	0.00	0.00
				Divisional Total	445.84		475.32		9.99	19.49	29.48
SURGERY	Ward 10	39.96	31.1		33.43		38.81	13.86	2.35	3.03	5.38
	Ward 11	39.96	32.5		34.51		38.81	11.08	1.27	3.03	4.30
	Ward 12	39.96	36.7		22.01		38.81	43.29	8.80	8.00	16.80
	Ward 20a*	47.87	13.3		47.87		47.87	0.00	0.00	0.00	0.00
				Divisional Total	137.82		164.30		12.42	14.06	26.48
WOMENS	Ward 23*	20.71	8.4		20.71		20.71	0.00	0.00	0.00	0.00
				Divisional Total	20.71		20.71		0.00	0.00	0.00
COMMUNITY	Hollybank*	23.23	16.8		21.80		23.23	6.16	1.14	0.29	1.43
				Divisional Total	21.80		23.23		1.14	0.29	1.43

The skills mix review undertaken in January 2022 indicates a requirement for an increase in RN and CSW establishments from that indicated in the June 2021 review and approved by the Trust board in October 2021 of 23.55.WTE registered staff and 33.83 CSWs.

Chart 3 demonstrates WTE demand from the review.

Exceptions are highlighted in grey; Wards 20a, 23 and Hollybank are an exception and low SNCT results have been received due to the SNCT not being accurate in departments of 16 beds or less. Wards 4 and 12 are an exception due to the previous budget not being aligned to this department current service provision.

Chart 3 – WTE Difference between Budgeted Establishment and SNCT



**** positive figure= SNCT recommends higher than current budget***

It is accepted that being within 10% of SNCT in terms of WTE is within tolerance and further consideration is given to those areas outside of 10% (in Chart 4 demonstrated by the red threshold line). Despite the following areas being within the SNCT 10% accepted tolerance, the professional judgement discussion indicates some changes to establishment based upon clinical care. Skill mix review meetings took place between the Director of Nursing, Head of Nursing for Workforce, Head of Nursing for Division and Corporate Lead Nurse for Workforce.

Wards 1 and 3 are identified as having a high number of patients requiring 1:1 care and patients at high risk of falls. Where this has been identified, the Director of Nursing is working with the Divisional Director of nursing and Quality Team to review the approach and find appropriate solutions to providing safe care to patients who have care needs that would traditionally be identified as requiring 1:1 care across the Trust

Ward 7- Currently one of the Registered Nurses on duty at night holds a cardiac arrest call bleep. This means that they are required to attend any cardiac arrest call across the Trust and can be absent from the ward for a considerable length of time. When this occurs staffing levels are reduced on the ward to 2 RNs. A decision is required as to whether there remains a clinical need for a member of Coronary Care staff to attend all cardiac arrests at night.

Ward 17-NIV care pathway and ICU step down for Medicine Division. The development of the NIV service is subject to a separate business case – this is subject to a business case

Ward 10- At the previous establishment review in June 2021 and the paper approved by Trust board, ward 10 required 5 RNs and 4 CSWs during the day and 3 RNs and 3 CSWs at night. This review confirms there is no requirement for change. However, it has identified that the budgets were not adjusted appropriately following the June 2021 review and therefore an adjustment of 2.35 RNs and 3.03 CSWs is required to reflect previously agreed establishments.

Chart 4-% difference between current budget and acuity tool

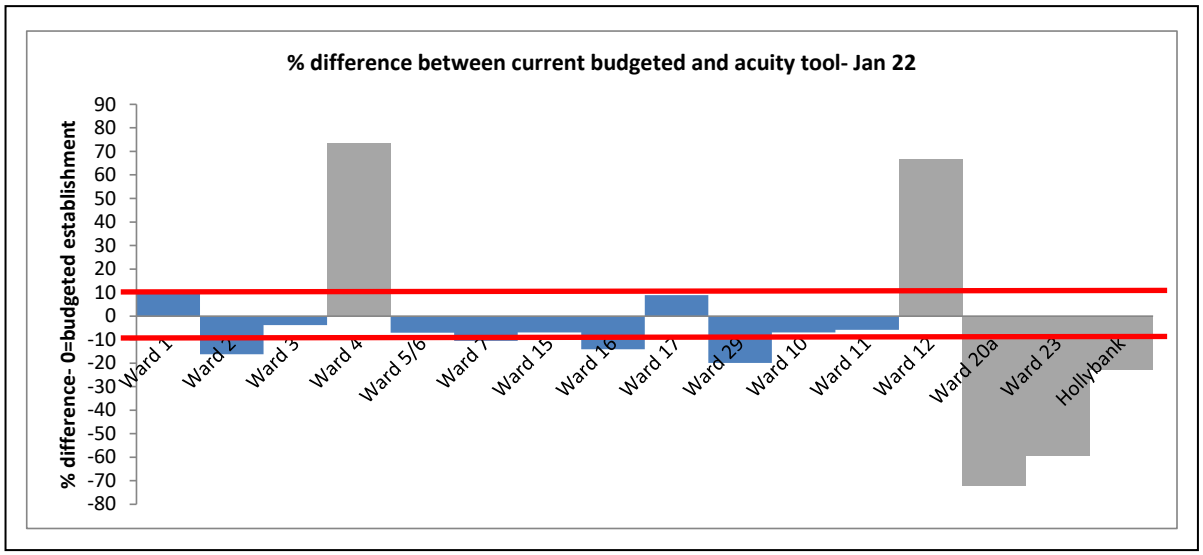
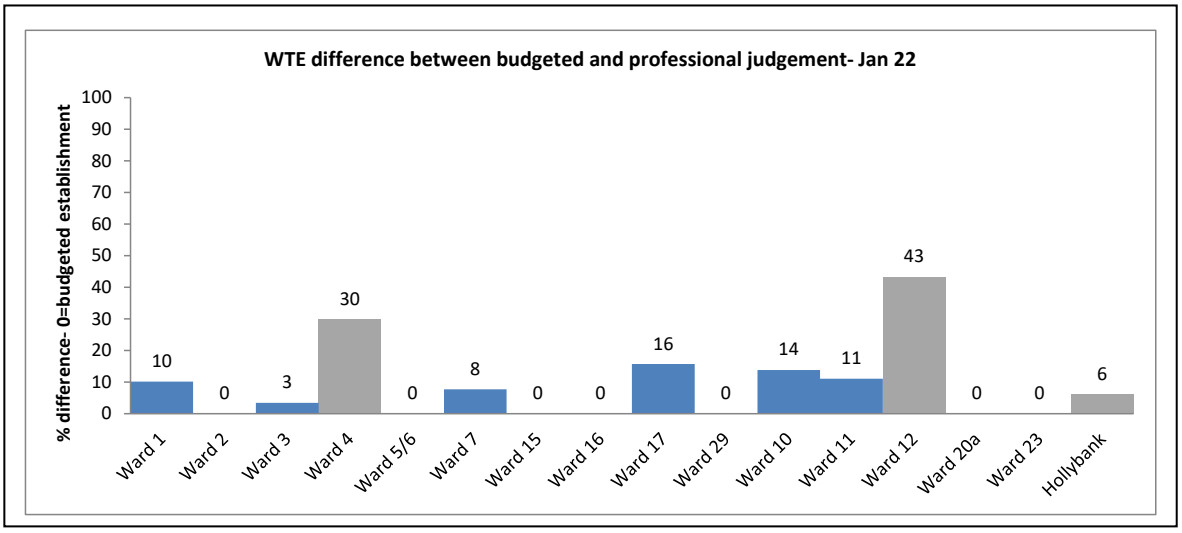


Chart 5 shows the variation between the current budgeted establishment and professional judgement.

Graph 5 - % variation from current establishment to professional judgement



ANALYSIS

It is essential that decisions to change to staffing requirements are based on a thematic analysis over time rather than a single point measurement unless:

i. One measurement has changed significantly and is support by other triangulated data.
ii. Activity and/or acuity has been altered significantly (change of speciality/bed base change).

In this case other triangulated evidence is summarised in each individual departments' summary.

The skill mix review was concluded by the Director of Nursing, Head of Nursing for Workforce, Corporate Lead Nurse for Workforce and appropriate Divisional Head of Nursing for each division.

Over page is table 4 which is demonstrates Budgeted Establishments and the establishments indicated by this skill mix review.

- Highlighted in yellow are areas where a change of more than 10% is indicated by the data and professional judgement review.
- Highlighted in grey are areas that fall out of the SNCT 10% parameters.

Table 4- Department breakdown

									20/21 Budgeted WTE								Jan 22 Required Budgeted WTE											
Division	Ward	WTE- Professional Judgement Jan22	WTE- SNCT Acuity Tool Jan 22	Areas that breach 10% SNCT threshold	CHPPD	Number of Funded Beds	Occupancy		Band7	Band 6	Band 5	Band 4	Band 3	Band 2	WTE- Total Budgeted 21/22		Band 7	Band 6	Band 5	Band 4	Band 3	band 2	WTE-Total budgeted required post skill mix review	% change from current budget	Ratio (Reg%) (B6/B5/B4)	WTE per bed	REG- Difference required from Current to Required budget (%)	CSW- Difference required from Current to Required budget (%)
MLTC	Ward 1	52.87	52.4		6.21	34	90%		1.00	4.00	18.90	3.00	0.00	20.60	47.50		1.00	4.00	18.9	3.00	0.00	25.97	52.87	10.16	48.99%	2.03	0.00	5.37
	Ward 2	47.5	39.8		7.38	34	85%		1.00	4.00	18.90	3.00	0.00	20.60	47.50		1.00	4.00	18.9	3.00	0.00	20.6	47.50	0.00	54.53%	1.83	0.00	0.00
	Ward 3	49.21	45.7		7.27	34	80%		1.00	4.00	18.90	3.00	0.00	20.60	47.50		1.00	4.00	17.83	3.00	0.00	23.38	49.21	3.47	50.46%	1.89	-1.07	2.78
	Ward 4	49.21	53.6		5.6	34	99%		1.00	2.52	9.71	0.00	0.00	17.68	30.91		1.00	2.52	14.11	3.00	0.00	23.38	44.01	29.77	44.60%	1.69	7.40	5.70
	Ward 5/6	74.7	69.4		7.7	45	89%		2.00	7.00	29.80	5.00	0.00	30.90	74.70		2.00	7.00	29.8	5.00	0.00	30.9	74.70	0.00	55.96%	2.87	0.00	0.00
	Ward 7	36.22	29.9		6.84	23	89%		1.00	7.56	12.24	0.00	0.00	12.63	33.43		1.00	7.56	14.67	0.00	0.00	12.99	36.22	7.70	61.37%	1.39	2.43	0.36
	Ward 15	40	37.2		6.83	28	80%		1.00	4.00	15.00	2.00	0.00	18.00	40.00		1.00	4.00	15	2.00	0.00	18	40.00	0.00	52.50%	1.54	0.00	0.00
	Ward 16	39.1	33.6		7.03	25	88%		1.00	3.00	15.00	3.00	0.00	17.10	39.10		1.00	3.00	15.00	3.00	0.00	17.10	39.10	0.00	53.71%	1.50	0.00	0.00
	Ward 17	41.41	38		6.48	25	93%		1.00	5.20	12.80	3.00	0.00	12.90	34.90		1.00	5.20	14.03	3.00	0.00	18.18	41.41	15.72	53.68%	1.59	1.23	5.28
	Ward 29	50.3	40.3		9.09	36	67%		1.00	4.00	19.70	5.00	0.00	20.60	50.30		1.00	4.00	19.7	5.00	0.00	20.6	50.30	0.00	57.06%	1.93	0.00	0.00
					Divisional Total				11.00	45.28	170.95	27.00	0.00	191.61	445.84		11.00	45.28	177.94	30.00	0.00	211.10	475.32				9.99	19.49
SURGERY	Ward 10	39.96	31.1		7.14	26	83%		1.00	2.52	9.82	4.94	0.00	15.15	33.43		1.00	2.52	12.17	4.94	0.00	18.18	38.81	13.86	50.58%	1.49	2.35	3.03
	Ward 11	39.96	32.5		6.25	25	95%		1.00	2.60	14.76	1.00	0.00	15.15	34.51		1.00	2.60	16.03	1.00	0.00	18.18	38.81	11.08	50.58%	1.49	1.27	3.03
	Ward 12	39.96	36.7		8.15	27	79%		1.00	2.00	10.43	1.00	0.00	7.58	22.01		1.00	2.00	19.23	1.00	0.00	15.58	38.81	43.29	57.28%	1.49	8.80	8.00
	Ward 20a*	47.87	13.3		8.87	16	78%		1.00	4.32	21.34	1.00	0.00	20.21	47.87		1.00	4.32	21.34	1.00	0.00	20.21	47.87	0.00	55.69%	1.84	0.00	0.00
					Divisional Total				4.00	11.44	56.35	7.94	0.00	58.09	137.82		4.00	11.44	68.77	7.94	0.00	72.15	164.30				12.42	14.06
WOMENS	Ward 23*	20.71	8.4		11.66	20	*49%		1.00	1.00	11.13	0.00	0.00	7.58	20.71		1.00	1.00	11.13	0.00	0.00	7.58	20.71	0.00	58.57%	0.80	0.00	0.00
					Divisional Total				1.00	1.00	11.13	0.00	0.00	7.58	20.71		1.00	1.00	11.13	0.00	0.00	7.58	20.71				0.00	0.00
COMMUNITY	Hollybank*	23.23	16.8			12	81%		1.00	3.52	7.18	0.00	0.00	10.10	21.80		1.00	3.52	8.32	0.00	0.00	10.39	23.23	6.16	50.97%	0.89	1.14	0.29
					Divisional Total				1.00	3.52	7.18	0	0	10.10	21.80		1.00	3.52	8.32	0	0	10.39	23.23				1.14	0.29

DIVISION OF MEDICINE AND LONG-TERM CONDITIONS

WARD 1- Acute Older People

Ward 1 is a 34 bedded unit based in the Modular block of the Main hospital and has 4 Side rooms. Bay 3 has limited visibility due to the ward layout.

Nurse Sensitive Indicators for January 22 are: 7.74 falls per 1000 bed days, with no Pressure Ulcers recorded, 2 Medication errors reported and no HCAI Incidents. Occupancy in Jan 22 was at 90%.

This Establishment Review indicates the need for an increase of 2 CSW to the night shift which will result in staffing of:

Shift	RN	CSW
Day	6	5
Night	4	5

To facilitate the staffing numbers indicated in the review requires an increase in the band 2 establishment:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Required WTE	1.00	4.0	18.9	3.0	0.00	25.97	52.87
Total WTE difference required	0	0	0	0	0	5.37	5.37

The indication for the increase is due to the current high levels of need for patient.

Recommendation: The Nurse sensitive indicators are good – no change recommended at the present time, await further themed results and next acuity predictions. Review in June 2022

WARD 2 –Combined Medically Fit/ Acute Older People

Ward 2 is a 34 bedded unit based in the Modular block of the Main hospital and has 4 Side rooms. Bay 3 has limited visibility due to the ward layout and 1 side room also has limited visibility

The nurse sensitive indicators results for January 2022 are: 1.15 falls per 1000 bed days, with no Pressure Ulcers, 1 Medication error reported and no HCAI Incidents. Occupancy in Jan 22 was at 85%

This Establishment Review indicates no change to the current budgeted establishment and staffing numbers will be:

Shift	RN	CSW
Day	6	5
Night	4	3

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Required WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further actions at this time. Review in June 2022

WARD 3- Combined Medically Fit/ Acute Older People

Ward 3 is a 34 bedded unit based in the Modular block of the Main hospital and has 4 Side rooms. Bay 3 has limited visibility due to the ward layout.

The nurse sensitive indicators results for January 2022 are: 5.75 falls per 1000 bed days, with no Pressure Ulcers, 3 Medication errors reported and no HCAI Incidents. Occupancy in Jan 22 was at 80%

This Establishment Review indicates a decrease in RN to the day shift which will result in staffing of:

Shift	RN	CSW
Day	6	5
Night	4	4

To facilitate the staffing numbers indicated in the review requires an increase in the band 2 establishment and a decrease in RN establishment:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Required WTE	1.00	4.0	17.83	3.0	0.00	23.38	49.21
Total WTE difference required	0	0	-1.07	0	0	2.78	1.71

Recommendations: Nurse sensitive indicators within limits no change recommended at the present time, await further themed results and next acuity predictions. Review in June 2022

WARD 4- Combined Medically Fit/ Acute Older People

Ward 4 is a 34 bedded unit based in the Modular block of the Main hospital and 4 Side rooms. This ward has historically been budgeted for 28 beds and the Division has had a business case accepted for this to continue to be established at 28 beds. There is potential for the ward to increase capacity by 6 beds funded through winter monies. Throughout winter 2021/22 these additional beds have remained open and at the time of writing this report the ward remains open to 34 patients. The division has a plan to close these beds by early June 2022.

The ward has not previously included band 4 Nursing Associates within its establishment staff within the registered cohort and the Division are keen to include the development of this within their workforce on Ward 4.

The nurse sensitive indicators results for January 2022 are: 9.51 falls per 1000 bed days, with 2.85 Pressure Ulcers, 2 Medication errors reported and no HCAI Incidents. There was 1 complaint received in January 22 and Occupancy was at 99%.

This Establishment Review indicates staffing per shift of:

Shift	RN	CSW
Day	5	5
Night	3	4

To facilitate the staffing numbers indicated in the review requires an increase in the band 5 and 2 establishment and the introduction of band 4 Nursing Associates.

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.52	9.71	0.00	0.00	17.68	30.91
Required WTE	1.00	2.52	14.11	3.00	0.00	23.38	44.01
Total WTE difference required	0	0	4.4	3.00	0	5.7	13.10

Recommendations: This acuity and professional judgement score was based on 34 beds – the ward is reducing back to budgeted establishment. Review NSI with staff. Ensure that additional beds do not open without establishment. Review June 2022

WARD 5/6-AMU- Acute Medical Care

Ward 5/6 – AMU is a 45 bedded unit based in the West Wing of the Main hospital consisting of 2 wards, ward 5 has 3 bays with 6 beds, 1 bay of 3 beds and 3 side rooms, ward 6 has 3 bays of 6 beds and 3 side rooms.

The nurse sensitive indicators results are: 2.86 falls per 1000 bed days, with no Pressure, 9 Medication errors reported and no HCAI Incidents. There were 3 complaints received in January 2022 and Occupancy was at 89%. Appendix 3 includes details of 1:1 care required by this ward

Recommendation: This Establishment Review indicates no change to the budgeted establishment for AMU as a separate business case has been approved.

WARD 7- Cardiology

Ward 7 is a 28 bedded unit based in the West Wing of the Main hospital site and has 5 monitored Coronary Care beds. The department has 3 side rooms of which 2 are not directly visible at the Nurses Station.

A significant requirement for this department is that they are required to attend out of hours cardiac arrest calls. Current staffing of 3 RNs on duty at night results in 2 RNs being left in the department when staff attend to cardiac arrest calls out of hours.

A decision is required as to whether there remains a clinical need for a member of Coronary Care staff to attend all cardiac arrests at night.

The nurse sensitive indicators results for January 22 are: 3.14 falls per 1000 bed days, with 1.57 Pressure Ulcers, 1 Medication error reported and no HCAI Incidents. Occupancy in January 2022 was at 89%

This Establishment Review indicates the need for an increase of 1 RN to the night shift if there remains a requirement to attend cardiac arrests out of hours resulting in staffing of:

Shift	RN	CSW
Day	5	3
Night	4	2

To facilitate the staffing numbers required to support a member of staff attending cardiac arrests across the Trust at night, requires an increase of 2.43 band 5 RNs.

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	7.56	12.24	0.00	0.00	12.63	33.43
Required WTE	1.00	7.56	14.67	0.00	0.00	12.99	36.22
Total WTE difference required	0	0	2.43	0	0	0.36	2.79

Recommendations: that the nursing model is reviewed with regard to staff holding the cardiac arrest bleep at night. Review again June 2022

WARD 15-General Medicine/ Diabetes/ Haematology

Ward 15 is a 28 bedded unit based in the West Wing of the Main hospital site and has 4 side rooms

The nurse sensitive indicators results for January 2022 are: 12.69 falls per 1000 bed days, with 2.82 Pressure Ulcers, 0 Medication errors reported and no HCAI Incidents. Occupancy in January 2022 was at 80%.

This Establishment Review indicates no change to current establishment, which will result in staffing of:

Shift	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	15.0	2.00	0.00	18.0	40.0
Required WTE	1.00	4.0	15.0	2.00	0.00	18.0	40.0
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: no further action at this time

WARD 16- Gastroenterology

Ward 16 is a 25 bedded unit based in the West Wing of the Main hospital site and has 4 side rooms. This ward caters for Gastroenterology and general medical patients

The nurse sensitive indicators results for January 2022 are: 1.44 falls per 1000 bed days, with 1.44 Pressure Ulcers, 0 Medication errors reported and 1 case of C-Diff in month. 1 complaint was received, and occupancy in January 22 was at 88%

This Establishment Review indicates no change to the current budgeted establishment and will result in staffing of:

Shift Mon-Fri	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing numbers requested budgeted establishment will remain:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	3.0	15.0	3.0	0.00	17.0	39.10
Required WTE	1.00	3.0	15.0	3.0	0.00	17.0	39.10
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further action at this time – review June 2022

WARD 17- Respiratory

Ward 17 is a 25 bedded unit based in the West Wing of the Main hospital site and has 4 side rooms, 3 of which have limited visibility from the Nurses Station.

The nurse sensitive indicators results for January 2022 are: 9.51 falls per 1000 bed days, with no Pressure Ulcers, 0 Medication errors reported and 1 case of C-Diff in month. Occupancy in January 22 was at 93%. A recent request to temporarily uplift staffing, which was supported by the Director of Nursing has improved quality indicators and staff morale within the department- 3 senior staff left at the end of 2021 citing stress and work-related activities as a reason for their departure. Data from the department demonstrates an improvement with outcomes since the staffing was supported to be elevated.

This Establishment Review indicates staffing of:

Shift	RN	CSW
Day	5	4
Night	4	3

To facilitate the staffing indicated in the review requires an increase in band 5 RN and band 2 CSWs:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	5.20	12.80	3.00	0.00	12.90	34.90
Required WTE	1.00	5.20	14.03	3.00	0.00	18.18	41.41
Total WTE difference required	0	0	1.23	0	0	5.28	6.51

Recommendations: To work with the ward to understand the requirements further – review in June 2022 with validation from the workforce team. Due to tool, NSI and professional judgement consideration to HCAs required. Confirmation and validation of figures to occur in June 2022 and review against planned business case for an NIV Unit potential

WARD 29- Acute Medical

Ward 29 is a 36 bedded unit based in the Modular block of the Main hospital and has 6 side rooms. The client group is acute short stay medicine.

The nurse sensitive indicators results for January 2022 are: 11.46 falls per 1000 bed days, with 1.29 Pressure Ulcers, 4 Medication errors reported and no HCAI. Occupancy in January 22 was at 67%

This Establishment Review indicates no change to the establishment and staffing numbers will remain as:

Shift	RN	CSW
Day	6	4
Night	5	4

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	19.7	5.0	0.00	20.6	50.3
Required WTE	1.00	4.0	19.7	5.0	0.00	20.6	50.3
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further action at this time – review June 2022

DIVISION OF SURGERY

WARD 10- Trauma

Ward 10 is a 27 bedded unit based in the West Wing of the Main hospital site and has 3 side rooms.

Ward 10 is the Trauma ward within the hospital accepting admissions for fracture Neck of Femur as part of their cohort.

The nurse sensitive indicators results for January 2022 are: 2.71 falls per 1000 bed days, with 1.36 Pressure Ulcers, 0 Medication errors reported and 1 C-Diff case. 1 Complaint was received in January 2022 and Occupancy was at 83%

At the previous establishment review in June 2021 and the paper approved by Trust board, ward 10 required 5 RNs and 4 CSWs during the day and 3 RNs and 3 CSWs at night. However, it has identified that the budgets were not adjusted appropriately following the June 2021 review and therefore an adjustment of 2.35 RNs and 3.03 CSWs is required to reflect the previously agreed establishments.

This Establishment Review of January 2022 indicates no change to the establishment and staffing numbers agreed in June 2021 and will remain as:

Shift	RN	CSW
Day	5	4
Night	3	3

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.52	9.82	4.94	0.00	15.15	33.43
Required WTE	1.00	2.52	12.17	4.94	0.00	18.18	38.81
Total WTE difference required	0	0	2.35	0	0	3.03	5.38

Recommendation: No change from the establishment agreed in June 2021. Further review in June 2022

WARD 11- Complex Surgery

Ward 11 is a 25 bedded unit based in the West Wing of the Main hospital site and has 3 side rooms with limited visibility to 2 side rooms.

The nurse sensitive indicators results for January 2022 are: 1.33 falls per 1000 bed days, with 0 Pressure Ulcers, 10 Medication errors reported and no HCAI. 2 Complaints were received in January 2022 and Occupancy was at 95%

The Establishment Review indicates staffing of:

Shift	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing indicated in the review requires an increase in band 5 RN and band 2 CSWs

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.60	14.76	1.00	0.00	15.15	34.51
Required WTE	1.00	2.60	16.03	1.00	0.00	18.18	38.81
Total WTE difference required	0	0	1.27	0	0	3.03	4.30

Recommendations: Nurse staffing indicators are within range. Review again in June 2022 with validation from the workforce team

Ward 12-Emergency Surgery

Ward 12 is a 27 bedded unit based in the West Wing of the Main hospital site and 3 side rooms with limited visibility to 2 side rooms.

Wards 11 and 12 were historically managed as one ward (ASU) with a single budget. Following a reconfiguration over a year ago ward 11 became a complex surgical ward and ward 12 the emergency surgical ward. At the point of this change being made the budgets and establishments were split. The decision on allocation of the budget between the two wards was not based on the acuity or dependency of patients or any other nurse sensitive indicators.

Ward 12 is currently staffed to 5 RNs and 4 CSWs during the day and 4 RNs and 2 CSWs at night. This was approved at the June 2021 review and there is no change required following this establishment review. The current budget following the split from ward 11 does not align to the approved safe staffing levels, with a deficit on the budget lines on 8.80 WTE Band 5 RNs and 8 WTE band 2 CSWs and this needs resolving.

The nurse sensitive indicators results for January 2022 are: 1.37 falls per 1000 bed days, with 0 Pressure Ulcers, 1 Medication error reported and no HCAI. 0 Complaints were received in January 2022 and occupancy was at 79%

This Establishment Review indicates no change to the establishment and staffing numbers will remain as:

Shift	RN	CSW
Day	5	4
Night	4	2

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.00	10.43	1.00	0.00	7.58	22.01
Required WTE	1.00	2.00	19.23	1.00	0.00	15.58	38.81
Total WTE difference required	0	0	8.80	0	0	8.0	17.8

Recommendations: No change to current staffing levels. Review in June 2022. The budget anomalies identified need addressing separately

Ward 20a-Elective Surgery

Ward 20a plus 20b is a 28 bedded unit based in the Main hospital, but the layout of the area means there is an expansive floor area of cover. Ward 20a has 16 beds with 8 side rooms. Though the SNCT has been used to measure in this department, its use is not recommended as a tool of choice due to the low number of beds in the ward. Professional Judgement weighs heavily in the decision making for this department.

The combined department has a bay of 4 Enhanced Recovery beds which are in use as per national guidelines to support patients who may otherwise require Intensive Care support. Since the reintroduction of elective activity as part of the post pandemic elective recovery plans the department has been used to its full potential and is influencing positive outcomes for surgical recovery. A separate business case will be developed to support the future of enhanced recovery

The nurse sensitive indicators results for January 2022 are: 5.48 falls per 1000 bed days, with 0 Pressure Ulcers, 0 Medication errors reported and no HCAI. 1 Complaint was received in January 2022 and occupancy was at 78%

This Establishment Review indicates no change to the establishment and staffing numbers will remain as:

Ward 20a			Enhanced recovery		
Shift	RN	CSW	Shift	RN	CSW
Day	4	4	Day	1	1
Night	3	2	Night	1	1

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.32	21.34	1.00	0.00	20.21	47.87

Required WTE	1.00	4.32	21.34	1.00	0.00	20.21	47.87
Total WTE difference required	0	0	0	0	0	0	0

Recommendations: No change at this time. Further review in June 2022. NSI within limits

DIVISION OF WOMENS AND CHILDRENS

WARD 23-Gynaecology

Ward 23 is an 8 bedded unit based in the Main hospital site and this area delivers gynaecological care. Though the SNCT has been used to measure in this department, its use is not recommended as a tool of choice due to the low number of beds in the ward. Professional Judgement weighs heavily in the decision making for this department. The department also support the Gynaecology Assessment Unit with CSW cover at weekends.

The nurse sensitive indicators results for January 2022 are: 0 falls, 0 Pressure Ulcers per 1000 bed days, 0 Medication errors reported and 0 HCAI. Occupancy was at 49% based upon use of 12 beds

This Establishment Review indicates no change to the establishment and staffing numbers will remain as:

Shift	RN	CSW
Day	2	1
Night	2	1

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	1.00	11.13	0.00	0.00	7.58	20.71
Required WTE	1.00	1.00	11.13	0.00	0.00	7.58	20.71
Total WTE difference required	0	0	0	0	0	0	0

Recommendations: No further change at this time. Review June 2022

DIVISION OF COMMUNITY

HOLLYBANK HOUSE-Stroke Rehabilitation

Hollybank is a 12 bedded unit based off site in Willenhall. There is limited visibility of all bays from main desk due to layout. Though the SNCT has been used to measure in this department, its use is not recommended as a tool of choice due to the low number of beds in the ward. Professional Judgement weighs heavily in the decision making for this department.

The nurse sensitive indicators results for January 2022 are: 0 falls, 0 Pressure Ulcers per 1000 bed days, 0 Medication errors reported and 0 HCAI. Occupancy was at 81% based upon use of 12 beds

This Establishment Review indicates no change to the establishment and staffing numbers will remain as:

Shift	RN	CSW
Day	3	2
Night	2	2

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	3.52	7.18	0.00	0.00	10.10	21.80
Required WTE	1.00	3.52	8.32	0.00	0.00	10.39	23.23
Total WTE difference required	0	0	1.14	0	0	0.29	1.43

Recommendations: No further change at this time. Review June 2022

Recommendations to Trust Board following completion of skill mix review in January 2022

The skill mix review was undertaken in January 2022 during the peak of the Omicron COVID-19 variant. Skill mix reviews are undertaken every 6 months and the next review will take place in June 2022 (next month).

The Director of Nursing recommends the following:

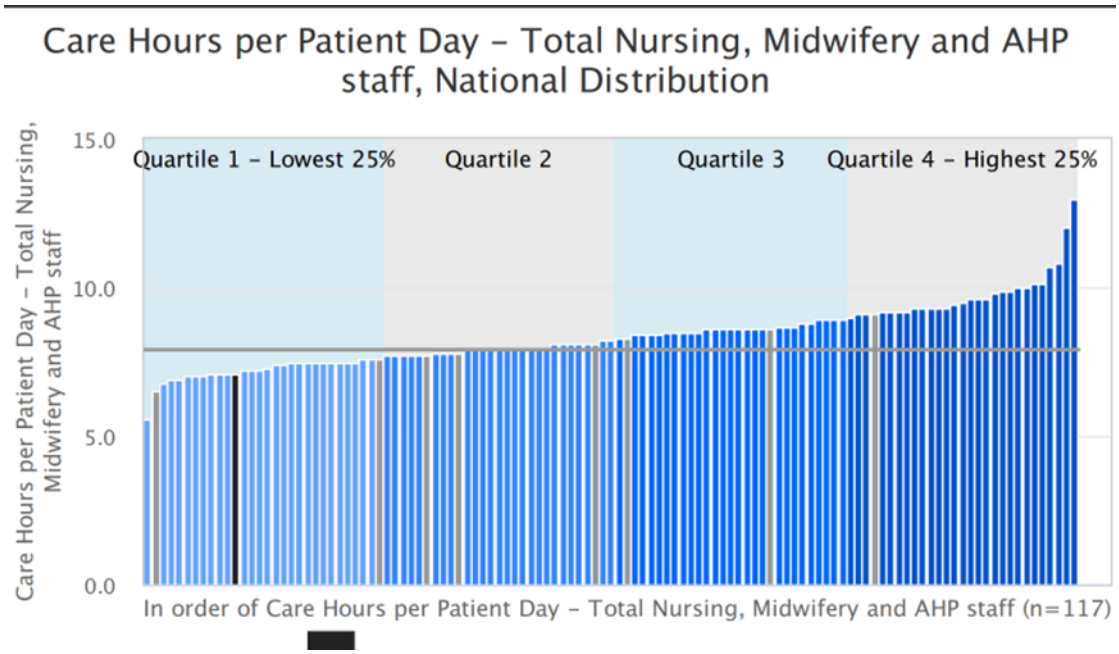
- Complete the planned skill mix review in June 2022 to enable a comparison between the data collected in January 2022 during the peak of a COVID-19 wave and at a point when we are living with COVID.
- Review the June 2022 SNCT data and Nurse Sensitive Indicators with Divisions to ensure professional judgement included in recommendations
- An updated paper will be presented to Trust board in August 2022 with recommendations for all wards.

NURSE SENSITIVE INDICATORS AND CARE HOURS PER PATIENT DAY (CHPPD).

An additional part of the skill mix review has been to use data available on the Model hospital to benchmark the Trust position with CHPPD (graph 4)

Graph 4 shows the most recent Model Hospital position (Dec21) of the Trust CHPPD both nationally and with peers, the Trust value is 7.1 against a national value of 8.2 or peer median of 7.9

Graph 4 – Care Hours per Patient Day – Total Nursing/Midwifery and AHP staff



APPENDIX 1

Levels of acuity and dependency

Level 0: Patient requires hospitalisation. Needs met by provision of normal ward cares.

•Elective medical or surgical admission

•May have underlying medical condition requiring on-going treatment

•Patients awaiting discharge

•Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly

•Regular observations 2 - 4 hourly

•**Early Warning Score** is within normal threshold.

•ECG monitoring

•Fluid management

•Oxygen therapy less than 35%

•Patient controlled analgesia

•Nerve block

•Single chest drain

•Confused patients not at risk

•Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence

Level 1a: Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate

Increased level of observations and therapeutic interventions

•Early Warning Score - trigger point reached and requiring escalation.

•Post-operative care following complex surgery

•Emergency admissions requiring immediate therapeutic intervention.

•Instability requiring continual observation / invasive monitoring

•Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly

•Arterial blood gas analysis - intermittent

•Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains

•Severe infection or sepsis

Level 1b: Patients who are in a STABLE condition but are dependent on nursing care to meet most or all the activities of daily living.

•Complex wound management requiring more than one nurse or takes more than one hour to complete.

•VAC therapy where ward-based nurses undertake the treatment

•Patients with Spinal Instability / Spinal Cord Injury

•Mobility or repositioning difficulties requiring the assistance of two people

•Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care)

•Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome

•Patients on End-of-Life Care Pathway

•Confused patients who are at risk or requiring constant supervision

•Requires assistance with most or all activities of daily living

•Potential for self-harm and requires constant observation

•Facilitating a complex discharge where this is the responsibility of the ward-based nurse

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / •Deteriorating / compromised single organ system

•Post-operative optimisation (pre-op invasive monitoring) / extended post-op care.

•Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure

•First 24 hours following tracheostomy insertion

•Requires a range of therapeutic interventions including:

•Greater than 50% oxygen continuously

•Continuous cardiac monitoring and invasive pressure monitoring

•Drug Infusions requiring more intensive monitoring e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium

•Pain management - intrathecal analgesia

•CNS depression of airway and protective reflexes

•Invasive neurological monitoring unit

Level 3: Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

•Monitoring and supportive therapy for compromised / collapse of two or more organ / systems

•Respiratory or CNS depression / compromise requires mechanical / invasive ventilation

•Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection.

APPENDIX 2

Nurse Sensitive Indicators

Formal complaints

Registered complaints about nursing/midwifery care/staff in the following three areas:

- Communication
- Clinical care
- Attitude

Medication Errors

Actual medication errors where nursing was the primary cause

Infection

Incidence rates of MRSA bacteraemia and Clostridium Difficile

Slips, trips and falls

Number of slips, trips and falls

Pressure Ulcers

Prevalence of pressure ulcers developed in hospital

REFERENCES

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c. Griffiths P, Ball J, Murrells T, Jones S, Rafferty AM (2016b) Registered nurse, health care support worker, medical staffing levels and mortality in English hospital Trusts a cross sectional study. BMJ open 5:e008751

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e. NHS England (2016) Leading Change, Adding value: A framework for nursing, midwifery and care staff http://www.england.nhs.uk/ourwork/leading-change

f. NICE (2013) Safe staffing for nursing in adult inpatient wards in acute hospitals. http://www.nice.org.uk/guidance/SG1

g. NQB (2016) How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability http://www.england.nhs.uk/ourwork/part-rel/nqb

h. The Safer Nursing Care Tool The Shelford Group – 2013 http://shelfordgroup.org/resource/chief-nurses/safer-nursing-care-tool http://shelfordgroup.org/library/documents/SNCT A4 pdf

i. Developing Workforce Safeguards – 2018 NHSI.

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Walsall Together Partnership Board
Date(s) of Committee/Group Meetings	Wednesday 18th May 2022
Chair of Committee/Group:	Professor Patrick Vernon
Date of Report:	23rd May 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• COVID-19 continues to circulate within the community and continues to impact on staff absences • There are potential implications for Walsall Healthcare as a result of the establishment of Place Based Partnerships. This includes changes to the governance of the partnership and also the scope of services contracted and provided by Walsall Healthcare. Walsall Healthcare is represented across several workstreams and an Executive Group, which are currently mobilising.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The Walsall Together Partnership Board met in full on Wednesday 18th May 22, Chaired by Professor Patrick Vernon • There were no items for escalation to the Trust Board.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Demand has subsided in some areas, allowing workforce to be redirected to relieve pressures in areas of continued high demand • Partnership risk registered was reviewed and approved • No significant risks or delays in the transformation programme
Recommendation(s) to the Board/Committee	• Members of the Trust Board are asked to note the contents of this report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• Partners received an overview of the Partnership Risks for which the Partnership Board is the monitoring group. Key themes within the risks reflect the continued demand across the system due to COVID-19 and restoration efforts. The detail of the risks was reviewed and approved.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• CPLG will continue to develop the 2022/23 transformation programme • Agree a schedule of Place Development Sessions for Board • Further scoping of organizational development for integrated health and social care teams delegated jointly to Workforce & OD Steering Group and Resilient Communities Steering Group

ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	**USER STORY: MINDKIND** • MindKind is an organisation that supports people living within deprived communities; they are a third-sector organisation that was successful in securing grant funding to support Walsall Together to reduce health inequalities. They have a varied workforce including social workers, mental health first aid trainers and healthcare assistants. Board members received an update on the broad work of Mindkind, which includes working with citizens to break down barriers to accessing services and building trust. The Board also heard about some of the challenges facing third-sector organisations in the context of a) securing investment from statutory organisations and b) sustaining valuable work in the context of non-recurrent funding. • The presentation was very well received and celebrated by Board members, recognising the invaluable work of this organisation with some of our most vulnerable communities. The Board resolved to maintain contact with Mindkind and to explore how we can work collaboratively in future achieve positive outcomes for residents in a more sustainable way. **COMMUNICATIONS** • The Board approved the monthly Communications Brief, which has since been disseminated across all partner organisations. **TRANSFORMATION PROGRAMME** • The board took assurance that there were no new or significant risks to delivery of the transformation programme. The planning round for the 2022/23 programme has been delayed due to operational pressures in early 2022 and remains in progress with oversight from the Clinical & Professional Leadership Group.

ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	**PLACE DEVELOPMENT** • The board received assurance that the agreed workstreams within the place development programme are now mobilising, with an initial focus on Governance, and Finance & Contracting. An Executive Group is being established to ensure strong leadership from across the Walsall Together partnership and Walsall Healthcare, due to the implications on both stakeholders as a result of proposed contractual and governance changes. A PMO approach is being established and the Board will receive a more detailed update, including timeframes, to the June meeting. • Partners noted the complexity and scale of work to be delivered by this programme and whilst the partnership is well sighted on the proposed direction of travel, stakeholders across the wider Place and System required more intensive support to ensure they are fully informed and engaged in the decision-making required. Board members also agreed the need to retain focus on delivering services and transformation for the residents of Walsall. • The Board resolved to hold a series of development sessions over the course of 2022 to ensure sufficient oversight and understanding is achieved for all partners collectively. **ORGANISATIONAL DEVELOPMENT: INTEGRATED LOCALITY TEAMS** • The Board considered an approach to developing our integrated locality teams using a coproduction approach grounded in connectivity with the communities we serve. • Alignment to the Wellbeing Framework, previously approved by the Partnership Board, was recognised and supported. • Partners wanted further assurance on the intended objectives and outcomes of the work, to ensure there was sufficient focus on developing improved integrated between health and social care, and to avoid duplication with existing work in Resilient Communities. The Board approved the proposal in principle with delegation to the Workforce & OD Steering Group and Resilient Communities Steering Group to undertake detailed project design. **OPERATIONAL UPDATE** • The Board took assurance that all operational risks and issues are monitored regularly by the established partnership groups. Demand has subsided in some areas during April, allowing workforce to be redirected to relieve pressures in areas of continued high demand. COVID-19 continues to circulate within the community and continues to impact on staff absences. • The Board received an overview of plans to secure funding and further develop the virtual ward model. There was a discussion about the risks associated with supporting patients from deprived communities, who may not have the resources required to support themselves in a traditional virtual ward model. The specific needs of Walsall residents and the impact of deprivation will need to be considered carefully as part of detailed project planning. Key points were also raised around: the need to consider mental health input into the model; the need to embrace digital technology whilst also securing support for patients that have difficulty in accessing digital technology; the involvement of housing partners that can provide assisted technology.
Matters presented for information or noting	• Partnership Management Committee Highlight Report • Clinical & Professional Leadership Group Highlight Report • Workforce & OD Steering Group Highlight Report

Self-evaluation/ Terms of Reference/ Future Work Plan	• The Board reflected on the cost-of-living crisis and the significant impact on several citizens in Walsall, recognising the implications for health and wellbeing. Members agreed to include a strategic discussion item at the June meeting to explore how the partnership can best support residents without duplicating effort or resources already mobilised across Walsall and the wider Black Country system
Items for Reference Pack	• n/a

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 8th June 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	• Hospital avoidance and step-up pathways continued within the borough and performance remained strong in the Care Navigation Centre which helped relieve pressure on the Ambulance Service as well as the hospital sector • A workstream is looking at local measures to address long-term market stability in the domiciliary care and care home sectors		
Advise	• This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain. • It includes operational performance for Community Services and Adult Social Care, situated within the context of Walsall Together • Risk 2624 (risk of sub-optimal care due to capacity) was de-escalated at Risk Management Executive in May, following assurance that no issues have arisen in the previous 3 months		
Alert	• There was significant volatility in month around the numbers of people who were medical stable for discharge at Walsall Manor Hospital • The Board Assurance Framework remains under review by the partnership and will be considered in the context of Place Based Partnerships policy and legislation		
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	Bids have been submitted to NHSE around the development of virtual wards and hospital at home schemes related to the use of technology		
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.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Care at Home Executive Summary
June 2022

1. PURPOSE OF REPORT

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

Updates on the transformation of services and place-based partnership arrangements in Walsall and across the Black Country Integrated Care System (ICS) are included in the Partnership Board Highlight Report.

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 May.

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

3.1 Demand: Demand for Community Locality Services reduced in April 2022 while the Care Navigation Centre saw a sustained high level of demand with 1,278 calls. Colleagues within PCNs report continued high demand on primary care services during April.

3.2 Capacity:

Locality Teams: The impact of two bank holidays on planned activity was noted during April. Staff absence reduced this month, but the Locality Community Teams delivered over 400 fewer hours of care than in the previous month and Adult Social Care undertook 265 reviews (initial & subsequent), which was over 100 fewer than in March.

Discharge & Step-Up Pathways: The number of people at Walsall Manor Hospital who were medically stable for discharge reduced to 50 compared with 53 in the previous

month. There was marked volatility, with the range being 35 – 70 patients in month. This was linked to a sustained increase in referrals for support with complex discharge, with a surge in referrals after the bank holidays which surpassed the additional capacity that had been laid on. Within community pathways, the average length of stay for people discharged from interim care home placements rose to 54 days but the overall number of people in beds decreased. This reflected an increase in staff available to support this part of the discharge pathway and the backlog work that they were able to undertake.

Systems Pressure Plan: The focus in April has been to respond to the request for bids from the Service Development fund aimed at increasing virtual ward activity using technology to support remote monitoring. A series of proposals totalling over £1.6m has been submitted to NHSE for consideration.

It was also agreed to work on market stability regarding the provision of domiciliary and care home services. These sectors are affected by competing employers and recruitment and retention issues. Partners are now focusing attention on support to recruitment and training, professional practice influencing demand, areas of overlap between health and social care and the use of care home beds.

4. BOARD ASSURANCE FRAMEWORK

The overall risk score on the Care at Home Board Assurance Framework (BAF) has reduced to level 12 to reflect the assurance now available regarding the partnership's ability to respond to significant system pressures. The BAF remains under review by the partnership and will be considered in the context of Place Based Partnerships policy and legislation.

There following risks remain on the Corporate Risk Register:

- 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.

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 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

5. 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

Walsall Together

Walsall Together Partnership Operational Update: May 2022

Matthew Dodd
Director of Transformation

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

Tier	Activity	Thresholds						
Tier 0: Resilient Communities								
Social Prescribing	whg - No. referrrals received							
	Primary Care - % referrrals received East 1	<0.4%		>= 0.4%				
	Primary Care - % referrrals received East 2	<0.4%		>= 0.4%				
	Primary Care - % referrrals received North	<0.4%		>= 0.4%				
	Primary Care - % referrrals received South 1	<0.4%		>= 0.4%				
	Primary Care - % referrrals received South 2	<0.4%		>= 0.4%				
	Primary Care - % referrrals received West 1	<0.4%		>= 0.4%				
	Primary Care - % referrrals received West 2	<0.4%		>= 0.4%				
	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22
Workforce: Anchor institutions	No. staff employed by whg via scheme				75	79	86	96
	% whg customer's				37%	37%	38%	39%

[Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

Tier	Activity in-month	Thresholds			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services												
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	5769.75	6038	6127	7015.75	6228.5	5210.5	5713.5	5495.25
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	1557	1255	1271	1093	861	920	1173	906
	% of hours demand unmet	>23%	20%-23%	<20%	21.2%	17.2%	17.2%	13.5%	12.1%	15.0%	17.0%	14.2%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	26	22	26	24	26	23	25	25
	No. referrrals received	<100	100-200	>200	34	26	30	27	25	24	22	19
	No. cases reviewed	<100	100-200	>200	92	88	120	103	108	89	117	83
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%
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).				3.1%	3.2%	3.4%	3.3%	3.3%	3.3%	3.6%	3.8%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).				84.6%	84.4%	84.4%	84.7%	84.9%	84.9%	85.1%	85.6%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	<9.1		>= 9.1	3.6	4.8	6.6	7.2	7.8	9.0	11.9	0.6
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8	306.9	344.6	405.9	437.6	479.2	510.9	562.4	47.5
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%	84.4%	81.7%	85.2%	74.8%	81.8%	80.4%	78.1%	84.6%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				661	695	738	724	831	718	930	905
	Care and Support Assessments and 3 Conversations Completed - Total				346	287	313	292	296	429	316	280
	Monthly Adult contacts completed by Team				1,131	1,071	1,235	1,019	1,228	1,207	1,314	1,162
	Total Initial & Subsequent Reviews Completed				290	290	268	249	288	304	372	265

[Emergent] Score Card for WT Tiers – Tier 2

Tier	Activity in-month	Thresholds			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Tier 2: Specialist Community Services												
ASC Safeguarding Concerns	Concerns received				286	316	297	265	291	336	323	284
	Concerns progressing to s42 eqnuiry				81	87	79	83	73	91	79	76
	% of concerns progressing to s42 enquiry				28%	28%	27%	31%	25%	27%	24%	27%
	Safeguarding cases in progress				17	35	31	7	34	86	63	80
Care Homes	Care Home residents	1,503<	1,503-1,650	>1,650	1,329	1,353	1,325	1,297	1,269	1,276	1,293	1,326
	Vacancies	>291	144-291	144<	370	357	412	416	494	432	409	418
	% vacant beds	>15%	8-15%	8%<	21.8%	20.9%	23.7%	24.3%	28.0%	25.3%	24.0%	24.0%
	Total No of Care Homes	53<	53-56	>56	58	58	59	59	60	60	59	61
	Closed to admissions	>8	3-8	3<	12	5	6	28	20	13	8	9
	% of available homes closed to admissions	>10%	5-10%	5%<	20.7%	8.6%	10.2%	47.5%	33.3%	21.7%	13.6%	14.8%

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)

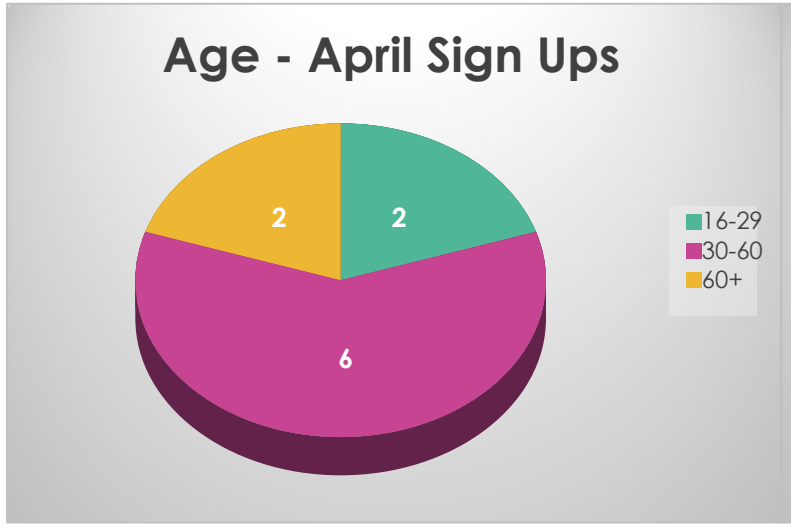
Walsall Together

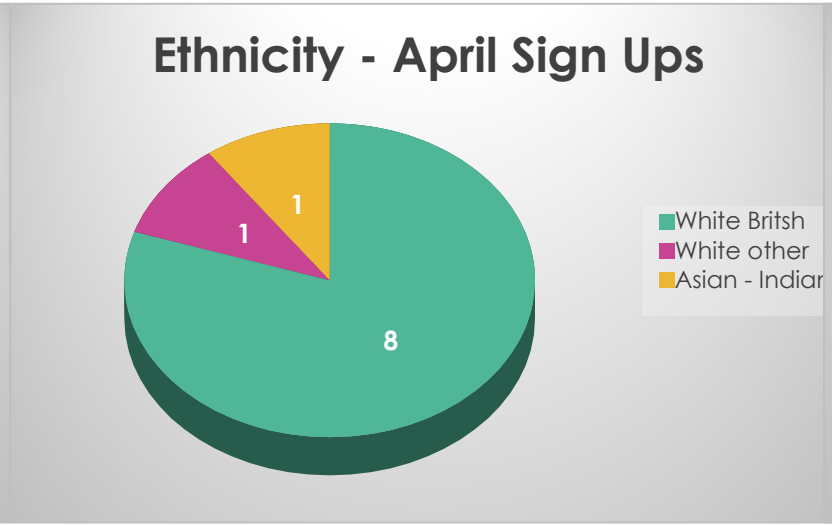
Tier	Activity in-month	Thresholds			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Tier 3: Intermediate Care, Unplanned Care & Crisis Services												
Care Navigation Centre	Calls received	<435	435-512	>512	869	925	861	1094	1225	1170	1338	1278
Rapid Response Team	Referrals received	<160	160-247	>247	227	230	264	268	260	254	294	281
	% admission avoidance	<73%	73%-87%	>87%	79.7%	87.4%	91.7%	90.7%	90.4%	91.3%	85.7%	91.9%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50- 57.5	<50	52.11	41.00	44.67	40.25	48.00	45.88	52.67	50.28
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	4.5	4.5	4.6	3.6	3.4	3.5	3.8	4.3
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	N/A	N/A	35	34	32	26	28	28
	Domiciliary Pathways - Average service users				N/A	N/A	196.5	207.75	200.2	181.5	180.25	198.25
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	N/A	N/A	33	50	43	38	37	54
	Bed-based Pathways - Average beds in use				N/A	N/A	86.5	68.5	74	82.5	90	75
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	113	84	94	85	158	168	162	210
	Early Supported Discharge	40<	40-54	>54	26	35	29	65	35	44	45	29
	Assisted Discharge	35<	35-50	>50	42	54	42	75	54	40	35	56
	Prevent Readmission	35<	35-50	>50	20	43	33	32	41	37	27	20

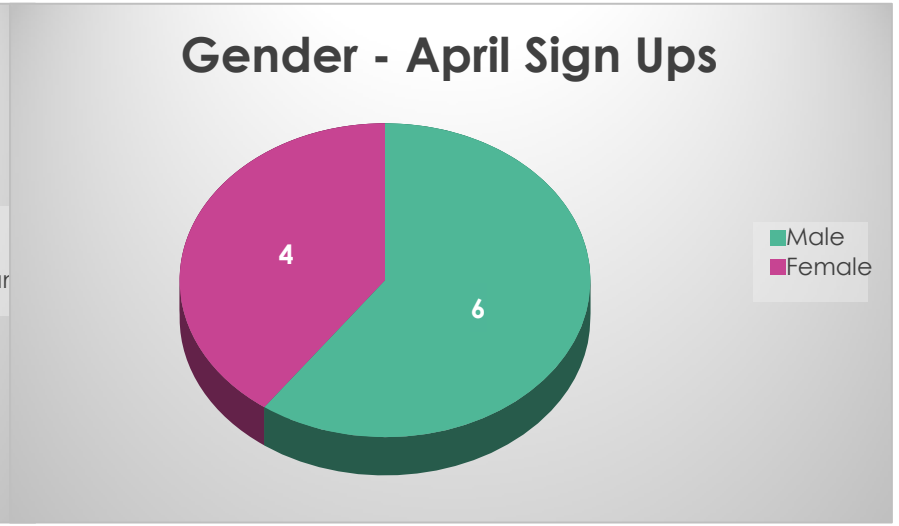
whg Social Prescribing programme April 2022

- 33 Referrals received in April
- 28 Clever Conversations completed (first contact)
- 10 Customers formally signed up to the programme
- 5 Customers signposted to other services
- 18 Customers awaiting support from a Link Worker

Referrals continue to remain high and we are now operating a waiting list . We will monitor this during the remainder of this quarter (April –June 2022)







Last updated on May 2022

whg H Factor Social Prescribing Case Study

'I can't wait to give back to the community, who has supported me so much".

- **Time spent on the Social Prescribing Programme 11 months**
- **Key issues , bereavement, loneliness and isolation debt**
- **Initial WEMWBS Score 20 – End WEMWBS Score 54**

RE is a 60-year-old white British male, who lives on his own in a 2-bedroom house in East Walsall .

RE was referred to SP due to bereavement . His wife had recently passed away and he was really struggling emotionally and financially and his mental and physical health was deteriorating . He explained that his wife had always managed their money and paid their bills, so he was getting into a difficult situation with his finances .

He stated he was lonely and feeling like there was nothing positive to look forward to . He reported he was very anxious and depressed and had an overall feeling of not being able to cope. As trust developed, we completed his first **WEMWBS** assessment with RE scoring **20** which is well below the national average . Using the WOOP approach (Wish Obstacle Outcome and Plan) we encouraged him to talk about the loss of his wife giving him time to think about their life together and moving onto discussions about bereavement counselling . This service had a waiting list however we managed to access a service from Walsall Talking Therapies who offered him weekly telephone counselling sessions . He quickly benefitted from these and he reported that they had helped him to think more positively about his future . Working on a strength based approach we discovered RE loves driving and enjoys getting out and about in his car . We talked about how this could be used to help him, and others . As a start he began to take family , friends and neighbours to appointments . This act of kindness has helped him and others increasing his feelings of being useful and helping him to find a new purpose in his life .

Last updated on May 2022

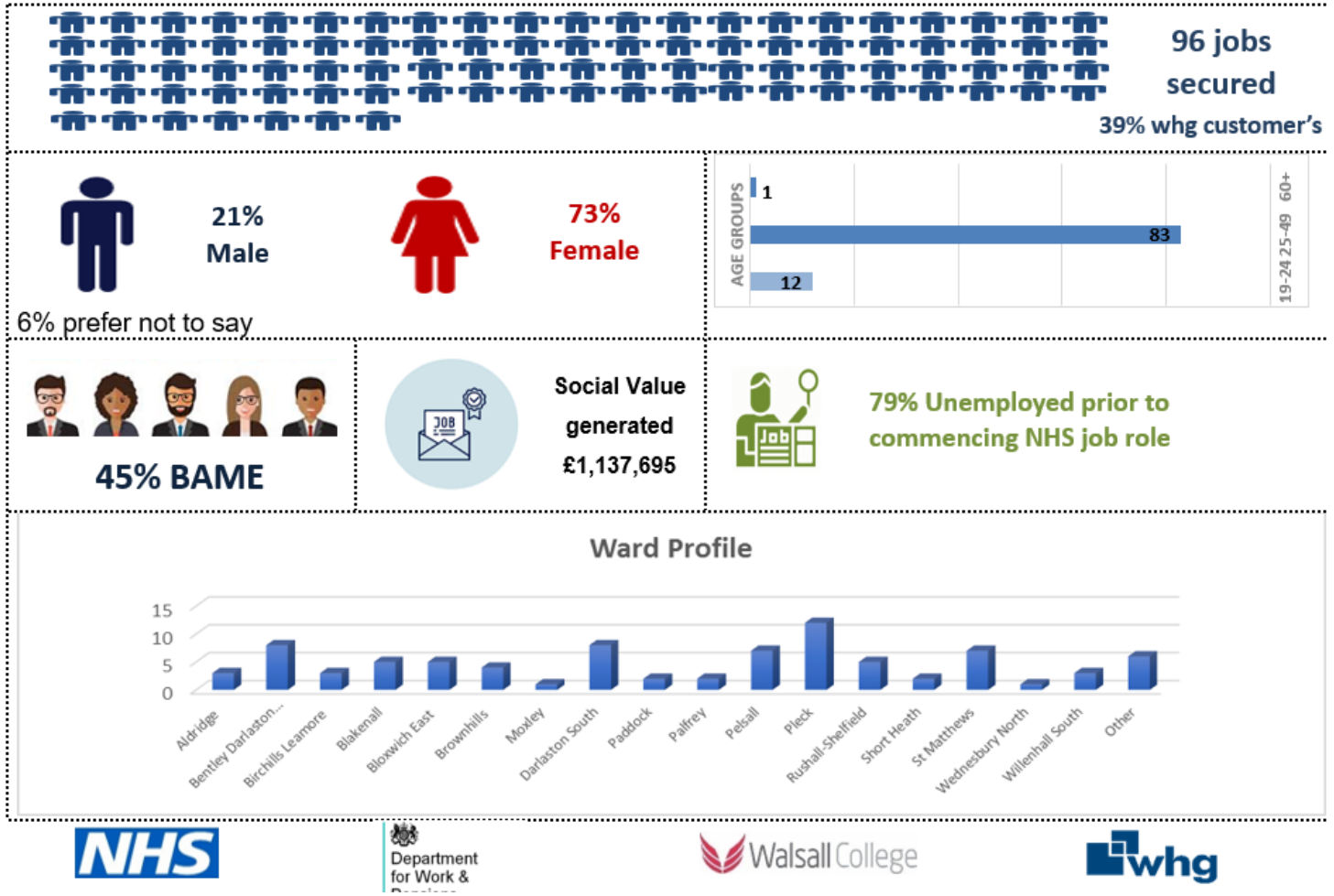
As he appeared to be more positive, we then talked about his finances which he was still struggling to manage. We discovered that RE has several illnesses (heart condition , high blood pressure , arthritis , depression , anxiety and memory loss) . I therefore talked to him generally about health-related benefits . With his permission I referred him to our internal money advice team who helped him apply for Personal Independence Payment . I also secured a **£200** grant towards his heating bills from LEAP a local Energy Action service who can assist people in fuel poverty . RE has 2 children and 3 grandchildren who he hasn't been able to see very much as he was shielding and he was still anxious about COVID-19. I explained I could refer him to whg's digital inclusion team, Click Start . He had never used the internet but with ongoing encouragement he completed whg's six-week Introduction to I.T . As part of whg's support we provided him with a tablet and access to the internet enabling him to **face time** his grandchildren who he had not seen for over 12 months . We encouraged him to attend online community groups which helped him to meet other people and expand his social contacts .
After a wait of around 12 weeks RE was able to attend a bereavement group and he says this has helped him to come to terms with his wife dying . He has also started to attend a guitar group and has even begun to lead the sessions. At the mid -point his WEMWBS score increased from **20** to **43** putting him nearer to a normal range for wellbeing . As his confidence continued to increase , RE was keen to help others in a similar situation . With encouragement he was trained as a volunteer for whg's Befriending service where he now volunteers once a week providing befriending support to older people who are lonely or isolated .
I worked with RE for 11 months and his journey was up and down . At the end of his time his score had improved to **55** . He states he '***is starting to feel like himself once again***'. He can't express he's gratitude enough for our service and support . He is now managing practical tasks such as budgeting , accessing online services and continues to use the support within bereavement counselling service . Social Prescribing has impacted very positively on this person who historically may have been prescribed medication . This would not have built his mental and social capital and may have resulted in him becoming increasingly dependant on services . Given that he is now using his experience to help others demonstrates the power of strength based non clinical support

TIER 2 Workforce Development Work 4 Health

Walsall Together

whg/Walsall NHS Trust's Recruitment Programme

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



NHS | Department for Work & | Walsall College | whg

Last updated on May 2022

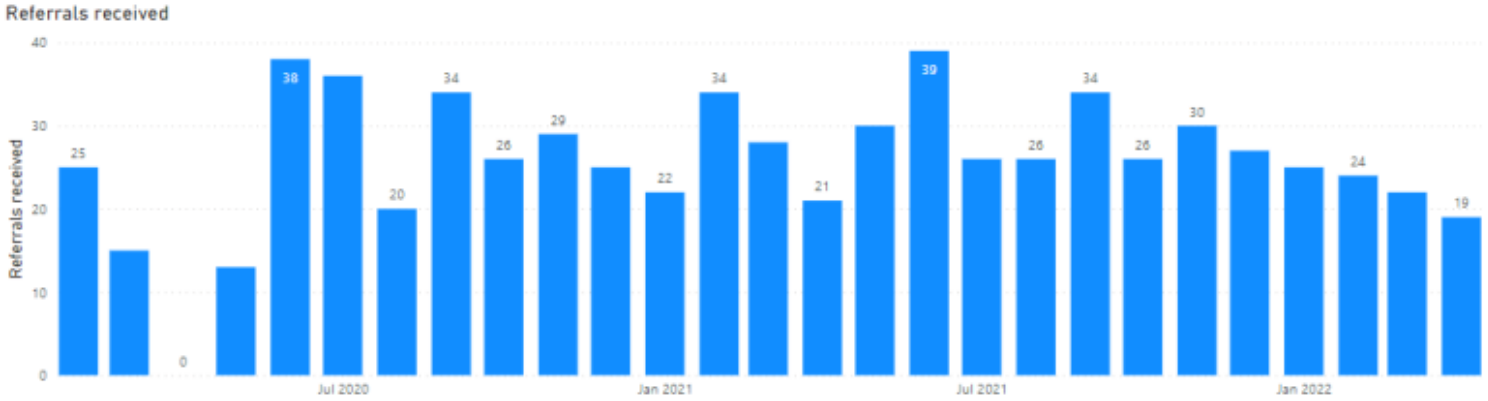
Tier 0: Walsall's Voluntary & Community Sector – One Walsall

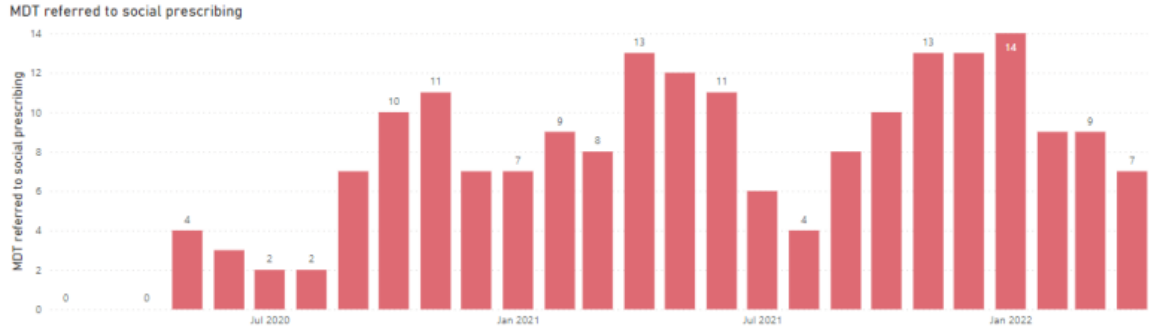
- Work is now underway to promote the Queen's Volunteer Awards ahead of this year's Jubilee. Several Jubilee events are begin held across the borough supported by various funding streams, including events in Mossley, Palfrey and Brownhills.
- Collaborative work and consortia approaches are emerging as a consistent theme for the sector, as groups identify partners to bid for potential contracts for community delivery. This is an encouraging trend as groups look increasingly to work together to enhance their capacity, sustainability and social value.
- Another trend emerging is the continued popularity of Community Interest Companies (CIC). OW will be launching a package of training, support and networking to enhance the offer that social enterprises offer in Walsall
- The six shortlisted applicants for the Health inequalities will be engaging shortly with quality assurance assessments via the One Walsall Development Tool), which will look at financial stability, governance, safeguarding and other areas that will assure funders of project delivery.

Last updated on May 2022

Tier 1: 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 May 2022

Tier 1: Primary Care Standard Operating Procedure (SOP)

- Primary care operating telephone triage and F2F appointments for patients – many practices are now allowing patients to make the choice
- Consultations are being completed via telephone, video consult, online and F2F

Current Pressures:

1. Access to appointments
    - LTC management backlog
    - Out patients backlog
    - Acute Covid appointments
2. Ongoing delivery of the Vaccine programme 4th booster vaccine
3. Access to Out-patient services
4. Patient Demand
5. Zero Tolerance and abuse

Last updated on May 20212

Tier 1: Primary Care Appointment Access (Mar 2022)

- Black Country STP
  - 702,764 appts (increase on 13.05% on Feb 2022)
  - 551,853 attended (90.3%)
  - 41,573 – DNA (5.91) up by 0.5%
  - X1 appt per 2 patients (appt vs patient)

- 64% F2F appts up (62% Feb 2022)
- **91,594 more appointments then in Feb 2022**

Last updated on May 2022

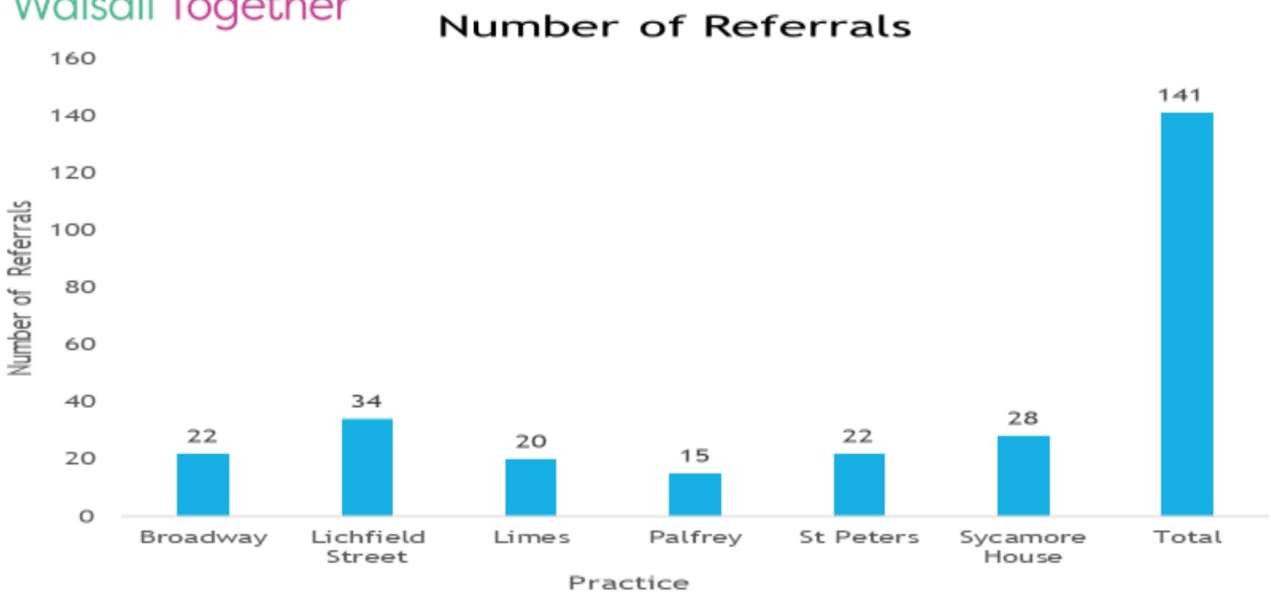
Tier 1: Primary Care Network(PCN) – Additional Roles Reimbursement Scheme (ARRS)

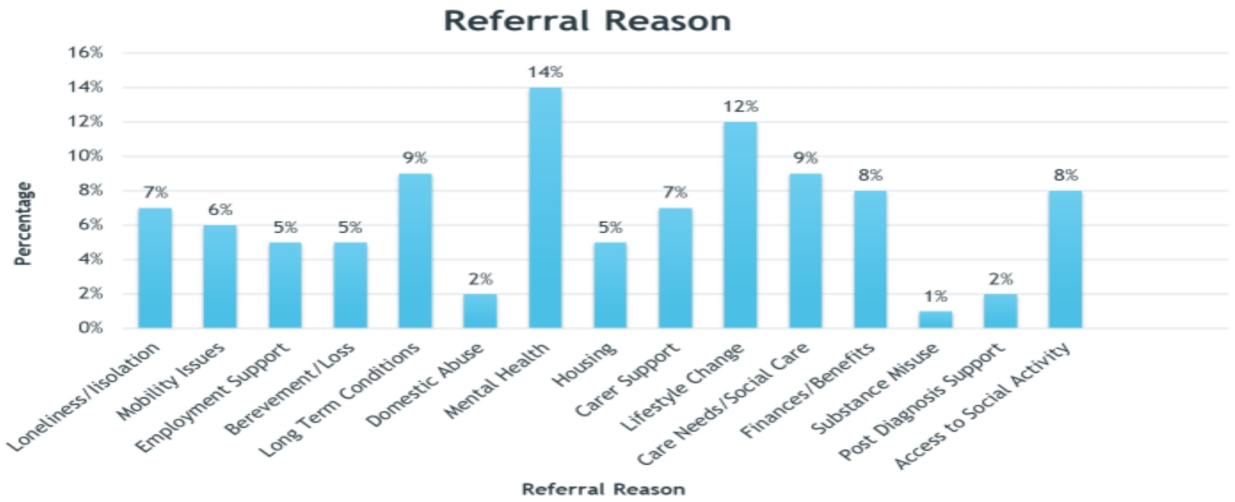
- Currently 3 projects involving PCN ARRS and WT.
  - First Contact Practitioner (FCP) - **just in South 2 PCN**
  - First Contact Mental Health Practitioner
  - SPs development and collaboration -
- Mental Health Practitioner recruitment and retention has been challenging with x1 successful applicant now leaving the post. Awaiting start dates for staff in other PCNs
- SPs have met at WHG with plans to share best practice and further strategic development for wider collaborative working

Last updated on May 2022

Social Prescribing – South 2

- 140-150 referrals per quarter on average - 1.5% over the full financial year
- Mental Health and Finance the majority of the issues
- SPs supporting wider PCN work in:
  - Increasing uptake in cervical screening
  - Weight management referrals
  - Cancer Care support Review

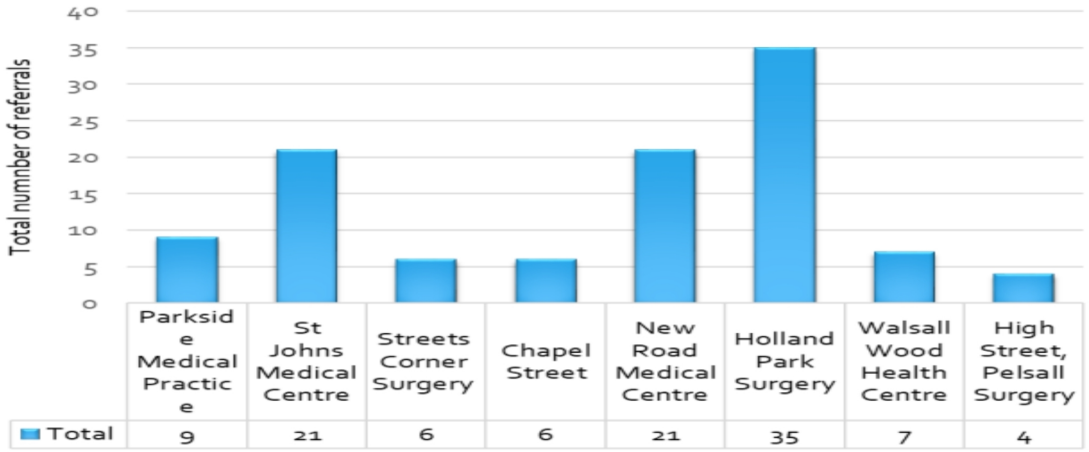


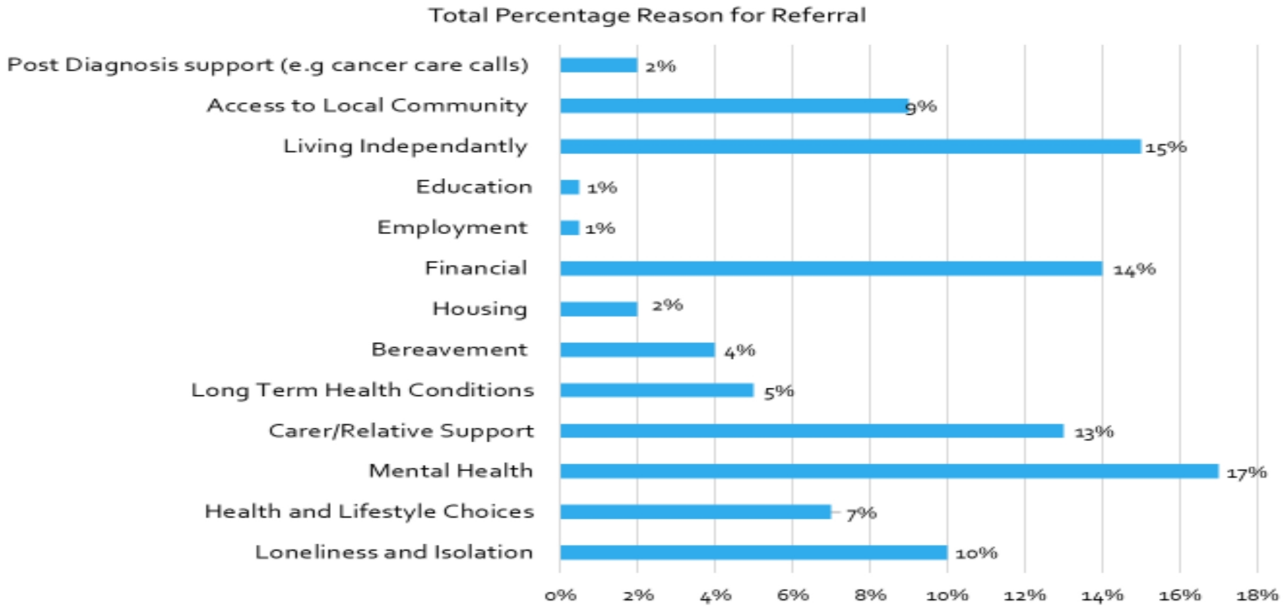


Last updated on May 2022

Social Prescribing – EAST 1

- 100 –130 referrals per quarter on average - 1.73% over the full financial year
- SPs supporting wider PCN work in:
  - Increasing uptake in cervical screening
  - Weight management referrals
  - Cancer Care support Review

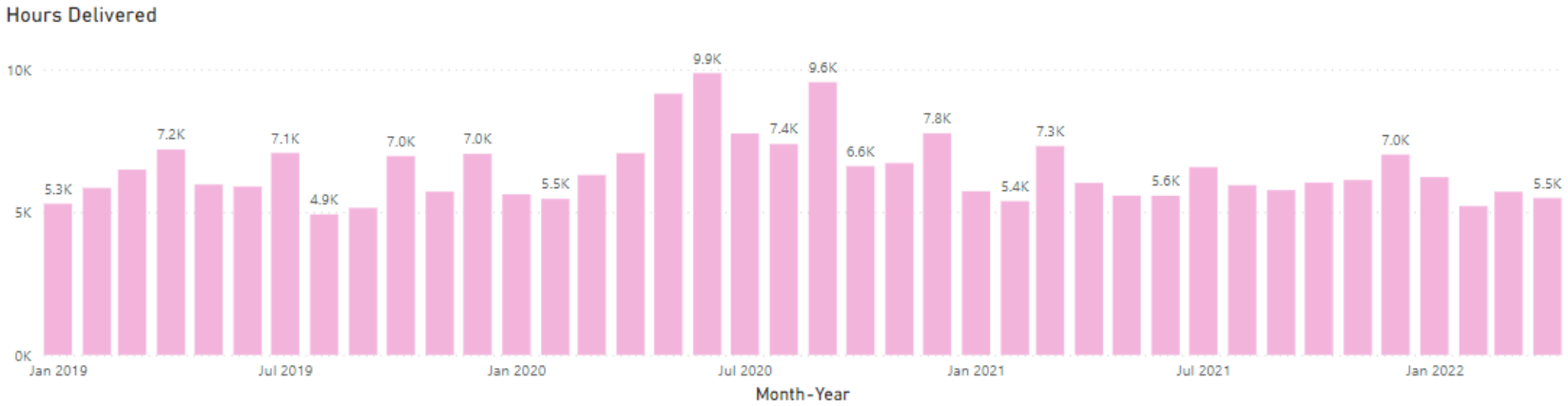


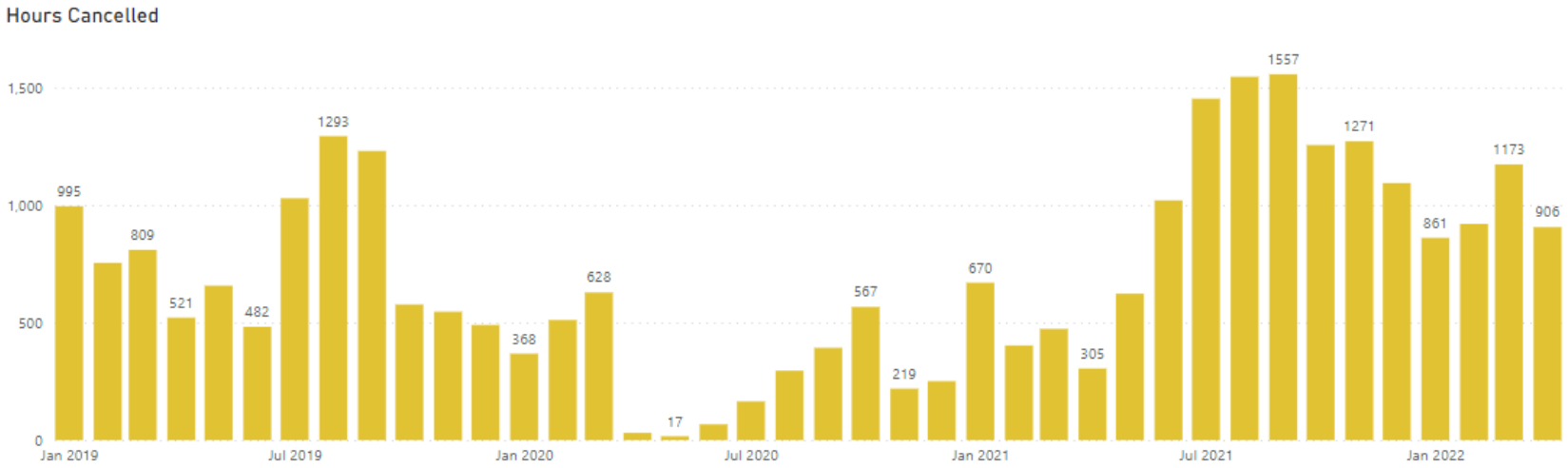


Last updated on May 2022

Tier 1:

Community Nursing Capacity and Demand: In April 2022, Locality District Nursing Teams, cancelled less hours than the previous month.





The Locality Teams delivered slightly less hours in April than were delivered in March due to the level of absence within the Teams.

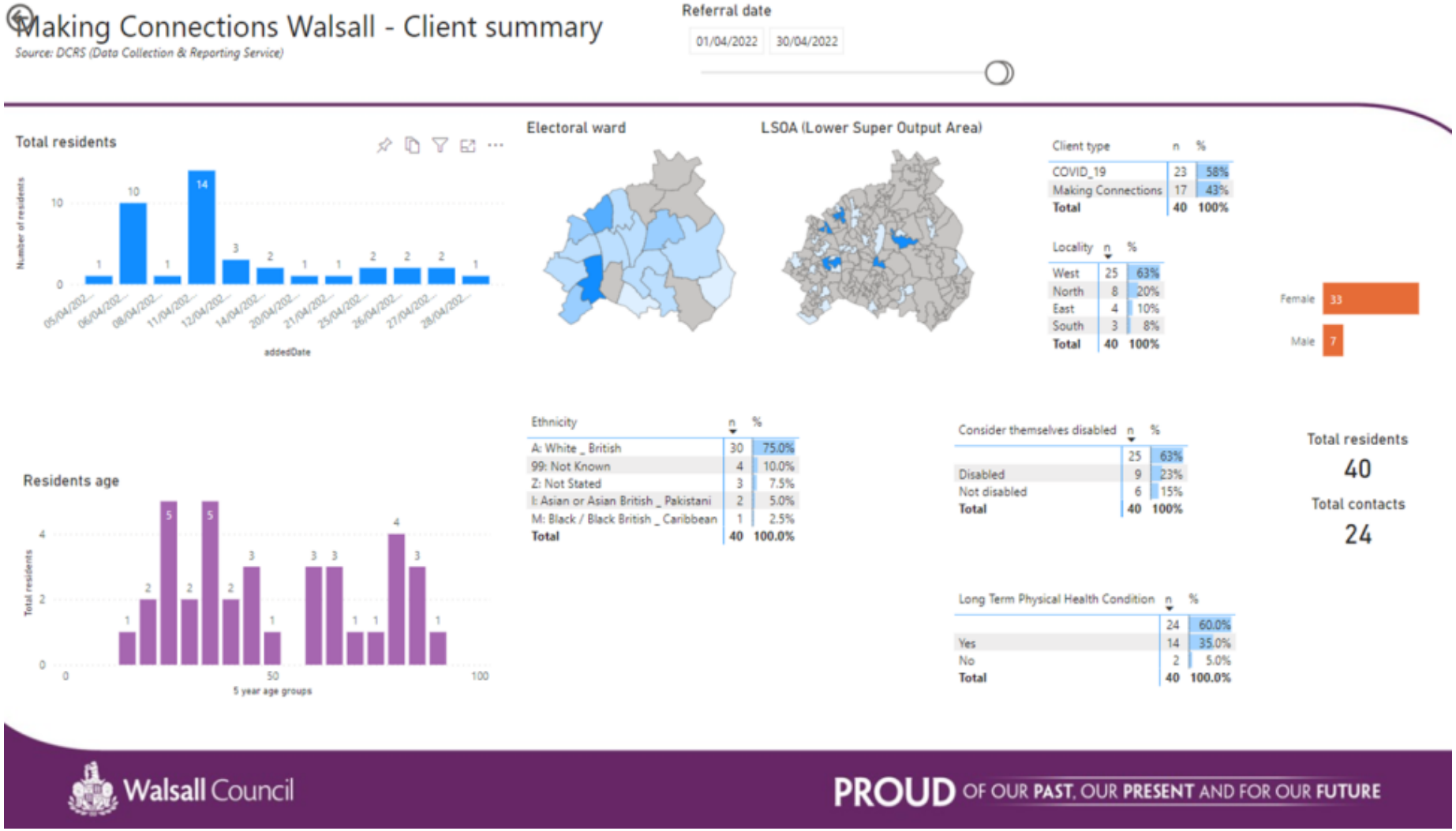
During the month of April, the Locality teams also saw an increase in complexity which included Palliative patients requiring syringe pumps and also complex social issues due to the late palliative diagnosis.

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

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

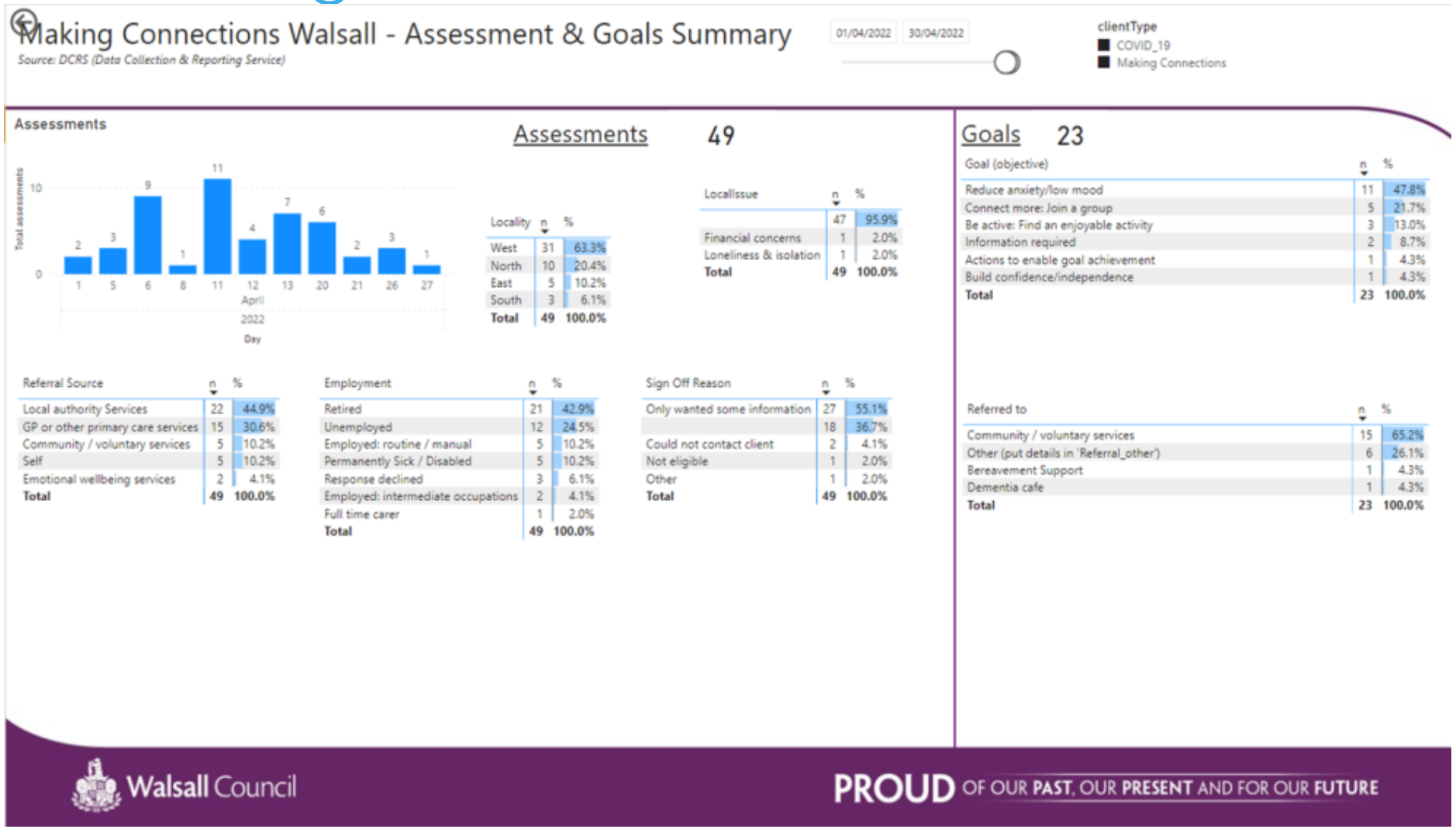
Last updated on May 2022

Tier 1: Making Connections Walsall



Last updated on May 2022

Tier 1: Making Connections Walsall



Last updated on May 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 3 wte of our 7 ARRS workers for year 1. ARRS Workers in Post

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

- Continuing with a rolling 3 month recruitment programme & we are working with workforce & development to explore initiatives to support recruitment
- Banding/NMP under review
- We have appointed a B5 to B6 Clinical Development Role with a view to preparing for B6 ARRS Worker/PCMH Nurse roles

Last updated on May 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 returning back to F2F working offering telephone/video conferencing where this is patient preference and where indicated/appropriate
- The nurses have approached surgeries to determine room availability
- Where an ARRS workers is appointed the PCMH Nurse will receive referrals direct form the ARRS workers
- April referrals dipped which is usual for the Easter period

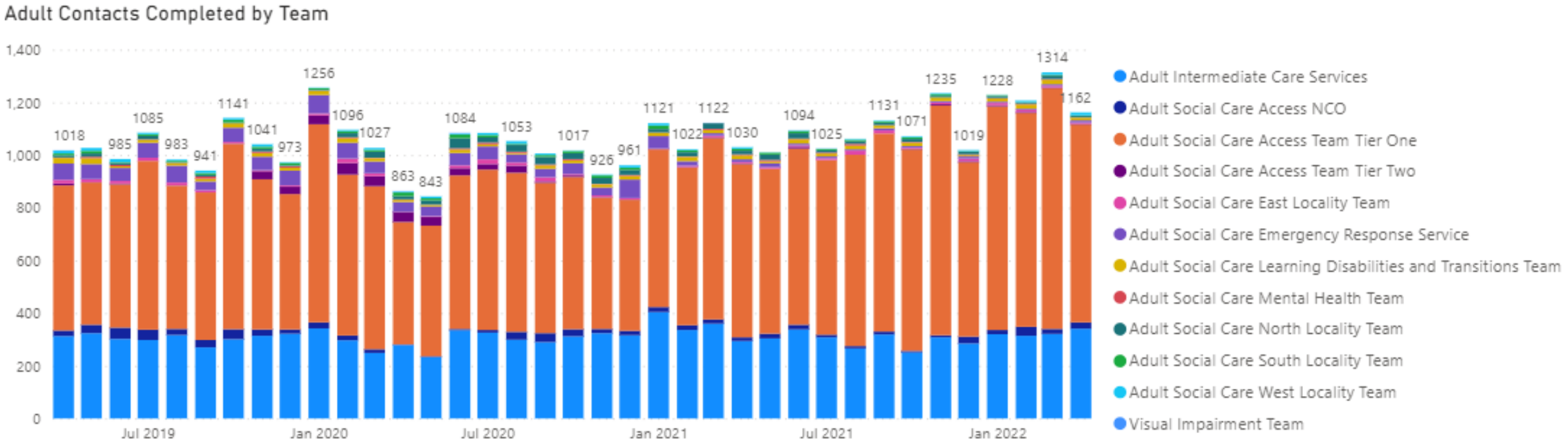
Last updated on May 2022

Activity – April 2022

PCN Name	Jan-22	Feb-22	Mar-22	Apr-22	Total
East 1 PCN	44	64	67	44	219
East 2 PCN	50	39	43	38	170
North PCN	80	61	92	68	301
South 1 PCN	65	67	61	47	240
South 2 PCN	39	33	43	33	148
West 1 PCN	41	53	46	34	174
West 2 PCN	66	56	66	31	219
Total	385	373	418	295	1471

Last updated on May 2022

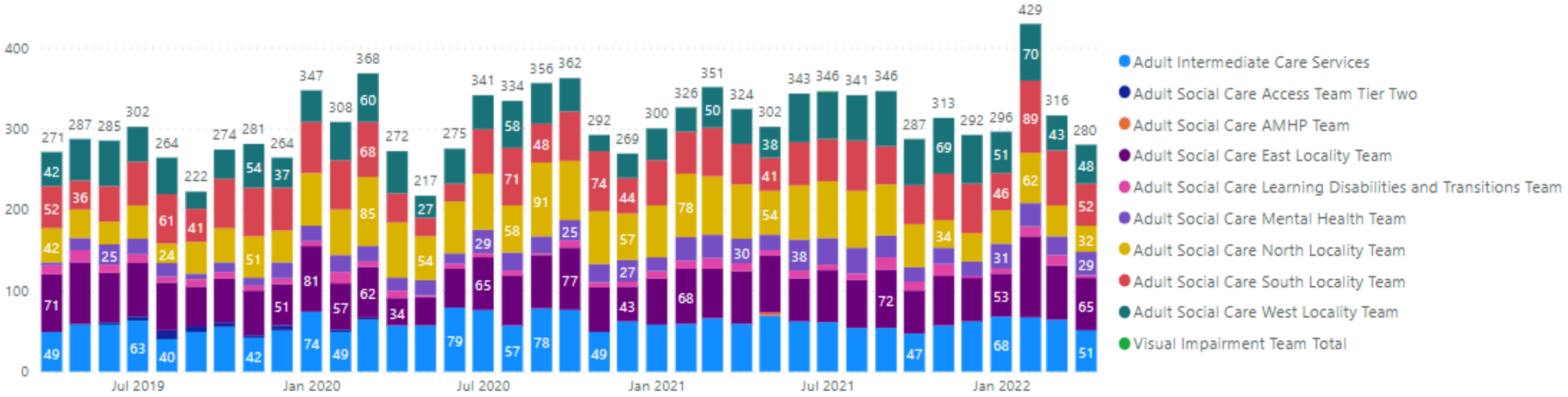
Tier 1:
Adult Social Care



Demand coming into Adult Social Care has increased again in March which has diverted resources to support therefore seeing a decrease in assessments but an increase in reviews completed.

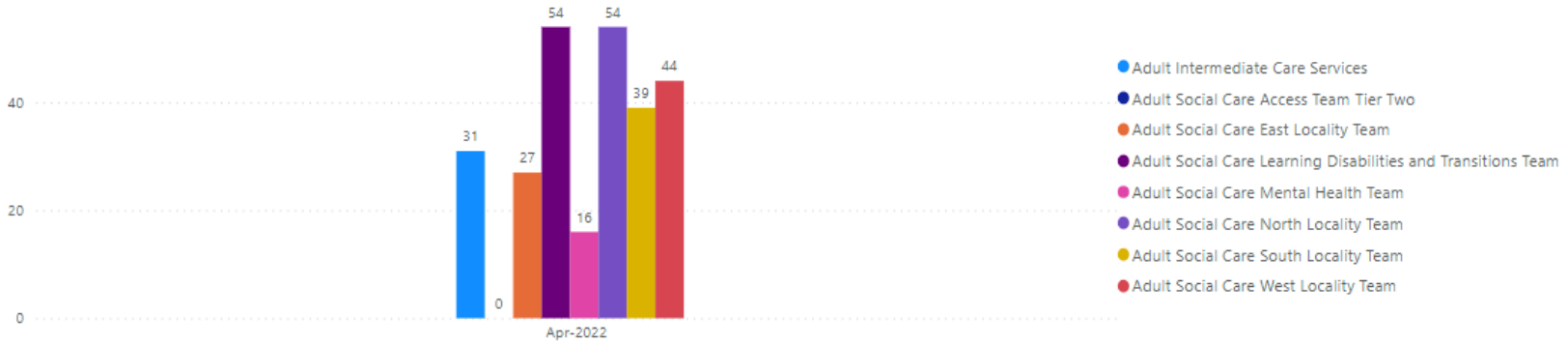
Last updated on May 2022

Care and Support Assessments and 3 conversations completed

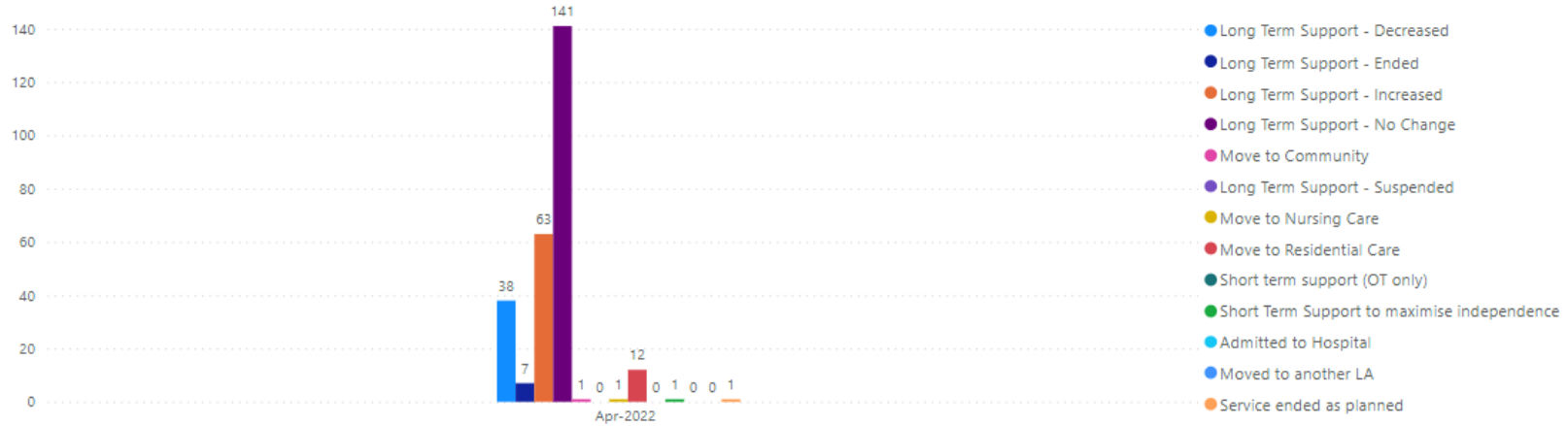


Last updated on May 2022

Initial and Subsequent Reviews Completed by Teams



Initial and Subsequent Review Outcomes



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
Mar-22	372
Apr-22	265

Last updated on May 2022

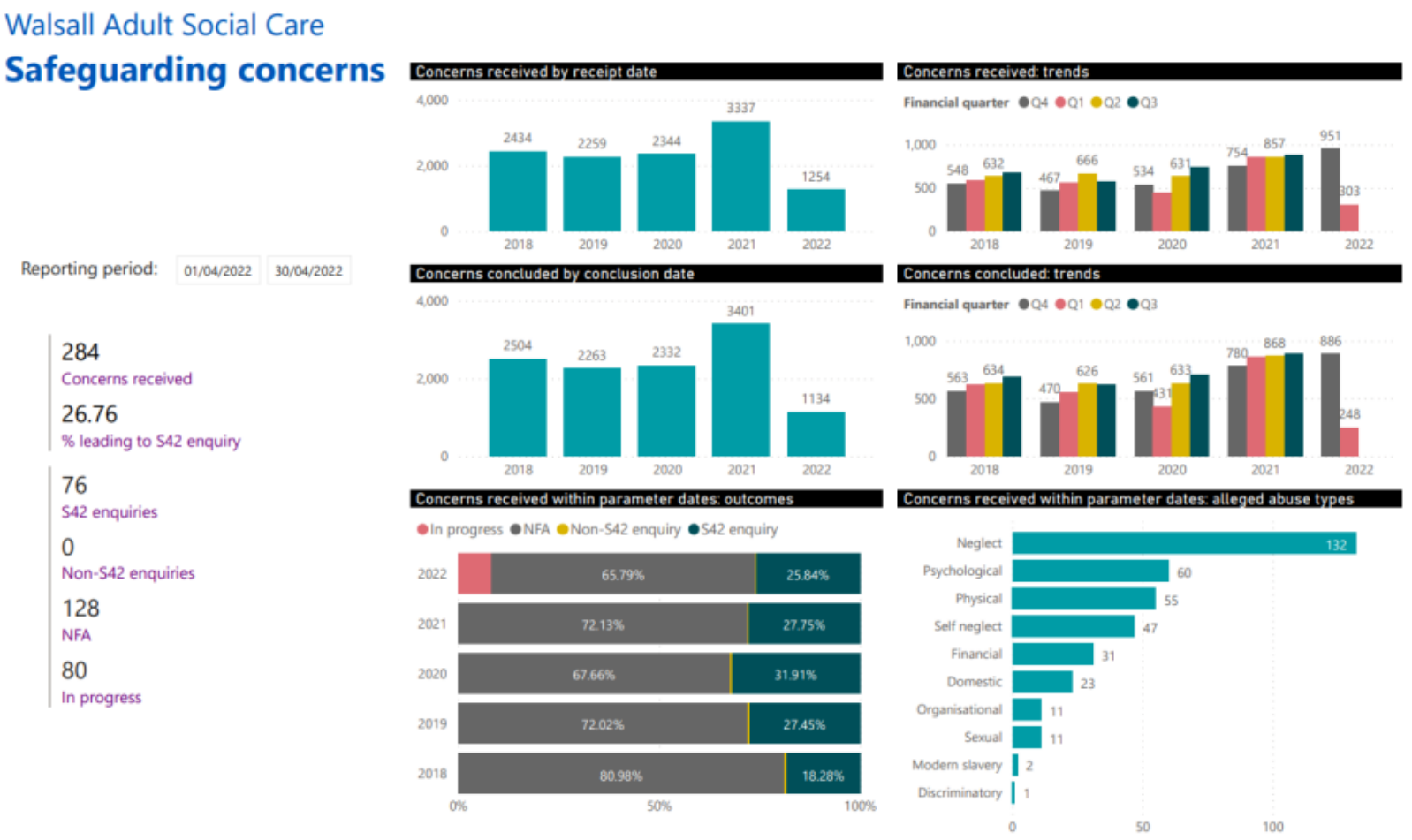
Tier 2:
Adult Social Care

ASC have received 284 concerns which is a reduction of 39 cases on the previous month.

The number of cases progressing to a s42 enquiry is a 26.76% received which is a slight increase on the previous period.

There are currently 76 open s42 enquiries. This has been raised with managers to ensure the timely completion of enquiries which includes caused enquiries.

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



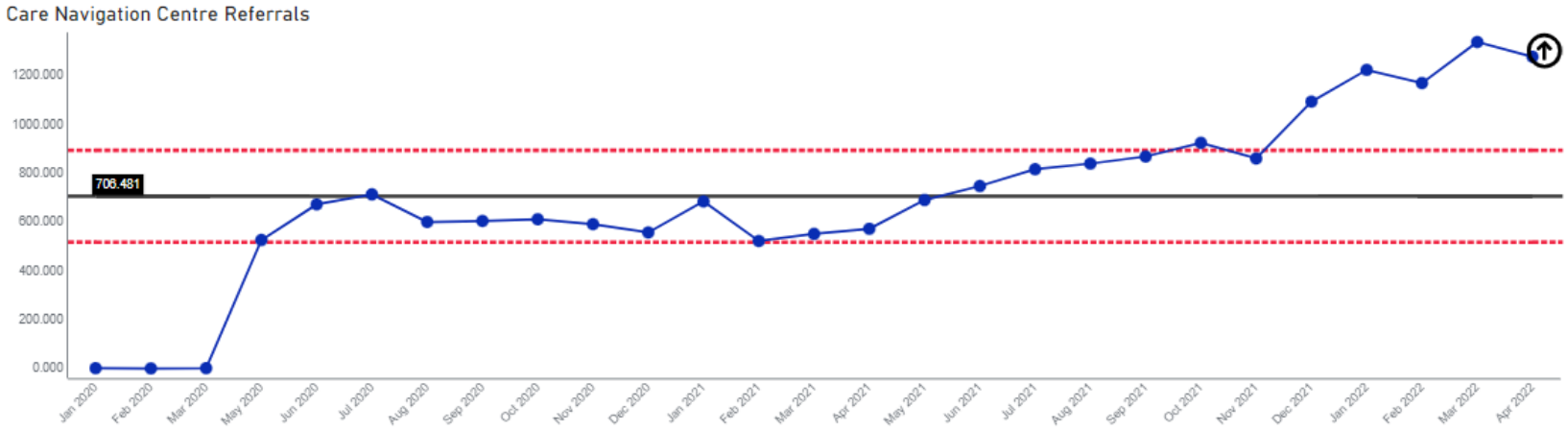
Last updated on May 2022

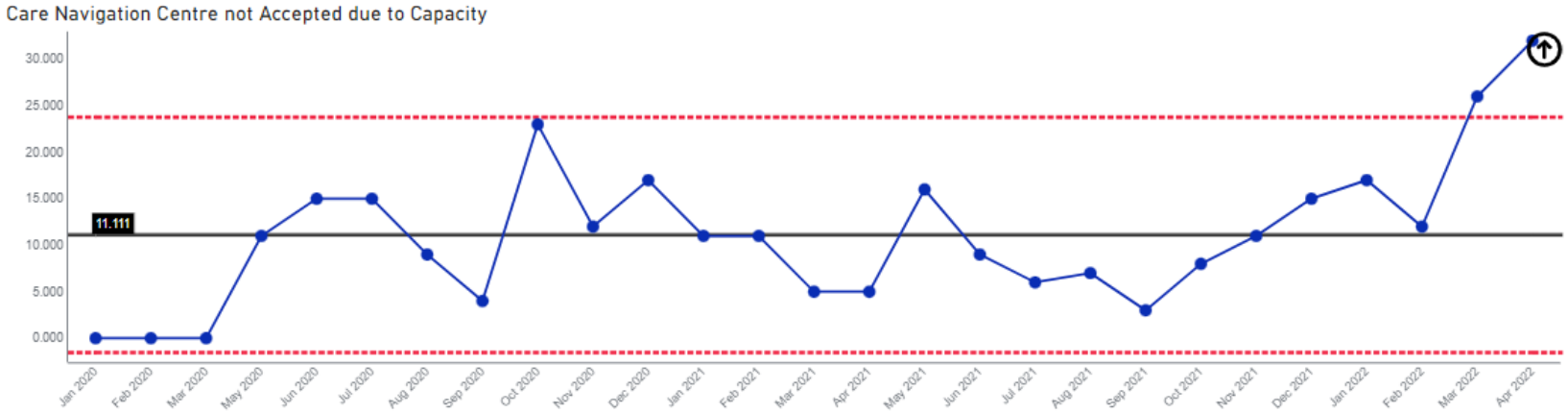
Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2022/23

Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	21/22 Result	April 22/23 Data	May 22/23 Data	June Q1 Data	July 22/23 Data	Aug 22/23 Data	Sept Q2 Data	Oct 22/23 Data	Nov 22/23 Data	Dec Q3 Data	Jan 22/23 Data	Feb 22/23 Data	Mar 22/23 Data	22/23 Target	Comments
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2183	2187													
	AACM	1895	1951	1954	2045	2100	2188	2183	2187													
	Jennie Pugh	**91.3%**	**97.3%**	**98.4%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**												**100.0%**	
1E: Proportion of adults **(aged 18-64)** with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	21	20												12	
	AACM	551	585	587	596	574	573	576	527													
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**3.6%**	**3.8%**													
1G: Proportion of adults **(aged 18-64)** with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	490	451													
	AACM	551	585	587	596	574	573	576	527													
	Jeanette Knapper	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**85.1%**	**85.6%**												**80.0%**	
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	20	1												15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500													
	Jennie Pugh	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**11.9**	**0.6**												**9.1**	
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	271	309	311	329	301	311	284	24												300	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500													
	Jennie Pugh	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**562.4**	**47.5**													
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	79	93													
	Provider Services	317	130	266	73	91	125	103	110													
	TBC	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**78.1%**	**84.6%**												**82.0%**	

Last updated on May 2022

Tier 3:
Care Navigation Centre (CNC): Received a high number of referrals in April 2022.





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

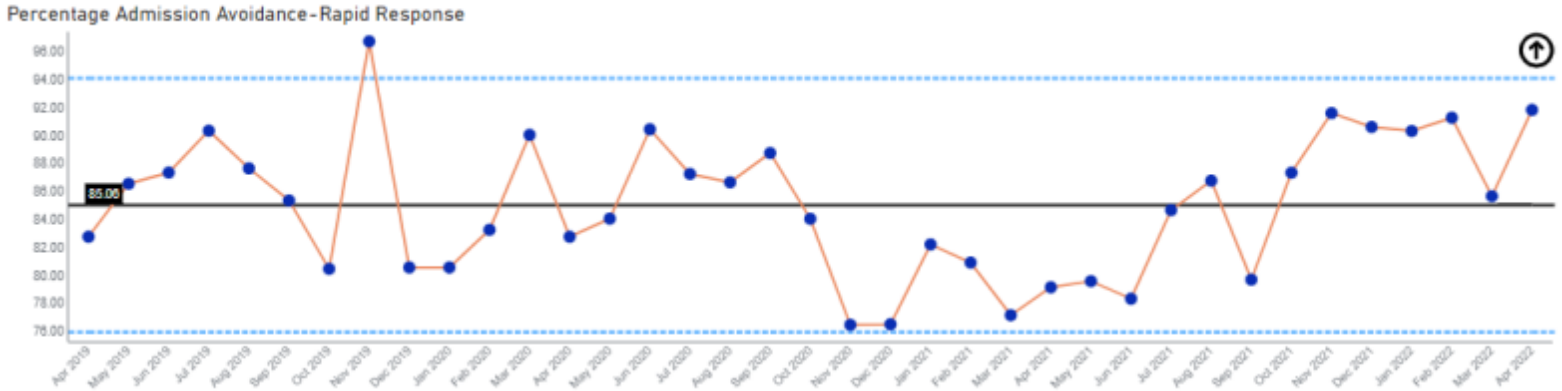
The expansion of capacity that has been embedded has enabled the CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

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

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

Last updated on May 2022

Tier 3: Rapid Response
The high levels of admission avoidance are being maintained

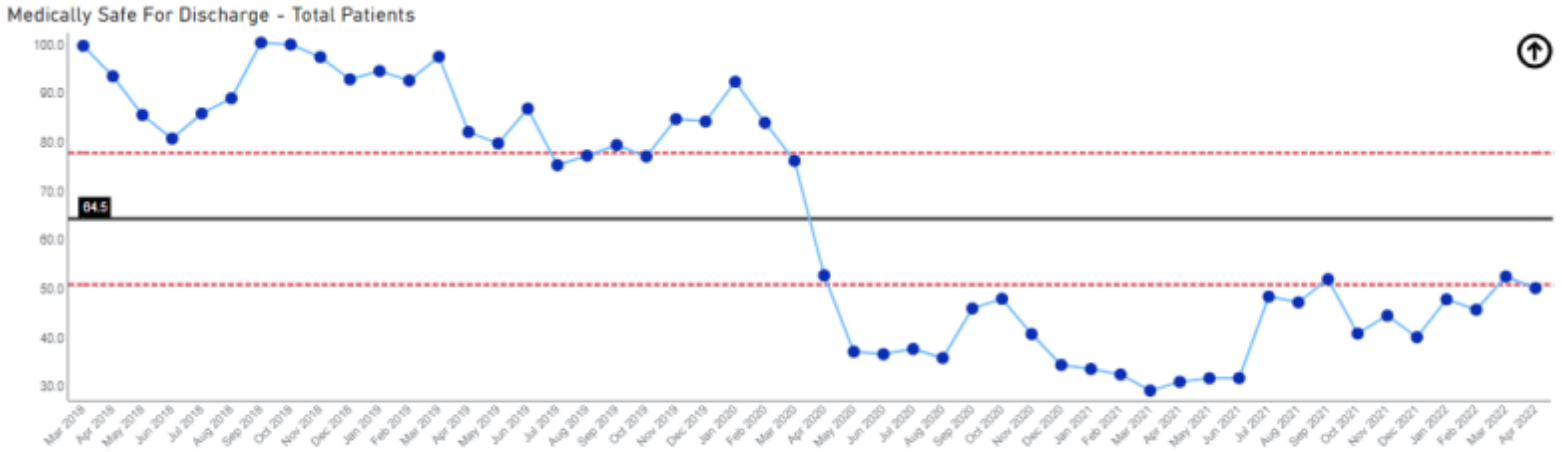


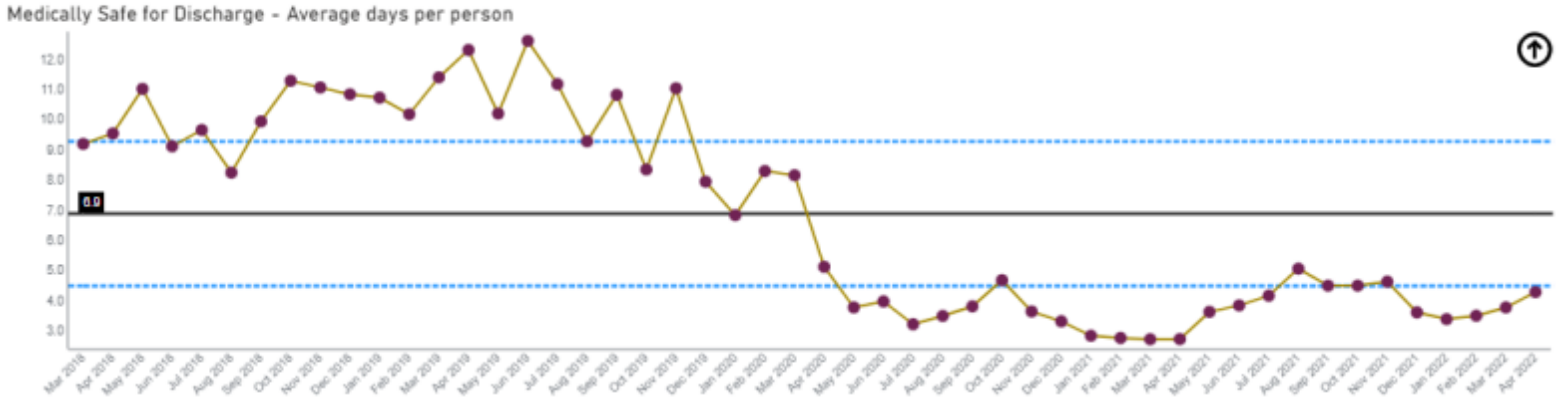
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present capacity 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 May 2022

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 50 patients during April 2022





The number of patients on the MSFD list averaged 50 patients during April 2022. This was due to high demand for the service. Despite the high numbers of patients, the average length of stay was maintained below 5 days.

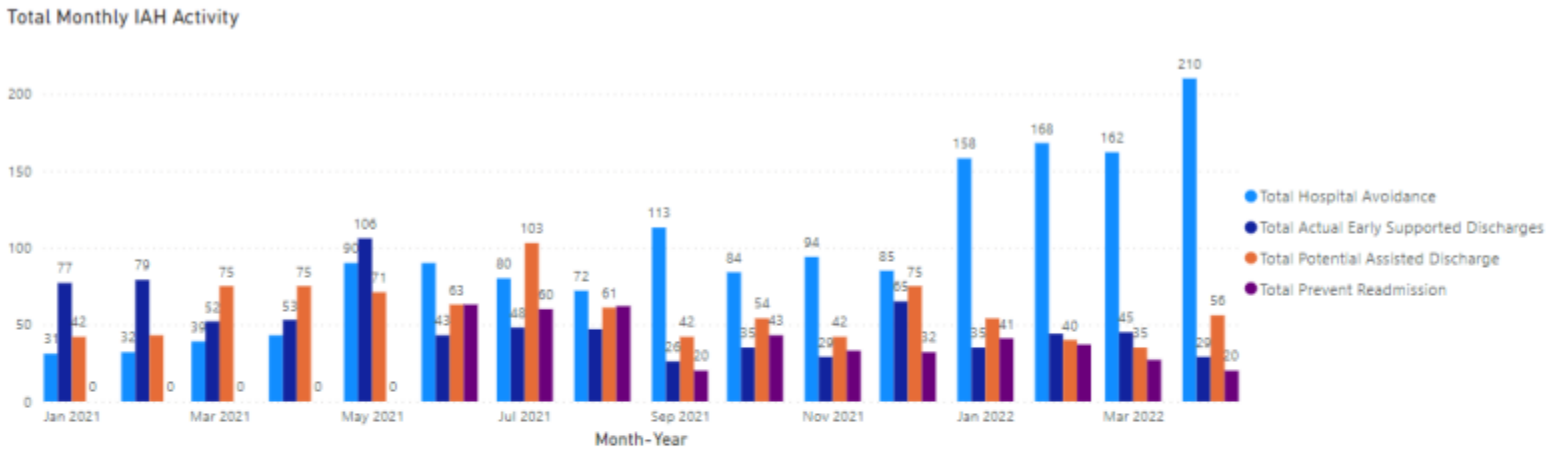
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients.

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

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

Last updated on May 2022

Tier 3/4:
Integrated Assessment Hub:

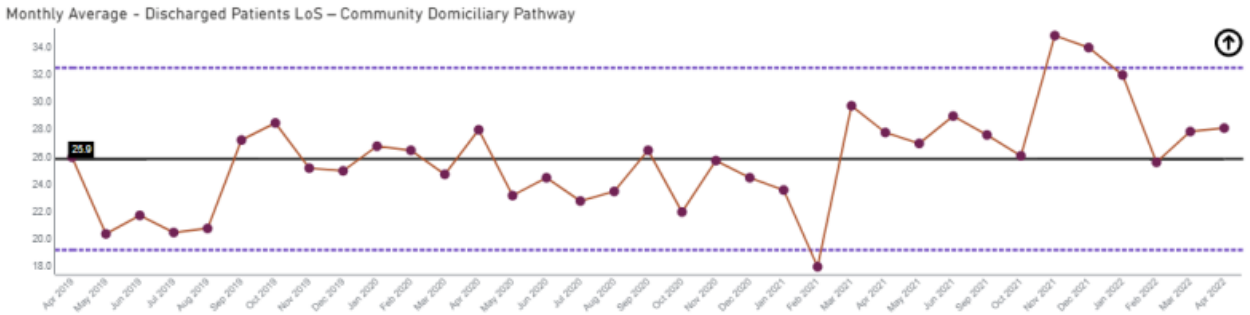


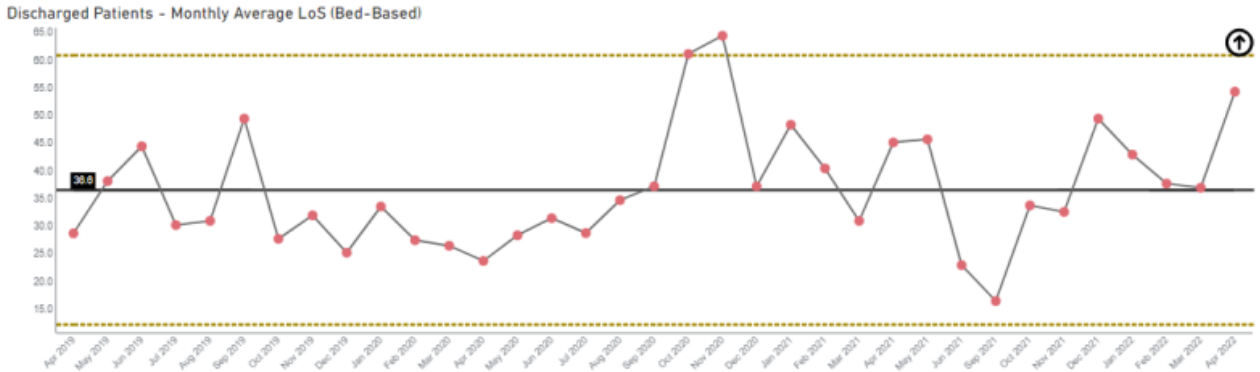
Integrated Assessment Hub

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

Last updated on May 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 May 2022

MEETING OF THE PUBLIC TRUST BOARD - 8th June 2022			
Information Governance Strategy & Policy Documentation Report			
Report Author and Job Title:	Sharon Thomas Information Governance Lead/DPO	**Responsible Director:**	Kevin Bostock, Director of Assurance
Recommendation & Action Required	Members of the board are asked to note the contents of this report. Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• 7 Policies have been reviewed, updated, ratified, and disseminated to colleagues during the last 6 months. The documents clearly set out the expected behaviours of all and are aligned to the 10 National Data Standards and the Data Security & Protection Toolkit (DSPT).		
Advise	• The remaining Policies are scheduled to be reviewed and updated in line with the recommendations by December 2022.		
Alert	• The Information Governance Strategy is outstanding its full review and will be replaced with the Information Governance Policy. This is scheduled to complete and be in place by August 2022. • The Non-Clinical Records Management Strategy, in addition to the Records Retention & Destruction Policy, is considered excessive and does not align to a Policy Tree illustrated on page 3. The recommendation has been made to de-ratify this strategy.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report does not specifically mitigate risk included in the BAF or Trust Risk Register however it touches all strategic objectives.		
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 ☒		

INFORMATION GOVERNANCE STRATEGY & POLICY

DOCUMENTATION REPORT

MAY 2022

1. PURPOSE OF REPORT

The purpose of this report is to outline the position with the Trusts Suite of Information Governance and Data Security Policies. The report also illustrates progress towards the Cyber Operational Readiness Support (CORS) reviews recommendations, and highlights documentation that is no longer required and will be subsequently de-ratified.

2. BACKGROUND

2.1 In 2020, NHS Digital commissioned Templar Executives to deliver a limited CORS review to enable NHS organisations to identify vulnerabilities and develop a roadmap for enhanced Cyber Security resilience.

As part of the refocused CORS Agenda, the Trust requested three elements from the service. This included a review of Information Governance and Data Security Policy Documentation.

The purpose of the documentation review was to ensure that the Trust had a suite of Board level strategic Cyber Security policies that could be used to drive the Cyber Security agenda without adversely impacting the operational effectiveness of the organisation. By implementing the recommendations made, the Trust would be able to demonstrate its Cyber Security policies are aligned to prevailing industry standards and best practice.

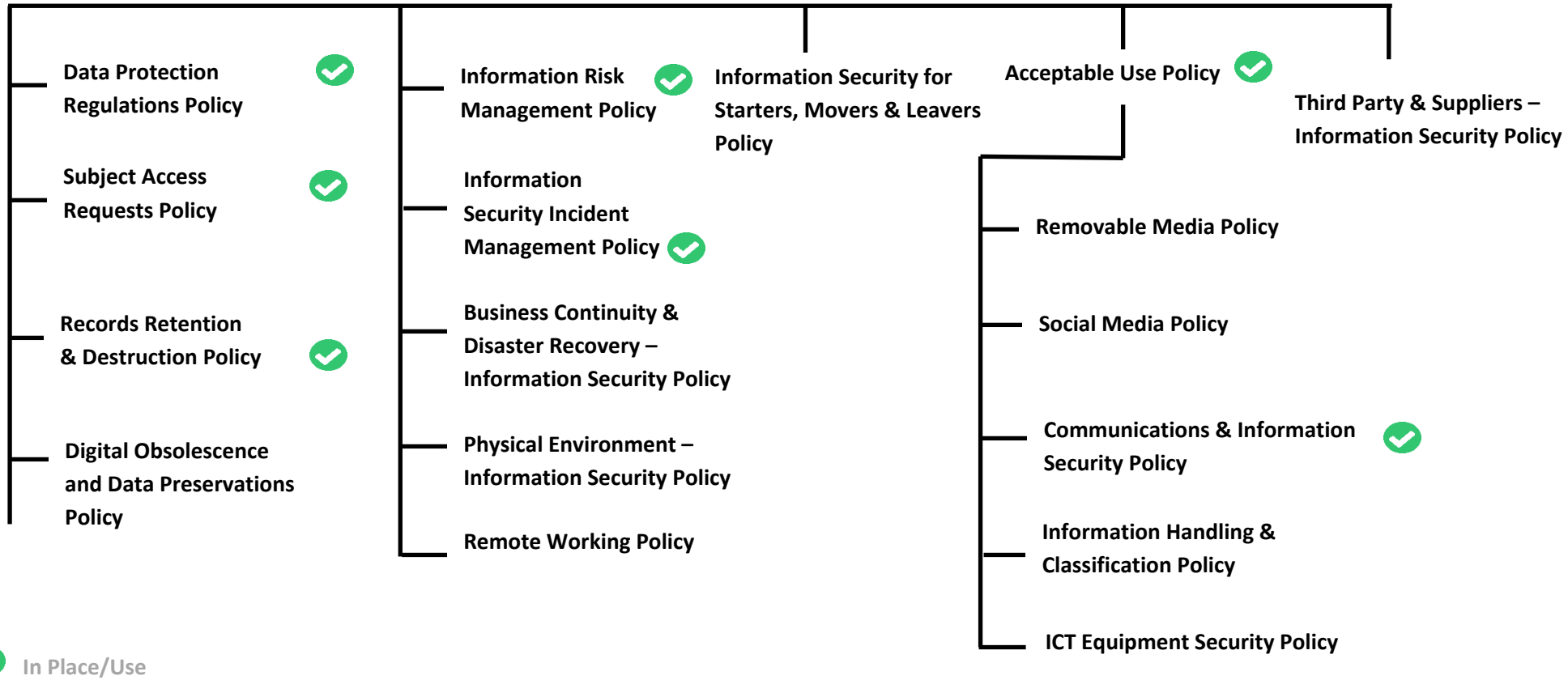
3. DETAILS

3.1 The findings of the review showed that whilst the 2020 Policy Suite was thorough, it lacked a collective level of coherence as policies appeared to be separate documents, rather than working in collaboration, or were missing. It also highlighted significant duplication and policy documents that were overly procedural.

The recommendation was made to introduce a broader suite of 18 policies which would provide a comprehensive IG approach. By adopting the missing core policies recommended in the Policy Tree below, and restructuring the good practice contained within the current suite, the Board would improve internal governance of the Trust's Cyber Security posture and provide a robust focus for information risk.

CORS Recommended Board-Level Information Governance Policy Suite:

Information Governance Policy



In Place/Use

3.2 Since the recommendations were accepted by the Board in early 2021, the following policies have been introduced:

Policy
IG001: V2.0 - Acceptable Use Policy
IG002: V2.0 - Information Security & Incident Management Policy
IG003: V1.0 - Communications & Information Security Policy
IG004: V1.0 - Data Protection Regulations Policy
IG005: V8.2 – Information Risk Management Policy
IG006: V2.0 - Records Retention and Destruction Policy
IG007: V2.0 - Subject Access Requests Policy

In addition, these Standard Operating Procedures have also been updated or introduced:

Standard Operating Procedures (SOPs)
IGS02: V1.0 - Data Protection by Design Procedure
IGD201: V1.0 - Data Protection Impact Assessments Procedure

Subsequently, a number of documents have been de-ratified with their contents now merged within the policies or procedures above, in accordance with the review recommendations.

Information Governance Strategy:

The current Information Governance Strategy is outstanding a full review. This will be undertaken during the next 3 months and will result in this document being replaced with the Information Governance Policy. The Information Governance Policy sits at the top of the Policy Tree and mandates the necessary approach within the rest of the Suite.

The Information Governance Policy will be presented to the Information Governance Steering Group prior to formal ratification via Policy Management Core Group on behalf of the Board.

Non-Clinical Records Management Strategy:

The Records Retention and Destruction Policy has been reviewed and updated in line with the CORS recommendations. The Policy includes all relevant content and is aligned to National Records Management Standards and best practice. The Non-Clinical Records Management Strategy is deemed as excessive and therefore no longer required.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the content of this report in providing assurance of the Trusts governance framework in relation to appropriate information handling.

Sharon Thomas, Information Governance Lead and Data Protection Officer
Report provided on 24th May 2022

MEETING OF THE PUBLIC TRUST BOARD - 8th June 2022			
Information Governance: 2021/22 Data Security & Protection Toolkit (DSPT) Submission Report			
Report Author and Job Title:	Sharon Thomas Information Governance Lead/DPO	**Responsible Director:**	Kevin Bostock, Director of Assurance
Recommendation & Action Required	Members of the Committee are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• The Trust submitted the 2021/22 baseline assessment to NHS Digital on 28.02.22 and were able to demonstrate compliance with 121/142 evidence items. • Internal Audit have assessed the Trusts submission against the Strengthening Assurance Framework and awarded a rating of 'substantial assurance with some improvement required'.		
Advise	• The full assessment of compliance against the 10 data security standards will be published on 30.06.22. • There are currently 96/109 mandatory items that have been satisfied. • Assurance has been provided from individual leads that the gaps in compliance or evidence will be addressed in readiness for the submission. This will enable the Trust to achieve 'Standards Met' when the assessment is published.		
Alert	• 13 items remain outstanding – these are required to enable the Trust to achieve Standards Met on publication. • An Improvement/Action Plan is in place to support achievement – overseen by the Information Governance Steering Group; SIRO, Caldicott Guardian, Director of Assurance and Information Governance Lead.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	1818 – Training Compliance against 95% Standard. This report does not directly impact any specific strategic objective but touches them all.		
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 ☒		

DATA SECURITY & PROTECTION TOOLKIT (DSPT) SUBMISSION

STATUS REPORT

MAY 2022

1. PURPOSE OF REPORT

The purpose of this report is to advise on the Trusts compliance with the 10 National Data Standards through assessment and review against the 2021/22 Data Security & Protection Toolkit (DSPT), prior to submission on 30th June 2022.

2. BACKGROUND

The DSPT is an online tool that enables relevant organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care (DHSC), notably the 10 data security standards set out by the National Data Guardian in the 2016 Review of data security, consent, and opt-outs.

All organisations that have access to NHS patient data and systems must use this Toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. The Trust is required to carry out self-assessments of compliance against the assertions and evidence contained within the DSPT.

As a result of the COVID-19 Pandemic, the annual submission dates for both the baseline and full compliance assessment have been changed to 28th February and 30th June respectively. The DSPT no longer has levels for attainment - organisations either achieve a status of 'standards met' by providing evidence against the mandatory requirements, or 'standards not met'.

The current version of the toolkit is comprised of 142 items which the Trust must assess its compliance against; 109 are mandatory to achieve the expected standard.

The status of the Trust's assessment will be shared with NHS England and NHS Improvement. It is also an important evidence item used by the Care Quality Commission in the key lines of enquiry on 'Information' in any future Well Led inspection.

3. DETAILS

3.1 2021/22 – Baseline Submission (28th Feb 2022)

The DSPT 'baseline' was published on 28th February 2022, with the full submission due on or before 30th June 2022.

The baseline is an interim evaluation to indicate that self-assessment is under way. It is also helpful to highlight areas which may need particular focus in advance of the full assessment deadline of 30th June 2022. It is not formally assessed by NHS Digital but allows insight and is used to determine whether further guidance or support is required.

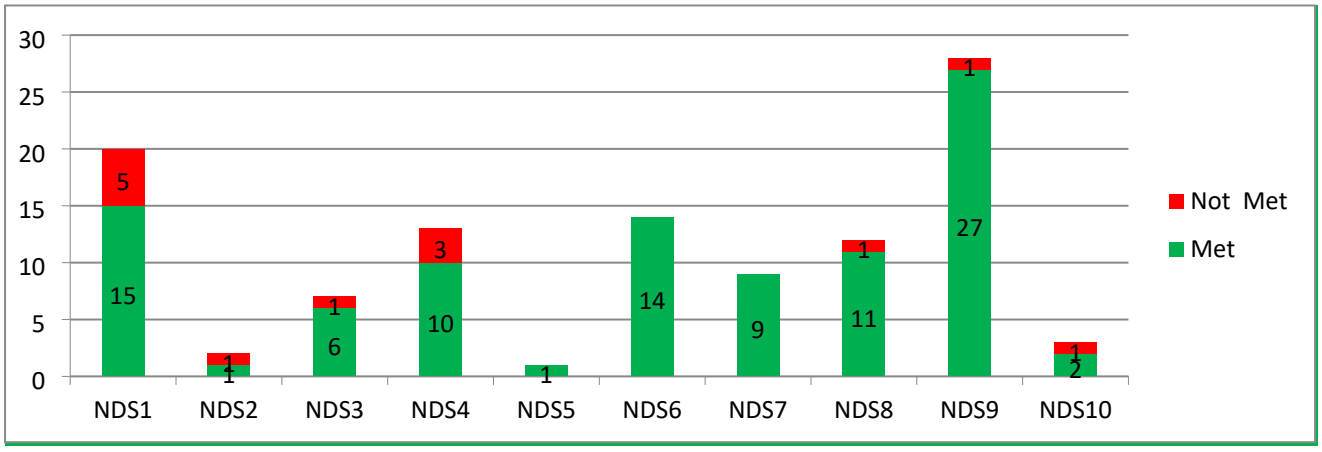
At the time of this submission, the Trust is able to demonstrate compliance with **121/142** evidence items. There are 109 mandatory entries of which the Trust was able to provide an acceptable level of compliance assurance for 95 items.

An Improvement Plan was developed to address any gaps in evidence or assurance prior to full submission. This continues to be monitored by the Information Governance Lead with oversight and escalation via the Information Governance Steering Group, chaired and attended by Senior Information Risk Owner (SIRO), Caldicott Guardian (CG) and Director of Assurance.

3.2 2021/22 – Full Submission: Current Status (as at 25.05.22)

The Trust is currently able to demonstrate compliance with **124/142** evidence items, of which there is an acceptable level of assurance for 96/109 mandatory items.

The table below shows the 10 National Data Standards as categories and where assurance or evidence shortfalls are against the mandatory requirements only:



1 – Personal Confidential Data (75%)
2 – Staff Responsibilities (50%)
3 – Training (85%)
4 – Managing Data Access (76%)
5 – Process Reviews (100%)
6 – Responding to Incidents (100%)
7 – Continuity Planning (100%)
8 – Unsupported Systems (91%)
9 – IT Protection (96%)
10 – Accountable Suppliers (67%)

3.3 Gap Analysis:

Overall, there are 13 mandatory assertions where the Trust is unable to demonstrate the required level of assurance for full submission in June 2022.

The 2021/22 DSPT Improvement/Action Plan can be found at Appendix 1 and provides further details of the requirement, Lead and expected completion date.

All Leads have provided a level of assurance to the Information Governance Lead that the evidence will be available in advance of the submission, resulting in the Trust predicting a 'Standards Met' position at publication.

3.4 Independent Assurance Audit:

It is a requirement of NHS Digital, via the DSPT, for organisations to undertake an independent assurance audit. The audit scope and approach is aligned to NHS Digital's Strengthening Assurance Framework and Guidance and considers compliance with 13 mandatory assertions; with all sub items for assurance which results in 48 evidence items being assessed.

3.4.1 Independent Assurance Audit – Grant Thornton

The audit was facilitated by the Information Governance Lead and field work undertaken during the week of 31st January 2022. The objectives were to consider:

- The assessment of the overall risk associated with the Trusts data security and data protection control environment, i.e. the level of risk associated with controls failing and data security and protection objectives not being achieved; and
- An assessment of the veracity of the Trusts self-assessment submission and the auditors confidence that the submission aligns to the assessment of the risk and controls.

The audit concluded that the processes have provided a **significant level of assurance with some improvement required**.

The assurance level based on the confidence level of the assessor in the veracity of the self-assessment was '**medium'**.

3.4.2 Independent Assurance Audit – KPMG

In addition to the Internal Audit undertaken by Grant Thornton as part of the planned Audit Schedule, the Trust, along with several other NHS organisations, were approached by NHS Digital and offered a centrally funded audit by KPMG. The purpose of this additional commissioned audit was to provide intelligence

directly to NHS Digital and Subject Matter Experts on how assurance can be further strengthened through the route of audit for future versions of the DSPT.

Whilst Grant Thornton assessed the Trust's compliance as 'Substantial with some improvement', KPMG rated it as 'Limited with improvement required'. There is some cross-over, however KPMG were much more aggressive in their evidence requests; some of which was impossible to satisfy within the short timeframe for the field work exercise.

The Information Governance Lead provided feedback to NHS Digital, via the National Senior Information Governance Network. Our experience was consistent with other NHS organisations where 80% of other NHS Trusts, who received the centrally commissioned audit, were also rated as 'Limited' or 'Low' assurance.

In view of the fact that the Grant Thornton assessment was undertaken in advance of the Trusts baseline submission on 28th February, this assessment/rating has been utilised for this year's Toolkit. However, the recommendations that have been made as part of KPMG's review have also been incorporated into the overarching Improvement Plan (Appendix 1). The aim is to improve organisational resilience overall, and ensure the Trust maintains and sustains its current status of 'Standards Met' at this and subsequent publications. This approach will also place the Trust at an advantage for future, more in depth, independent audit assessments.

CONCLUSION:

This status report is intended to provide an overview of the full submission due to be published on or before 30th June 2022. It aims to provide assurance of the level of compliance with the National Data Standards and highlight areas where improvement continues to be made.

Currently, the Trust is able to provide an acceptable level of assurance and evidence of compliance with **124/142** items. Evidence for all outstanding assertions will need to be confirmed by the Information Governance Team in advance of the full submission date.

There are **109** mandatory assertions across the 10 National Data Standards, of which the Trust are able to demonstrate an acceptable level of compliance against **96** items. There are **13** items outstanding that are classified as mandatory and therefore required as a minimum to achieve the expected status of 'standards met'.

An Extraordinary meeting of the Information Governance Steering Group has been scheduled for Thursday 23rd June 2022. The Group will review and approve the DSPT submission on behalf of the organisation. The Information Governance Lead will

subsequently publish the assessment on or before 30th June 2022 and, based on assurances provided to date from Operational Leads on their assigned assertions, is predicting achieving 'Standards Met' status.

4. RECOMMENDATIONS

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

Sharon Thomas, Information Governance Lead and Data Protection Officer
Report provided on 25th May 2022

Appendix 1: 2021/2022 DSPT IMPROVEMENT PLAN (V 3.0) AGAINST FULL SUBMISSION (30.06.22)

*Includes recommendations from Internal Reviews undertaken by KPMG and Grant Thornton - **mandatory assertions only** *

Evidence Ref:	Description of assertion(s)/Findings:	Action required to meet requirement:	Action Owner:	Completion Date:
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Review Records of Processing to ensure fully representative of new sharing agreements and systems (DPIAs) introduced since last review.	Nicky Kaur	**27.05.22**
1.1.3	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Review planned to include critical information systems. A report will be presented to SIRO via IGSG for assurance.	Rupel Tarpara	**27.05.22**
1.1.4	When did your organisation last review both the list of all systems/information assets holding or sharing personal information and data flows?	Last reviewed June 21. A review is planned to ensure Asset Registers and Data Flows are up to date. A report will be presented to SIRO via IGSG for assurance.	Rupel Tarpara	**27.05.22**
***1.3.1**	Are there board-approved data security and protection policies in place that follow relevant guidance? Approval of updated and reviewed: Patient Records Policy, Information Management and Technology (IM&T) Policy, Disaster Recovery Plan, Password Policy and Log Retention Policy	Update and approve the following policies and procedures ahead of the DSPT submission deadline: Patient Records Policy IM&T Policy Disaster Recovery Plan Password Policy Log Retention Policy DQ Policy	Mark Harrison Mo Ahwaiz	**10.06.22**

Evidence Ref:	Description of assertion(s)/Findings:	Action required to meet requirement:	Action Owner:	Completion Date:
***1.3.5/1.3.6**	Risk Management: The Trusts Top 3 data risks (management of endpoint patching, data transfer assurance between services when migrating to a new environment, legacy software, and hardware) are not visible on the Corporate Risk Register. Supply chain risks are also not included within the CRR.	Inclusion of data security and supply chain risks within the Data Security Risk Register and CRR.	Richard Pearson	**20.05.22**
***2.1.2**	Employee Contracts contain appropriate data security, confidentiality, and IT security clauses.	Update Consultant and Speciality Contracts to include the Trusts data security requirements including confidentiality and IT Security to bring in line with other contracts.	Michala Dytor	**27.05.22**
***3.4.2**	All board members have completed appropriate data security and protection training?	Not all members compliant. Lead to provide evidence that all members (including NEDS) are compliant with this requirement.	Keith Wilshere	**20.05.22**
***4.1.2, ◊ 9.3.4**	Privileged Access Controls: evidence of the user access lists to the organisations key systems and plans to improve privileged user access and review DNS server.	Evidence required of formal and periodic review of privileged users, including domain administrators with access to the DNS server.	Gareth Evans	**10.06.22**
4.4.1	The organisation ensures that logs, including privileged account use, are kept securely and only accessible to appropriate personnel. They are stored in a read only format, tamper proof and managed according to the organisation information life cycle policy with disposal as appropriate.	To establish a SOP or Policy which supports this requirement and sets out the rules defining log retention. The most important logs for identifying malicious activity should be held for a minimum of 6 months.	Mark Harrison	**10.06.22**

Evidence Ref:	Description of assertion(s)/Findings:	Action required to meet requirement:	Action Owner:	Completion Date:
***4.5.1 (see 1.3.1)**	Do you have a password policy giving staff advice on managing their passwords?	Establish a policy that meets the criteria below and ensure it is accessible to staff: (a) How to avoid choosing obvious passwords (such as those based on easily-discoverable information). (b) Not to choose common passwords (use of technical means, such as using a password blocklist, is recommended). (c) No password reuse. (d) Where and how they may record passwords to store and retrieve them securely. (e) If password management software is allowed, and if so, which. (f) Which passwords they really must memorise and not record anywhere. (g) Assessing risks to ensure systems use appropriate authentication measures e.g. high-strength passwords enforced technically for all users of internet-facing authentication services.	Mark Harrison	**10.06.22**
***4.5.4**	Password Management is in place and includes recommended criteria regarding default passwords and social media accounts.	Policy in draft and does not include the requirement to ensure that default passwords are changed as part of the implementation of a system or infrastructure component. Passwords for social media accounts are not included. Finalised and approved policy to be provided as evidence prior to DSPT submission.	Gareth Evans	**10.06.22**

Evidence Ref:	Description of assertion(s)/Findings:	Action required to meet requirement:	Action Owner:	Completion Date:
8.2.2	The SIRO confirms that the risks of using unsupported systems are being managed and the scale of unsupported software is reported to your board along with the plans to address.	A list has been provided (8.2.1). Evidence is required that confirms SIRO has been briefed on the unsupported systems and accepts the associated risks.	Richard Pearson	**06. 05.22**
***9.3.2,** ◊ **9.3.5, 9.3.6**	IP ranges are not reviewed and TLS v1.2 configuration was not in place for browsers. The penetration test action plan has not been approved by SIRO.	An action plan resulting from the latest pen test report must be approved by SIRO prior to DSPT submission ensuring that progress with mitigating vulnerability are periodically reported. Evidence of IP range reviews and configuration showing TLS 1.2 encryption enabled for browsers.	Gareth Evans	**27.05.22**
9.3.8	The organisation maintains a register of medical devices connected to its network.	The register should be uploaded and include vendor, maintenance arrangements, any network segmentation in place and whether network access is given to the supplier/maintainer.	Nigel Malone/ Richard Pearson/ Michael Koushi	**31.05.22**
***10.1.1**	The organisation has a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration.	Requires work to produce a cohesive extract that meets the criteria of this assertion taken from both record systems (Procurement and Digital). An updated Supplier List to be provided which includes the type of data being processed by listed suppliers in advance of submission deadline.	Gillian Farr	**10.06.22**

◊ Requirement in place – awaiting evidence items to upload to meet Standard

MEETING OF THE TRUST BOARD			
Update on the five-year joint strategy development between WHT with RWT			
Report Author and Job Title:	Roseanne Crossey, Head of Business Planning and Development	**Responsible Director:**	Simon Evans, Interim Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• The development of the joint strategy is underway and running to the planned timescales. • Internal and external stakeholder engagement has been undertaken.		
Advise	• The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) intend to develop a joint strategy and set of objectives for approval by both Boards in August 2022. • A sub-group of the Committee in Common will oversee the development, on behalf of the Board.		
Alert			
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	A 50K budget was utilised for the internal and external engagement undertaken by Deloitte		
Legal and/or Equality and Diversity implications	The strategy will seek to improve equality, diversity and inclusivity.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Update on the Five-Year Joint Strategy Development Between WHT with RWT

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the progress being made in developing a joint strategy between Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT).

2. BACKGROUND

The Boards of both organisations have previously approved the extensions of the trusts' current strategies to allow time for the development of a single, joint strategy covering both organisations. This joint strategy reflects the emphasis on the NHS Long Term Plan and the recent White Paper, which focuses on collaboration and the integration of services, as well as the ongoing collaboration between the two organisations

3. DETAILS

3.1 Engagement

Since the last update, the focus in May has been to continue engagement with our internal and external stakeholders with a view to informing the development of the strategic objectives. A successful procurement exercise was undertaken and concluded in Deloitte being awarded a contract to facilitate this engagement, overseen by the Head of Business Development and Planning at WHT and her counterpart at RWT.

The following planned activities have taken place so far:

An engagement plan has been implemented, encompassing:

- Eight internal engagement sessions (four at each trust) available for all staff to attend. The sessions were run at different times of the day to accommodate different shift patterns.
- An initial engagement session with the trusts' Committee in Common took place on 6th April.
- An online staff survey, which enabled comments to be received from colleagues unable to join the online sessions.
- External sessions with the ICS executives; local authority representatives of Walsall and Wolverhampton, Healthwatch and service user groups across Wolverhampton and Walsall.
- An external survey for PLACE based colleagues.
- A public survey for the wider public to contribute their views.

All the above were publicised through internal and external channels including Trust Brief; Dose News; all user emails, diary invites, social media, peer to peer groups and specific meetings.

Having now concluded the engagement sessions the results will be collated and presented through the trust's governance structure.

3.2 Environmental Analysis

An analysis of the external environment has been prepared by Deloitte for review by both trusts. An analysis of the internal environment is underway to develop a 'SWOT' analysis of the organisations. Together with the PESTLE analysis, this will drive the development of strategic objectives.

These objectives will then be written into a public facing strategic document for circulation to wider stakeholders during July with a view to being approved by the Trust Boards/the Committee in Common in August.

3.3 Well-led

As part of the well-led development plans, a Guide to the Trust's Strategy, Enabling Strategies and Delivery Plans has been developed (Appendix 1).

This document explains that there will be only one trust strategy (the joint strategy between WHT and RWT). This single strategy will be supported by eight enabling strategies:

- People Engagement & OD
- Quality and Safety
- Patient Engagement
- Finance and Performance
- Innovation and Research
- Estates
- Digital and IT
- Trust Charity

Any other documents will be renamed as "Policies" or "Plans". Some of the enabling strategies will be joint with RWT, while others will address plans for WHT only.
The enabling strategies will be presented through the trust's governance structure as appropriate and including the Trust Board/Committee in Common.

4. RECOMMENDATIONS

The Board is asked to note the progress being made in the development of a joint strategy.

Enclosed: Appendix 1: Enabling Strategies.

Walsall Healthcare NHS
NHS Trust

A Guide to the Trust's Strategy, Enabling Strategies and Delivery Plans

1. Introduction

This document serves as a guide to the structure of the Trust's strategic documents and provides specific guidance for those writing enabling strategies and delivery plans as to their content and format.

The Trust has one overarching strategy, supported by 8 enabling strategies, broadly aligned to the committees of the board. Underpinning these are a set of delivery plans covering discreet areas of the Trust. This is summarised in Table 1 below.

Type of Document	Number of	Purpose
Trust Strategy	**1**	To set out the Trust's Strategy, Strategic Objectives and other key enduring themes and values
Enabling Strategies *(covers previous topic/area strategies, Enabling Strategies/* *Strategic Delivery)*	**8** • People engagement & OD, • Quality & Safety, • Patient engagement • Finance & performance • Innovation & Research • Estates • Digital & IT • Trust Charity	To set out the strategic approach and actions within each of these areas including the high level aims to be achieved over the life of the Enabling strategy and philosophy of delivery.
Delivery Plans *(covers previous Implementation Plans, Delivery Frameworks)*	**As agreed*** e.g. Under People: • Attraction and Retention • Engagement • Leadership and OD • Wellbeing • Employee Relations • Education	To set out the detailed objectives/deliverables and detailed philosophy of delivery together with a credible action plan to be monitored through the *relevant board committee.

Table 1: Strategic Document Structure

2. Structure of Documents

The Trust Strategy and Enabling Strategies will be formatted by the Trusts clinical illustration department. The guidance below is intended to support the writing of documents by articulating the headings to be used and detail to cover within them.

2.1. Trust Strategy

Our Vision and Values

The vision is the end point for which the organisation is trying to reach – it is our guiding aspiration and underpins the Trusts strategy (which in turn details the areas and issues that need to be addressed in order to fulfil the Trusts vision). The values are the qualities that are

important and define how the Trust needs to behave in order to achieve the vision; values may be expressed as beliefs, traits, characteristics or rules.

Our Strategic Context

The strategic context of the organisation covers a description for the reader of the organisation and the population it serves. It is useful to include information around the services on offer, how these are provided, the activity the Trust undertakes and the people it employs.

The strategic context should also cover the partnerships between the hospital and other stakeholders, e.g. commissioners, other providers etc.

Finally the strategic context should articulate the drivers that are guiding this strategy, e.g. the NHS Long Term Plan.

Strategic Analysis

The strategic analysis, as the name suggests, is an analysis of where we sit or compares to a given benchmark, e.g. other similar organisations, national targets etc. This analysis is usually split between the external environment, i.e. outside of the organisation and internal, i.e. within the organisation.

The external analysis should analyse the external landscape against the factors in the PESTLE tool – i.e. political, economic, societal, technological, legal and environmental. For each, it is useful to examine what the factors or drivers are against each domain and how that may impact on the Trust.

The internal analysis should focus on a SWOT analysis of the Trust – i.e. the strengths, weaknesses, opportunities and threats of the Trust. In considering each, it is useful to expand upon how strengths can be utilised, weaknesses can be overcome, opportunities can be pursued and threats can be mitigated.

Strategic Objectives

The strategic objectives are then a small list (typically no more than five) of targets to support the Trust in achieving its vision. Objectives should be SMART in their nature, i.e. specific, measurable, achievable, realistic and time based. For each objective, it is useful to set out the aspiration for the objective, where we are now, why this objective matters to us, what success looks like and how we are going to achieve this success.

Implementing the Strategy

Finally, the strategy should summarise how the strategy is being implemented into action. This will include how progress will be monitored and how the strategy will be reviewed. It is likely that this will vary depending on whether this is the Trust strategy (which will be the

focus on the Trust Board) or enabling strategies (where the focus will most likely be from committees of the Trust Board).

2.2. Enabling Strategies

The format of the enabling strategies should replicate (in the most part) that of the Trust Strategy – the main difference being that it is specific to the area in question, for example quality and safety. Enabling strategies should clearly reference the Trust Strategy and support the delivery of the strategic objective (relevant to the enabling strategy in question) in the Trust's corporate strategy.

Our Strategic Context

The strategic context of an enabling strategy should articulate the environment specific to the domain in question, e.g. quality and safety as well as the relative standing of the organisation within this environment. Similar to the Trust strategy, it should articulate the drivers that are guiding this strategy, e.g. the NHS Long Term Plan. The key difference being that this is at a theme level rather than corporate level. As an example, the reduction of sepsis related deaths may be one of the national priorities within the patient safety agenda.

Strategic Analysis

The strategic analysis, as the name suggests, is an analysis of where we sit or compares to a given benchmark, e.g. other similar organisations, national targets etc. For an enabling strategy, this analysis is similar to at a Trust strategy level however the PESTLE and SWOT analysis will be focused on the theme in question, for example political factors affecting the quality and patient safety theme specifically. Like with the Trust strategy, this is usually split between the external environment, i.e. outside of the organisation and internal, i.e. within the organisation.

The external analysis should analyse the external landscape against the factors in the PESTLE tool – i.e. political, economic, societal, technological, legal and environmental. For each, it is useful to examine what the factors or drivers are against each domain and how that may impact on the Trust.

The internal analysis should focus on a SWOT analysis of the Trust – i.e. the strengths, weaknesses, opportunities and threats of the Trust. In considering each, it is useful to expand upon how strengths can be utilised, weaknesses can be overcome, opportunities can be pursued and threats can be mitigated.

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specific, measurable, achievable, realistic and time based. For each objective, it is useful to set out the aspiration for the objective, where we are now, why this objective matters to us, what success looks like and how we are going to achieve this success.

Implementing the Strategy

Finally, the strategy should summarise how the strategy is being implemented into action. This will include how progress will be monitored and how the strategy will be reviewed. It is likely that this will vary depending on whether this is the Trust strategy (which will be the focus on the Trust Board) or enabling strategies (where the focus will most likely be from committees of the Trust Board).

3. Delivery Plans

Whereas the Trust strategy is based at a corporate level and enabling strategies cover a theme of work, e.g. patient safety, a delivery plan is specific to a single area of work. For example, you could have a dementia plan that falls under the patient experience enabling strategy or a CIP delivery plan falling under the finance and performance enabling strategy.

Delivery plans are much shorter in their nature to enabling strategies and should typically be no longer than 4 pages in length. Broadly, a delivery plan should cover:

Context

Covering the national and local agenda specific to the topic in question and what the drivers are for a delivery plan.

Current Position

How the organisation compares at the moment – where its strength and weaknesses lie and the work undertaken thus far.

Objectives

What is the Trust trying to achieve and what does success look like.

Action Plan

A traditional action plan articulating the action, owner, timescale and update on progress. The actions, as seems obvious, should clearly articulate how they support the achievement of the overall priority.

Risks and Mitigations

Any risks identified with the delivery of the plan should be recorded and mitigations in place or proposed should be clearly articulated.

4. Queries

For any queries on this process or the completion of strategies, please contact either Roseanne Crossey Head of Business Development and Planning or Keith Wilshere, Company Secretary on Roseanne.crossey@walsallhealthcare.nhs.uk or keith.wilshere@nhs.net.

MEETING OF THE Walsall Healthcare NHS Trust Board – Wednesday 9th May 2022			
Sustainability Report			
Report Author and Job Title:	Janet Smith Head of Sustainability	**Responsible Director:**	Simon Evans Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• To provide assurance that the Trust's Green Plan is aligned with the priorities of the Greener NHS agenda and will enable the Trust to evidence that we are working towards achieving the NHS commitment to achieve net zero carbon status by 2040.		
Advise	• To advise on the potential opportunities to the Trust in the next five years and to continue to enhance the ability of the Trust Sustainability Group in helping to move forward and meet the Greener NHS targets. • Advise on opportunities to promote the Trust Sustainability Agenda. • To strengthen the working relationship with the Black Country ICS Sustainability Group and other national and international Sustainability Groups to maximise opportunities for shared learning and best working practices.		
Alert	• To note, react and adapt to emerging factors affecting the delivery of Sustainable Healthcare in the next five years		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There is no risk implication associated with this report		
Resource implications	Revenue and Capital funding required to implement sections of the Green Plan, but external funding sources will be targeted for future investment in technologies, equipment, training and supplies to reduce the Trust's Carbon footprint.		
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 ☒		

Sustainability Report

1. PURPOSE OF REPORT

The purpose of the reports is to provide an update on the progress of the Trust compliance to the requirements and priorities of the Greener NHS agenda.

2. BACKGROUND

The Department of Health acknowledges that the health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint and has a major role to play in achieving the UK carbon reduction target. The NHS has therefore committed to being the world's first 'net zero' National Health Service by setting two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

On 30 September 2020, the roadmap to delivering a net zero National Health Services was published. It required each Trust to publish a Green Plan by 14 January 2022 and set out the key priority areas and target and commitments to achieve net zero carbon by 2040.

The Trust Board approved the Trust Green Plan on 2nd February 2022.

3. DETAILS

This report focuses on the Trust progress in achieving the Greener NHS year-end (01 April 2022) regional and national deliverables detailed in appendix 1, progress on Green Plan implementation as well as the action priorities in the next 6 months.

Greener NHS year-end (1 April 2022) regional and national deliverables

The Trust achieved majority of the deliverables except on the following:

a) ***Reduction of the proportion of desflurane used in surgery to less than 10% of overall volatile anaesthetic gases by volume***. As of March 2022, the proportion of desflurane used in surgery is at 11% this is a great achievement given that the Trust usage in September 2021 was at 42.5% which at the time was the highest in the country. The Anaesthetic Department will continue to implement the reduction measures that have commenced with the view of achieving the new target of desflurane used in surgery to less than 5% of overall volatile anaesthetic gases by volume.

b) ***Ensure that systems solely purchase and lease cars that are ULEV or ZEV, and work towards purchasing vans under 3.5 tonnes that are ULEVs or ZEVs.*** An audit of the current fleet will be undertaken and a transition plan to move the current fleet with Zero Emissions Vehicles (ZEVs) by 2030 will be put in place. The plan will include the capital required to install EV charging facilities in Walsall Manor Hospital and other Trust sites.

Green Plan implementation

The following was implemented between as of March 2022:

a) Launch of the Trust Green Plan via a virtual Sustainability Lunch Hour on 26 April.
b) Speech and Language Therapy, Audiology Services, Library and Knowledge Services, Manor Learning and Conference Centre and Infection Prevention Team have signed up to the "Greening Services Scheme".
c) Monthly Sustainability Lunch Hour launched.
d) Sustainability Impact Assessment Tool (SIA), Carbon Reduction Crib Sheet and the Sustainability Initiatives Tracker introduced through "Greening Services scheme".
e) Carbon footprinting exercise has commenced. Full report due end of May.
f) 66 tonnes of cardboard were recycled between 1 April 2021 and 31 March 2022 via our waste management supplier saving 1,406 kg CO2e.
g) 3,175kg of plastic waste from 2,216 old toilet roll dispensers were recycled through participation in RightCycle Programme saving 68 kg CO2e.
h) 350 tonnes of general waste were turned into energy using an off-site incinerator via our waste management supplier.
i) 29 tonnes of food waste were turned into compost to use in local farms.

Action priorities for the next 6 months are the following:

1. Development, sign off and implementation of the Trust Sustainability Communication Plan including publishing the Trust Sustainability webpage and recruitment of carbon champions.
2. Update Green Plan carbon reduction targets and action plan based on the result of the carbon footprinting exercise.
3. Recruit clinical and non-clinical services in "Greening Services Scheme".
4. Expand the use of the Sustainability Impact Assessment tool (SIA) in business development, investment, and procurement decisions to allow the Trust to show verifiable progress towards reduction in carbon intensive activities in the delivery of our service.
5. Mid-year review of the Green Plan.
6. Sign off an adaption plan as required in the newly released Green Plan guidance.

Carbon reduction initiatives that require capital funding are:

7. Implementation of mixed recycling scheme in all Trust sites. This includes the funding required to implement the walking aids reuse scheme.
8. Transition of Trust grey fleet to zero emissions vehicle. The 2022-23 NHS Standard Contract requires the Trust to put in place a transition plan.
9. Decarbonising Trust estates.

4. RECOMMENDATIONS

To discuss the progress, the priorities for the next 6 months, and the resource implication for planned initiatives.

Appendix 1

Walsall Healthcare NHS
NHS Trust

Project Title	Greener NHS Deliverables
Project Lead	Janet Smith

Current Date	31 March 2022

Key:

Status	At Risk	Priority
Not Started	Yes	High
On Track	No	Medium
Slippage		Low
On Hold		
Overdue		
Closed		

Project Name	Task	Description	Deadline	Days Remaining	Status	At Risk	Priority	Lead	Notes
Governance	All trusts have a Green Plan that aligns to ambitions in Delivering a Net Zero NHS by April 2022.	100% yes responses by April 2022 Questions Raised - Does your trust have a board-approved Green Plan in place? Yes/in progress/no	01-Apr-22	0	On Track	No	High	Head of Sustainability	The Trust Green Plan was approved by the Trust Board on 02 February
Governance	All trusts have a Board-level lead with net zero in their portfolio by April 2022.	100% yes responses by April 2022 Questions Raised - Does your trust have a board-approved Green Plan in place? Yes/in progress/no	01-Apr-22	0	On Track	No	Medium	Trust Board	
Medicines	Support patient choice of less carbon intensive inhalers, for example dry powder inhalers, where clinically appropriate, resulting in a 2% reduction of emissions by March 2022.	Questions raised, Data collection source and Regional Ambition date to be confirmed.	TBA	N/A	Not Started	No	Medium	Respiratory Department Pharmacy	An assessment to be carried out to establish the current level of use of carbon intensive inhalers in the Trust
Medicines	Work with regional team to ensure schemes for green disposal of inhalers are rolled out across the Trust.	Questions raised, Data collection source and Regional Ambition date to be confirmed.	TBA	N/A	Not Started	No	Medium	Respiratory Department Pharmacy	Work closely with the ICS respiratory group in implementing the agreed scheme
Medicines	Reduce the proportion of desflurane used in surgery to less than 10% of overall volatile inaesthetic gases by volume in all trusts.	All trusts use less than 10% proportion by volume desflurane by April 2022. The data collection source for this is Pharmacy dataset, Rx-Info Define (which feeds into Model Hospital).	01-Apr-22	0	Slippage	Yes	High	Surgical Services/ Anesthetic Department / Pharmacy	As of 31 March 2022, the use of desflurane has reduced to 11%
Medicines	Implement approaches to optimise use of medical gases, including reducing waste and preventing the atmospheric release of medical gases.	100% yes responses by April 2022. Questions Raised - Does your system have an approach to reduce nitrous oxide waste? Yes/in progress/no	01-Apr-22	0	On Track	No	High	Medical Gases Management Group	The medical Gas Management Group reviews medical gas usage by the Trust.
Travel and Transport	Ensure that systems solely purchase and lease cars that are ULEV or ZEV, and work towards purchasing vans under 3.5 tonnes that are ULEVs or ZEVs.	100% yes responses by April 2022. Questions Raised - Does your provider purchase or lease solely cars that are ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs)? Yes/no	01-Apr-22	0	Slippage	Yes	High	Estates and Facilities	An audit of the current fleet will be undertaken and a transition plan to move the current fleet with Zero Emissions Vehicles (ZEVs) by 2031 will be in place.
Travel and Transport	Ensure that systems solely purchase and lease cars that are ULEV or ZEV, and work towards purchasing vans under 3.5 tonnes that are ULEVs or ZEVs.	Does your provider working towards purchasing vans under 3.5 tonnes that are ULEVs or ZEVs? Yes/no	01-Apr-22	0	Slippage	Yes	High	Estates and Facilities	The completion of the audit of the current fleet will give us a realistic response to this question
Travel and Transport	Ensure that only ULEVs or ZEVs are available to staff through car salary sacrifice schemes	100% yes responses by April 2022. Questions Raised - Does your organisation's salary sacrifice scheme for vehicles allow only for the purchase of only ULEVs or ZEVs? Yes/no	01-Apr-22	0	On Track	No	High	Estates and Facilities	This is achievable pending negotiation with the provider
Travel and Transport	Ensure each trust has a cycle-to-work lead.	100% yes responses by April 2022. Questions Raised - Does your organisation have a cycle-to-work lead? Yes/no	01-Apr-22	0	Slippage	Yes	Low	Estates and Facilities	This will be assigned to the Sustainability Officer – once recruited
Travel and Transport	Ensure all systems have a salary sacrifice cycle-to-work scheme in place for staff.	100% yes responses by April 2022. Questions Raised - Does your organisation have a salary sacrifice cycle- to-work scheme for staff? Yes/no	01-Apr-22	0	On Track	No	Medium	Estates and Facilities	
Travel and Transport	Ensure that all sites have facilities available to encourage staff and visitors to cycle to work.	100% yes responses by April 2022. Questions Raised - Does your organisation provide facilities to encourage active travel for staff and visitors (e.g. cycle storage, showers, lockers)? Yes/no	01-Apr-22	0	On Track	No	Medium	Estates and Facilities	Manor Hospital – Cycle Parking, Lockers, and Showers for staff
Estates and Facilities	Ensuring all trusts only purchase renewable energy.	Regional expectation: 100% yes responses by April 2022. Questions Raised - Does your organisation purchase 100% of its electricity from renewable sources? Yes/no	01-Apr-22	0	On Track	No	High	Estates and Facilities	
Single Use Plastics	Following a significant organisational uptake in the Plastics Pledge in February 20, we will lead regional projects aimed at reducing the use of clinical single-use plastics.	This is the regional priority 1. Regional expectation: 100% yes responses by April 2022. Has your organisation eliminated single use plastics where appropriate? Yes/no	01-Apr-22	0	Slippage	No	Medium	All Trust Departments	The Trust has signed the plastics pledge but there has been some slippage due to Covid-19. Will be reviewed by the Sustainability Group
Paper	We will support ensuring all systems only purchase 100% recycled content paper for all office-based functions as soon as possible and across non-office-based functions as soon as practically possible.	This is the regional priority 2. Questions raised, Data collection source and Regional Ambition date to be confirmed.	01-Apr-22	0	On Track	No	Low	All Trust Departments	

Audit Committee
Chair Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Audit Committee
Date(s) of Committee/Group Meetings	9th May 2022 – Virtual meeting
Chair of Committee/Group:	Mary Martin
Date of Report:	23 May 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The Security report raised the issue of Patient Watch. A total of just over 8000 hours was recorded in the last twelve months and it was highlighted that security staff may not be the most appropriate people to sit with the patient. The committee will track progress with the Enhanced Observation Policy and has also asked for QPES to review the report at its next meeting.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	. • 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.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Grant Thornton is still in process of completing the 2021/22 internal audit programme. Two reviews are still outstanding but should be completed for the Annual Internal Audit opinion to be finalised for the Annual report • Good progress continues to be made on closing audit recommendations. Going forward it has been proposed that the executive member nominated to oversee each piece of internal audit work would be invited to attend Audit Committee for that item. • The external audit continues to progress in accordance with the timeline. Extra focus is on accruals this year.
Recommendation(s) to the Board/Committee	• Recommendation to the Board to delegate approval of the Annual report and Accounts to the committee at its next meeting on 13th June 2022.
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 the efficiency programme for Financial Year 22/23 and on appointing substantive staff to reduce the reliance on agency staff. • Early warning from TMC around the potential impact of the reduction in Covid-19 funding.

ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	. • GT - Internal Audit Report on Data Security & Protection Toolkit – significant assurance with some improvement required. • GT - Internal Audit Report – Improvement programme Part 1 - significant assurance with some improvement required. • RSM – Internal Audit Report – Electronic Patient Records – there were a number of areas for improvement and lessons for managing large projects going forward. • RSM – Internal Audit report - Medical Records – the report highlighted the need to move away from paper records as a matter of urgency. It also highlighted the need for a number of policies and procedures to be updated/put in place.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Review of work being undertaken in connection with cyber resilience • Review and approval of RSM Internal Audit Plan for 2022/23. This will cover the mandatory areas of Board assurance Framework, Risk Management, Data Security Protection Toolkit and Key Financial Controls. The remaining days in the work plan would focus on Risk exposure, Data Quality, Temporary staffing (effective rostering), Cyber security, and the efficiency programme. • Review and approval of the Local Counter Fraud Plan. Primary areas of focus will be Conflicts of Interest, Procurement, Invoice Fraud and Recruitment. • Review of draft Annual Accounts • 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 • Single tender actions • Review of Annual report • Annual Audit Committee Report
Self-evaluation/ Terms of Reference/ Future Work Plan	
Issues identified potentially relating to Equality, Diversity, and Inclusion	

MEETING OF THE TRUST BOARD			
Freedom to Speak Up Quarterly Report			
Report Author and Job Title:	Shabina Raza- Lead Guardian/Clinician Kim Sterling, Val Ferguson- Freedom to Speak Up Guardians Ayshia Aziz	**Responsible Director:**	Catherine Griffiths Director of People and Culture
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• Freedom To Speak Up (FTSU) Guardians continue to engage with staff of all levels to to hear different ideas and suggestions, enhance worker experience, prevent patient harm, and learn and improve when things don't go to plan or could be better. • The Raising Concerns at Work Policy which details how to speak up has been reviewed in partnership with trade union and HR colleagues and is due to be ratified for approval in June 2022. This will provide an opportunity to restate responsibilities for providing feedback when concerns are raised.		
Advise	• The regional Midlands network, Freedom to Speak Up (FTSU) Guardians have recently developed best practice guide to help respond consistently when colleagues advise they have experienced some form of disadvantageous and/or demeaning treatment as a result of raising a concern. This will be reviewed by the service and incorporated into the Freedom to Speak Up policy and process.		
Alert	• There remains a high number of 'open' concerns whereby feedback is required to the F2SU service to assure them that concerns are being addressed and feedback provided to those colleagues that have raised a concern. • Over Q4 of 21/22 of the 31 concerns raised; 29% of concerns had an element of patient safety and the quality of care we provide and 41% of concerns relate to attitudes and behaviours.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The work programme described within this report will provide positive assurance to the committee on the following BAF risk: **BAF 04 (a) - Value our Colleagues** Lack of an inclusive and open culture impacts on staff engagement, staff morale, patient care, Leadership, Organisational Development and Culture.		
Resource implications	There are some costs implications associated with following this programme of work; all resource will be aligned through existing budgets.		

Legal and/or Equality and Diversity implications	Black, Asian or minority ethnic employees often face more barriers than non BAME employees when raising concerns. The data available is not yet sufficient to reliably determine and evidence equality and diversity impacts. This is being addressed through collecting concerns electronically through the incident reporting system, Safeguard and work being undertaken by the Equality, Diversity and Inclusion Committee.	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Quarterly Report of the Freedom to Speak Up Guardians

1. Purpose

The intention of this report is to detail the number and nature of concerns raised through contact with the Trust's Freedom to Speak Up (FTSU) Guardians in the final quarter of the last financial year: the period 1st January 2022 to 31st March 2022. This information is reported quarterly to the National Guardians Office.

2. Background

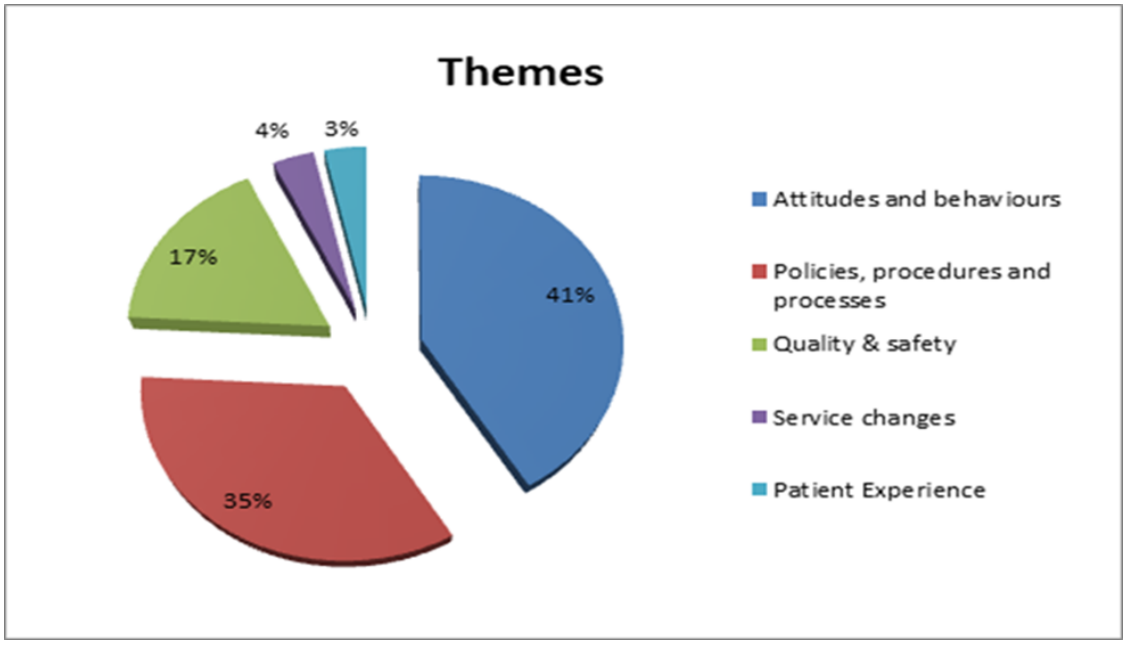
FTSU is now established as the model for NHS Trusts to remove the barriers to raising patient safety concerns. Colleagues are encouraged and supported to escalate issues that prevent delivery of high quality, safe care. The Trust is committed to embedding this process in the culture of the organisation. This open culture will be demonstrated by employees who feel safe to raise concerns and are confident that their concerns will be listened to and addressed accordingly.

This report provides detail on the number and nature of concerns raised through FTSU during the period noted.

3. Details

There were 31 concerns raised through FTSU during the period, 1st January 2022 to 31st March 2022.

This diagram illustrates the breakdown of the FTSU cases by themes.



The organisation continues to hear from colleagues who are concerned about the attitudes and behaviours of their colleagues. This is reflected in the nature of the

concerns raised to the FTSU guardians where these types of concerns represent 41% of all concerns in this quarter.

Overall, a total of 9 cases (29%) bought to the attention of the Guardians which had an element of direct patient safety and quality of care. It is important to note that these matters had already been escalated to the appropriate manager with an unsatisfactory response prior to escalation to a guardian.

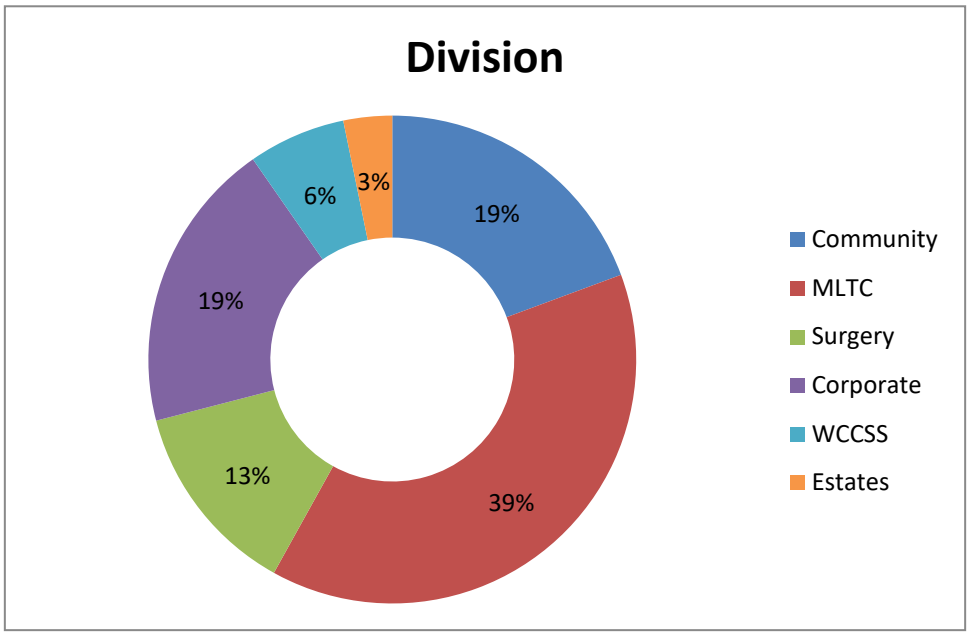
The underlying spirit of speaking up in healthcare is that all concerns have an indirect impact on patient quality and care. The work of Chris Turner on 'Civility Saves Lives' has scientifically evidenced the link between the impact of incivility on performance and this will affect patient outcomes.

Although the guardians meet with the divisional leads to discuss cases, much work is still needed to provide assurance that necessary actions are being taken to address concerns, especially around those directly linked to patient safety. Triangulation of data also needs to be thoroughly analysed from other sources such as incident reporting to support the assumptions made on the direct level of potential risk and harm.

The lack of reporting to FTSU may indicate that colleagues feel safe to report on patient safety through the other routes available to them. It could also indicate that the division's response to issues relating to patient safety are addressed and resolved and this has increased confidence in escalation locally in departments. However, it is also possible that staff may feel a lack of confidence in speaking up, following lack / insufficient feedback and assurance which could also result in staff being 'silenced.'

It might be beneficial to the divisions to carry out work to investigate the reasons that colleagues with other types of concern will seek support from the FTSU Guardians.

The following chart shows the percentage of concerns from each division.



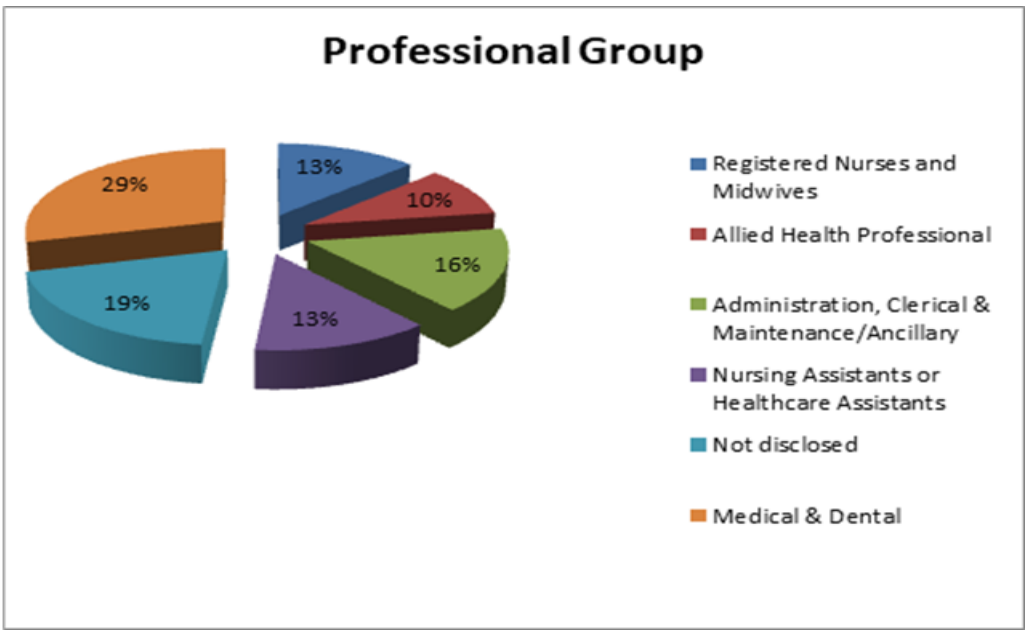
The table below can be used to assess the speak up culture within the divisions. Taking into consideration that the size of the speak up caseload should be proportionate to the number of employees in the division, the presence of under/over representation is to be questioned.

The number of concerns reported by the estates division and the division of WCCSS is disproportionately lower than the employee size of the division. There could be several reasons why this might be the case and exploration by the divisions to uncover the reasons why, will help improve the culture.

Division	Number of staff	% of Trust	% Concerns
Community	914	19.4	19
Corporate (inc COVID vaccination centre)	572	12.1	19
Estates	409	8.7	3
MLTC	978	20.7	39
Surgery	965	20.5	13
WCCSS	878	18.6	7
Grand Total	**4716**	**100%**	**100%**

In this quarter the FTSU route for escalating concerns has been accessed by colleagues from diverse professional groups.

Registered midwives and nurses have been replaced by colleagues from a medical and dental background as the largest professional group who have utilised FTSU the most to support them to escalate their concerns.



Furthermore, the guardians need to have assurance that all senior leaders are engaged with speaking up and provide an ‘open door’ approach, accessible at any time practically possible to address urgent concerns, especially those around patient safety.

Overall, the lack of feedback and assurance provided by senior managers on specific concerns bought to the guardians provides a degree of mistrust and a lack of confidence by staff.

The table below outlines the number of 'open concerns' that require assurance that the concerns have both; been addressed and appropriate feedback provided to the individual and the guardian to enable the concern to be closed.

Q4 2021/22	Q3 2021/22	Q2 2021/22	Q1 2021/22	Q4 2020/21 and earlier
21	22	3	7	9

The F2SU service have explored the potential to use Safeguard to alert managers to up date the progress of the concerns and to be proactively involved in closing cases with appropriate outcomes/actions. This experience is being taken forward with the implementation of Datix.

Recommendations

Members of the Trust Board asked to:

i. Note the report and discuss the contents within
ii. Continue with their commitment to making Speaking Up routine day-to-day practice
iii. Ensure concerns are heard and responded to, supporting guardians to seek the assurance that is required.

MEETING OF THE TRUST BOARD XXXXX			
Staff Networks			
Report Author and Job Title:	Sabrina Richards Talent Inclusion and Resourcing Lead & Clair Bond, Deputy Director of People & Culture	**Responsible Director:**	Catherine Griffiths- Director of People and Culture
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• In May, the People and Organisational Committee were assured that the Trusts BAME Decision Making Council, LGBTQ+ and Allies Network and Women and Allies Networks were maturing well and each had clear structures and aims to deliver against. • The Committee are assured that connections between staff networks across Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust are developing well.		
Advise	• The Staff Network groups are a crucial component of staff experience and engagement. The Trust Board committed to developing a model of shared governance and decision making as part of the Trust Board pledge of ensuring staff voice is evident from ward to board. • A further network supporting neuro diversity in the workforce is being developed between Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. • An appointment has been made to provide dedicated support to further development and maturity of the staff networks. This short term role commences in June 2022.		
Alert	• The Staff Network group for Long term conditions needs to be re-established to raise awareness of disability in the workforce, to ensure colleagues with disability are supported at work and do not suffer detriment due to their disability or lack of organisational awareness of support required. • The inability to secure protected time for those involved in chairing the group has slowed progress. The People and Organisation Development Committee noted budget has been identified within an investment case on improving the Trust culture. This is critical to addressing the elements relating to bullying and discrimination and this will remain a trust risk until the requisite support is in place to take the next step to empower staff to make improvements at local level • The indicators on WDES – workforce disability equality standard worsened during the 2022-2023 year and show differential experience.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The contents of this report relate to the BAF 04 - Value our Colleagues: risk 2489. Poor colleague experience in the workplace. A significant loss of workforce diversity, talent, productivity and retention arising from poor colleague experience which prevents staff from reaching their potential and being their best selves at work (reduction in effort above and beyond contractual requirements), lack of opportunity to develop and progress, not feeling safe due to unacceptable behaviours such as racism, bullying and harassment, workforce fatigue and not valued for the incredible job that they do and therefore not recommending the trust as a place to work or a place to be treated.	
Resource implications	A recent benchmarking exercise that has been carried out to review EDI infrastructures in neighbouring Trusts in the Black Country and West Birmingham region illustrates that there needs to be a focused resourced plan to support significant improvement with the EDI agenda. This will ensure that maximum impact is achieved to improve upon some of the culture behavioural workforce indicators.	
Legal and/or Equality and Diversity implications	Staff Networks and providing a voice to under represented staff groups within the Trust is a key element of the Equality, Diversity and Inclusion Strategy and Delivery Plan, which provides assurance that the organisation is taking action to eliminate unlawful discrimination in line with the Equality Act 2010 by monitoring progress against the four equality objectives and the EDI delivery plan and associated KPIs. The successful implementation of the EDI strategy is a good barometer of how successful we are in our ambition to be an inclusive employer. The ability to provide additional resources to support improvements with equality and diversity and inclusion will support overall improvements in the culture of the organisation and staff recommending Walsall as a great place to work and a place to be treated. This will result in the organisation being able to demonstrate due regard in terms of how it is meeting the Public Sector Equality Duty (promoting equality of opportunity and fostering good relations with people that share a protected group and with those that do not).	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Walsall Healthcare NHS Trust

The Power of Staff Networks

People and Organisation Development Committee

23 May 2022 – Staff Story

Staff INCLUSION Network

Staff INCLUSION Network
LGBTQ+ and Allies Network Lead

Walsall Healthcare NHS Trust
BAME
Black Asian Minority Ethnic
Shared Decision Making Council

Staff INCLUSION Network
Women and Allies Network Lead

Caring for Walsall together

Safe, high quality care | Care at home | Partners | Value colleagues | Resources | Respect Compassion Professionalism Teamwork

BAME Shared Decision Making Council

BAME Shared Decision Making Council

- Meeting held with Nottingham City Hospital in June 2020 to share best practices as they established over ninety shared decision-making councils.
- Shared decision making a model of leadership which places staff at the heart of the decision-making process.
- Shared decision-making enables collective ownership to develop and improve patient care, outcomes, and staff satisfaction.
- WHT BAME shared decision-making council started the conversation about bias and racism in the workplace amongst the Nursing workforce during the peak of the COVID-19 pandemic. The Council wanted to ensure that everyone has the same access to opportunities and, fair treatment.
- The BAME shared decision-making council launched in September 2020
- Highly Commended – BHM ICS regional awards ceremony
- Diversity and Inclusion WHT Staff Award

Executive Sponsor: Catherine Griffiths- Director of People and Culture

What has the Council Implemented?

- Set up monthly meetings with the council group members (approx 35 Members)
- Designed a logo and banner representing BAME shared decision-making council.
- Raised the profile of BAME shared council in the Trust Daily Dose and Chief Executive updates.
- Promoted Black History Month as part of the BAME Council launch
- Attended training delivered by the Royal College of Nursing cultural Ambassadors training to challenge and address cultural bias and discriminatory practices
- Set up a staff network forum where staff can share experiences and issues affecting their work, health and well-being, career progression, and professional development.
- Promotional video to encourage BAME colleagues to take up the COVID19 vaccine
- Hosted career and leadership development workshops targeted at Black Asian and Ethnic Minority colleagues

Aims of the BAME Shared Decision Making Council

- To create a safe space for members of staff from BAME backgrounds.
- A safe environment to challenge inequality and raise awareness of the importance of promoting diversity within the organisation.
- Empower staff in the organisation to achieve their potential by strengthening, equality, diversity, and inclusion through ally ship from non-black colleagues.
- Drive forward organisational change and eradicate workplace racial injustice, discrimination, and unconscious bias.
- Inclusive leadership organisation- raising the visibility and profile of the contribution that BAME staff make in the organisation.

LGBTQ+ Allies Network

Staff INCLUSION Network
LGBTQ+ Lead

Background

- LGBTQ+ Allies Network was established as a subgroup of the staff inclusion network earlier last year 2021
- 20 members to date which consists of colleagues from an LGBTQ+ Background and allies
- Aims of the network is to provide a safe space for colleagues who identify as LGBTQ+ to discuss matters related to LGBTQ + Equality and to support a climate of LGBTQ+ inclusion at WHT
- The network is a space for allies to seek advice and guidance /expertise on LGBTQ + matters.
- **Executive Sponsor: Ned Hobbs**

Activities of the LGBTQ+ Allies Network

Established LGBTQ+ Sub Group Meetings

LGBTQ + History Month in February

Rainbow Badges were given out to 150 colleagues and pledges were made to support LGBTQ+ Equality

Hosted LGBTQ+ webinar with the BLGBT Centre

Pride Flags were installed outside the main and rear entrance

NHS Pride – W/C 6-10 Sept:

Completed pictures for communication Team at NHS England and NHS Improvement and clip for National NHS Pride.

Celebration of PRIDE week in the Main Atrium

Rainbow badges were given out and additional pledges made by 75 colleagues

Activities of the LGBTQ+ Allies Network

National Inclusion Week 27/09/21

- Participated in Lunch and Learn Sessions for LGBTQ+ equality
- Blogs developed for the daily dose in partnership with LGBTQ+ straight Ally – Ned Hobbs

Member of the LGBTQ+ Regional Network set up by UHB – Planning for regional virtual PRIDE events and regional LGBTQ + History Month

Plans to work collaboratively with RWT LGBTQ+ Network (strength in numbers)

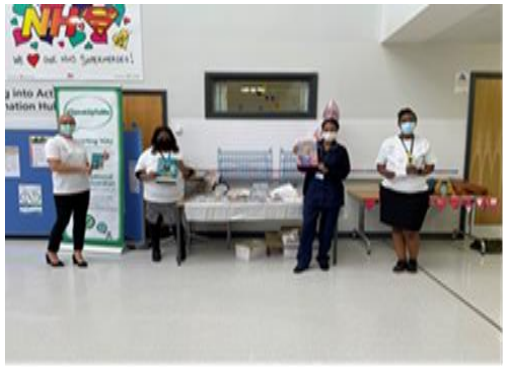
Developed SMART Objectives for the LGBTQ+ Network

Involvement in Rainbow Badge Phase 2 Initiative(Audit of LGBTQ+ inclusivity at the Trust.)

Support with Policy Development LGBTQ+ Trans Policy and Guidance

Articles developed for daily dose promoting LGBTQ+ events and celebration days.

Women & Allies Network



Women and Allies Network

Formally launched in October of this year

The female network and allies group held a stand at Costa Coffee to hand out useful information and encourage more staff to sign up to the new network. A TEAMS meet was also set up for those that could not attend face to face

We gave out cupcakes, t-shirts and costa coffee vouchers to the first 10 people that joined the network.

80 Members signed up to the network to date

Executive Sponsor: Manjeet Shehmar – Chief Medical Officer

Aims of the Women and Allies Network

- Our vision is to be a safe, non-judgmental, Easy to access network that will enable women to realise and fulfil their full potential.

- We want to create a forum where women can come together to share their experiences, knowledge, and ideas in order to help influence and shape the way the trust supports and invests in its female workforce

- We want to encourage women to support each other throughout their working journey so no one feels alone

Aims of the Women & Allies Network

- We will work to empower females to be the best they can be, so they have the confidence to take up opportunities/development in the workplace
- We will work to improve the challenges females face in the workplace ensuring their working time with the trust is a positive experience that enables them to fulfil their potential
- We will respect and show compassion to every member of the network whilst displaying professionalism
- We will encourage teamwork and provide support when needed
- We will listen and take forward ideas and improvements

What have we implemented so far?

- Set up the network which now has approx. 80 members
- Created a Menopause Champion Team who are currently working on a Menopause policy for the trust
- Research into how Walsall Healthcare can gain Menopause Friendly Accreditation
- Links made with Walsall College to gain access to free courses available to staff
- Met with Dr Omi Ohizua – Obs & Gynae Consultant to look at the support available to staff with Peri-Menopause/Menopause when facing challenges with their GP (potential for a new clinic)
- Secured engagement from Executive sponsor and Non-executive sponsor
- Hosted numerous guest speakers at the network meeting: Mental Health, Domestic Violence, RCN & Health & Wellbeing
- Promoted International Women's Day with a webinar
- Addressed Flexible/agile working issues
- Set up a Teams channel for the network to stay engaged

What do we plan to next?

- Introduce collaborative working with Wolverhampton
- Plan guest speakers for all meetings around areas of interest to the network
- Introduce a social network group for the network
- Identify ways in which we can keep the network interacting between meetings
- Engage with the Black Country Partnership (what can we learn, what's available)

Challenges

- Protected time for network members and Leads
- Budget (continued advertising and promotion & budget to support protected time)
- Actions raised in meetings being addressed in a timely manner (issues that are out of our control)
- Trust Executive Board Members being able to attend most of the meetings in order to participate, support, and provide feedback where required.

MEETING OF THE TRUST BOARD			
Guardian of Safe Working Hours Quarterly Reports August – October 2021 November 2021 – January 2022 February 2022 – April 2022			
Report Author and Job Title:	Mushal Naqvi, Guardian of Safe Working Hours (GoSWH)	**Responsible Director:**	Manjeet Shehmar Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• The GoSWH is able to provide assurance with the overall safety of working hours for junior doctors across all quarters. • The JDF demonstrated great professionalism despite working under huge pressure of another covid-19 wave, providing a list of volunteers happy to be redeployed if this were to be required. • The Clinical Fellowship Scheme is being utilized to addressed the pre-existing rota gaps in Surgery, providing a longer term solution.		
Advise	• The number of exceptions for Aug-Oct 21 and Nov 21 to Jan 2022 were the higher than the expected range likely to be related to the increase of covid-19 admissions and the associated increase in staff sickness. • FY1 doctors submit the highest number of exception reports; 95% Aug-Oct 21, 98% Nov 21-Jan 22 and 100% Feb 22 to April 22. • FY1 doctors in Medicine provided the most returns between Aug 21 and Jan 22 and 75% of exception reports between Feb and April 22 were from the Surgical Division this quarter.		
Alert	• Increase senior support arrangements for the newly qualified FY1s on their first day whilst the SHO level junior doctors attend their induction. • Increase medical staffing knowledge and awareness of exception reporting to provide information on vacancies and locum usage (for both trainees and non-trainees) to triangulate data ad further enable quality improvement • Implementation of an induction programme for locum doctors is required. • Ensure responsive feedback to concerns raised by the Junior Doctor Forum (JDF)		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	2664: Patient Safety and Training Issues in Medicine/ED Reputational Impact on the trust regarding Doctors in Training placements. Withdrawal of Doctors in Training placements by Health Education England. Financial reduction of Health Education income.		
Resource implications	There is no resource implications associated with this report at this point.		

GUARDIAN OF SAFE WORKING QUARTERLY REPORT (AUG/SEP/OCT 21)

ON THE SAFE WORKING HOURS OF DOCTORS IN TRAINING

Walsall Healthcare NHS
NHS Trust

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

GUARDIAN OF SAFE WORKING QUARTERLY REPORT (AUG/SEP/OCT 21)

ON THE SAFE WORKING HOURS OF DOCTORS IN TRAINING

Walsall Healthcare NHS
NHS Trust

1. PURPOSE OF REPORT

The purpose of the reports is to provide a report from the Guardian of Safe Working to the Board on the safety of doctors' working hours and rota gaps as required under the terms and conditions of the 2016 Junior Doctor Contract.

2. BACKGROUND

GUARDIAN OF SAFE WORKING - Safeguarding the working hours of doctors
The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The guardian of safe working has been introduced to protect patients and doctors by making sure doctors aren't working unsafe hours.
To do this, the guardian will:

- act as the champion of safe working hours
- receive junior doctors trainees' exception reports and record and monitor compliance against the 2016 terms and conditions of service for doctors in training
- escalate issues to the relevant executive director or equivalent for decision and action
- intervene to reduce any identified risks to junior doctors or their patients' safety
- undertake a work schedule review where there are regular or persistent breaches in safe working hours
- distribute monies received as a consequence of financial penalties, to improve junior doctor training and service experience.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures ensure the safety of doctors and therefore of patients.

For more information about the guardian role, visit
www.nhsemployers.org/juniordoctors

3. EXECUTIVE SUMMARY

August to October 2021 (appendix a)

a. 36 exception reports were submitted this quarter
b. Exceptions submitted were higher than the expected range per month for August
c. Almost 75% of exceptions reports submitted this quarter were from the Division of Medicine

d. There were two “Immediate Safety Concerns” this quarter
e. Improvements could be made to the annual induction process by ensuring FY1s have better access to senior support on the wards on their first day whilst SHO level doctors are away being induced
f. There appears to be gaps in the knowledge base of rota coordinators based in medical staffing regarding the exception reporting system
g. Data on vacancies (both for training and non-training junior doctors) and locum usage remains outstanding
h. As Guardian, I am comfortable in providing assurance with the overall safety of working hours for training Junior Doctors within the Trust

November 21 to January 2022 (appendix b)

a. 47 exception reports were submitted this quarter
b. Exceptions submitted were higher than the expected range per month for December and January which may relate to the last covid-19 wave and the associated increase in staff absence
c. Almost 60% of exceptions reports submitted this quarter were from the Division of Medicine
d. There were four “Immediate Safety Concerns” this quarter, all in the month of December
e. ISCs related to rota gaps (which were pre-known in Surgery) causing unsafe staffing to patient ratios, which was further compounded by staff sickness
f. A locum doctor induction is urgently required
g. The JDF also highlighted ventilation problems in the Communication rooms on the newly refurbished Surgical wards
h. Data on vacancies (both for training and non-training junior doctors) and locum usage remains outstanding
i. As Guardian, I am comfortable in providing assurance with the overall safety of working hours for training Junior Doctors within the Trust

February 2022 to April 2022 (appendix c)

a. 11 exception reports were submitted this quarter
b. Exceptions submitted were lower than the expected range per month
c. Almost 75% of exceptions reports submitted this quarter were from the Division of Surgery
d. There were no “Immediate Safety Concerns” this quarter
e. However, feedback provided via the JDF and also through email correspondence to the GoSWH highlighted concerns with staffing levels in Elderly Care and Surgery and therefore both the Divisional Directors of Medicine and Surgery were asked to conduct work schedule reviews to address this
f. Discussions with the Surgery Divisional Director of Operations and the Clinical Fellowship programme were undertaken to provide a longer-term solution for the already known rota gaps in Surgery, but this will not come into action until August 2022

g. Data on vacancies (both for training and non-training junior doctors) and locum usage remains outstanding
h. As Guardian, I am comfortable in providing assurance with the overall safety of working hours for training Junior Doctors within the Trust

Higher level data

Number of doctors in training (total)	Data not available
Number of doctors in training on 2016 TCS (total)	Data not available
Amount of time available in job plan for Guardian role	1 PA/4 hours per week
Admin support provided to Guardian (within the 37.5 hours per week worked by the Guardian admin support, additional responsibilities are also provided which include: i. appraisal & job planning administrator ii. medical staffing support iii. clinical fellowship programme support)	1 WTE/37.5 hours per week
Amount of job plan time for educational supervisors	0.25 PAs/trainee (with a maximum of 0.5 PAs/2 hours per week)

a. Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns (ISCs)	Total hours of work and/or pattern	Service support available	Working hours/pattern AND Service support	Educational opportunities/ support	**TOTAL**
AUG 21	2	23	0	4	1	**30 (83.3%)**
SEP 21	0	4	0	0	1	**5 (13.9%)**
OCT 21	0	1	0	0	0	**1 (2.8%)**
QUARTER	**2 (5.6%)**	**28 (77.8%)**	**0 (0%)**	**4 (11.1%)**	**2 (5.6%)**	**36 (100%)**

The number of exception reports for this quarter was higher than expected for the month of August but lower than expected for the month of October (previously, median number of reports per month = 10 with an interquartile range of 5 – 20).

Similar to previous quarters, FY1 level doctors submitted the majority of exception reports:

Exception reports by grade				
Grade	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	0	35 (%)	24 + 11	0
F2	0	1 (%)	1 + 0	0
Total	**0**	**36 (100%)**	**25 + 11 (69.4% + 30.6%)**	**0 (0%)**

The mean number of days between an exception occurring and the exception being reported was 2.5 days (median = 1 day, range = 0 – 17 days)

Almost three-quarters of the exception reports related to Medicine with the remainder from the Division of Surgery:

Exception reports by department					
Division	**Specialty**	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Medicine	Acute Medicine – AMU ward	0	11 (%)	9 + 2	0
Medicine	Gastroenterology – ward 16	0	7 (%)	3 + 4	0
Medicine	Elderly Care – wards 1, 2 & 4	0	6 (%)	6 + 0	0
Medicine	Cardiology – ward 7	0	2 (%)	2 + 0	0
Surgery	Gen Surg – wards 11 & 12	0	7 (%)	4 + 3	0
Surgery	Gen Surg – on call	0	2 (%)	1 + 1	0
Surgery	ENT	0	1 (%)	0 + 1	0
Total	**Med 26; Surg 10 (72%; 28%)**	**0 (0%)**	**36 (100%)**	**25 + 11 (69.4% + 30.6%)**	**0 (0%)**

Over two-thirds of exception reports submitted this quarter had a review meeting conducted by the supervisor. I then personally reviewed the remaining 11 outstanding reports and organized Time Off In Lieu (TOIL) for two exceptions and payment as compensation for remaining eight outstanding reports. However, when compensating trainees with TOIL, the lack of understanding by the Medicine Rota coordinator (based in medical staffing) on how TOIL is awarded became apparent – this issue has been highlighted to Head of Medical Staffing in order to ensure all rota coordinators are aware of the process.

Exception reports (response time)				
Grade	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
F1	7	6	11 + 11	0
F2	1	0	0 + 0	0
Total	**8 (22.2%)**	**6 (16.7%)**	**11 + 11 (30.6% + 30.6%)**	**0 (0%)**

The mean number of days between an exception report being submitted by a trainee and a review meeting occurring between the trainee and their supervisor was 21.9 days (median = 7 days, range = 0 – 84 days), which is is an improvement on the last quarter.

The data regarding the resolution of exception reports for each month of this quarter is as follows:

	TOIL granted	Payment for additional hours	Work schedule reviews	Resolved – no action required	Unresolved	**TOTAL**
AUG 21	17 + 2	4 + 6	0	1	0	**30**
SEP 21	0	2 + 3	0	0	0	**5**
OCT 21	1 + 0	0	0	0	0	**1**
QUARTER	**18 + 2 (55.6%)**	**6 + 9 (41.7%)**	**0 (0%)**	**1 (2.8%)**	**0 (0%)**	**36 (100%)**

b. Work Schedule Reviews

No work schedule reviews were requested or required this quarter.

c. Locum Bookings

Data not available

d. Locum Work Carried Out By Trainees

Data not available

e. Vacancies

Data not available

f. Fines

Fines by department

Department	Number of fines levied	Value of fines levied
General Surgery	2	£68.05
Total	**2**	**£68.05**

Fines (cumulative)	
Balance at End of Last Quarter	Not known + £412.78
Fines Paid to GOSWH This Quarter	£68.05
Expenses This Quarter	£0
Total Paid to Trainees this Quarter	£370.56
Balance at End of this Quarter	Not known + £480.83

Qualitative Information

Similar to previous Augusts, junior doctors above FY1 level are away from the wards to attend their induction leaving newly qualified FY1 doctors on the ward on their first day. The lack of support experienced by the FY1s is still leading them submit exception reports. Induction is a predictable, recurring event where we should be able to pre-empt and mitigate such exceptions taking place perhaps by cancelling elective work on the first Wednesday of August to enable senior members of the team to then be available on the ward to support FY1s on their very first day as a junior doctor.

This year, the “live” Guardian of Safe Working Hours (GoSWH) induction I provided to the FY1s (who form the vast majority of junior doctors that exception reporting) included submitting a “practise exception report” to ensure all had received a log-in to access the exception reporting system, as well as checking their ability to submit reports. Anyone identified as not able to access the system was subsequently contacted by the GoSWH admin support who provide log-ins - a strategy which proved very successful. However, trainees above FY1 level were scheduled to receive a “recorded” GOSWH induction. Unfortunately, it appears the recorded induction didn’t appear to be as successful in confirming all trainees had access to the exception reporting system; despite the induction asking the junior doctors to enter a “test exception report”, none were submitted. I am not clear on the reason behind why this didn’t occur (e.g., were there technical or time constraint reasons which prevented trainees from undertaking this exercise).

Issues Arising

There were two Immediate Safety Concerns (ISCs) this quarter. Both occurred at the start of August, originating from Medicine (the Gastroenterology ward specifically)

and related to the lack of senior support available on the ward for the new qualified FY1s on their first day whilst the SHO level doctors were being induced.

Actions Taken to Resolve Issues

The recurring induction issue which formed a common theme to both the ISCs submitted this quarter has been escalated to the Medical Director, Head of Medical Staffing and the Director of Post-Graduate Medical Education (DPGME), together with a potential a solution, where I hope a strategy will be put into action in good time to prevent a further recurrence next August.

Summary

As previous quarters, the majority of exception reports were submitted by FY1 level doctors. A higher-than-expected number of exception reports were submitted in August, including two ISCs relating to the lack of senior support available to FY1s on the ward on their first day working as a junior doctor, when the SHO level doctors are away being induced. I have suggested that on the first Wednesday of August, that all elective work be cancelled to enable senior members of the team to then be available on the ward instead and have escalated the issue to the Medical Director, Head of Medical Staffing and the DPGME.

Just under three-quarters of exception reports were from the Medicine Division with the remainder emanating from the Division of Surgery, with the main reason to exception report relating to working hours and not finishing on time at the end of a shift.

The “live” GoSWH induction provided to the FY1s successfully addressed the log-in issues encountered by junior doctors last year – unfortunately, the “recorded” GoSWH induction didn’t seem as effective for reason which aren’t entirely clear.

Questions for Consideration

As guardian, I am comfortable with the overall safety of working hours in the organisation in this quarter, with the proviso of improving the senior support available on the ward for FY1s on their first day as a junior doctor, when SHOs are away being induced.

I would therefore ask the board to note the report and to consider the assurances provided by the Guardian.

Appendix

Exception Report
Appendix Aug-Sep-(

Higher level data

Number of doctors in training (total)	Data not available
Number of doctors in training on 2016 TCS (total)	Data not available
Amount of time available in job plan for Guardian role	1 PA/4 hours per week
Admin support provided to Guardian (within the 37.5 hours per week worked by the Guardian admin support, additional responsibilities are also undertaken including: i. appraisal & job planning administrator ii. medical staffing support iii. clinical fellowship programme support)	1 WTE/37.5 hours per week
Amount of job plan time for educational supervisors	0.25 PAs/trainee (with a maximum of 0.5 PAs/2 hours per week)

a) Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns (ISCs)	Total hours of work and/or pattern	Service support available	Working hours/pattern AND Service support	Educational opportunities/ support	**TOTAL**
NOV 21	0	5	0	4	0	**9 (19.1%)**
DEC 21	4	2	0	7	3	**16 (34%)**
JAN 22	0	7	0	0	15	**22 (46.8%)**
QUARTER	**4 (8.5%)**	**14 (29.8%)**	**0 (0%)**	**11 (23.4%)**	**18 (38.3%)**	**47 (100%)**

The number of exception reports in this quarter was slightly higher than expected for the month of December (previously, median number of reports per month = 10 with an interquartile range of 5 – 20), given that usually there is an annual drop in exception reports submitted in the month of December, reflecting leave taken by many around the Christmas/New Year period, together with the associated reduction in elective workload and additionally, the concerted efforts to discharge many patients home so they also are able to spend the holiday season with their family and loved ones rather than remaining in hospital. The number of exceptions reported in January were also higher than expected. This may relate to the last wave of the covid pandemic where there was an associated increase in staff sickness as well as covid medical inpatient

admissions, where in response mandatory teaching was cancelled by HEE for the month of January (meaning trainees weren't able to take their self-development-time resulting in an increase in Educational exception reports this month).

Similar to previous quarters, FY1 level doctors submitted the majority of exception reports:

Exception reports by grade				
Grade	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	0	46 (97.9%)	31 + 15	0
F2	0	1 (2.1%)	0 + 1	0
Total	**0 (0%)**	**47 (100%)**	**31 + 16 (66% + 34%)**	**0 (0%)**

The mean number of days between an exception occurring and the exception being reported was 6.7 days (median = 4 days, range = 0 – 26 days).

Just under two-thirds (59.6% n=28) of the exception reports related to the Medical division with remainder emanating from the Department of Surgery:

Exception reports by department					
Division	**Specialty**	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Medicine	Elderly care	0	14 (%)	11 + 3	0
Medicine	Acute Medicine – AMU ward	0	9 (%)	1 + 8	0
Medicine	On call/ward cover	0	3 (%)	3 + 0	0
Medicine	Diabetes & Endocrinology – ward 15	0	2 (%)	2 + 0	0
Surgery	Gen Surg – wards 11 & 12	0	15 (%)	12 + 3	0
Surgery	Gen Surg – wards 20A & 23	0	1 (%)	1 + 0	0
Surgery	Gen Surg – floating	0	1 (%)	0 + 1	0
Surgery	Trauma & Orthopaedics – ward 9	0	2 (%)	1 + 1	0
Total	**Med 28; Surg 19**	**0**	**47**	**31 + 16**	**0**

	(59.6%; 40.4%)	**(%)**	**(100%)**	**(66% + 34%)**	**(0%)**

Two-thirds (66% n=31) of exception reports this quarter had a review meeting conducted by the supervisor – an improvement on the last quarter.

I personally reviewed the remaining 16 outstanding reports, organizing payment as compensation for these exceptions, allowing them also to be closed.

Exception reports (response time)				
Grade	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
F1	12	10	9 + 15	0
F2	0	0	0 + 1	0
Total	**12 (25.5%)**	**10 (21.3%)**	**9 + 16 (19.1% + 34.0%)**	**0 (0%)**

The mean number of days between an exception report being submitted by a trainee and a review meeting occurring between the trainee and their supervisor was 6.6 days (median = 5 days, range = 0 – 20 days).

The data regarding the resolution of exception reports for each month of this quarter is as follows:

	TOIL granted	Payment for additional hours	Work schedule reviews	Resolved – no action required	Unresolved	**TOTAL**
NOV 21	0 + 0	3 + 6	0	0 + 0	0	**9**
DEC 21	4 + 0	0 + 6	0	6 + 0	0	**16**
JAN 22	2 + 0	1 + 4	0	15 + 0	0	**22**
QUARTER	**6 + 0 (12.8%)**	**4 + 16 (8.5%+34%)**	**0 (0%)**	**21 + 0 (44.7%)**	**0 (0%)**	**47 (100%)**

b) Work Schedule Reviews

Due to the pressure departments were already working under relating to the last wave of the pandemic, I held off asking for work schedule reviews in this quarter.

c) Locum bookings

Data not available

d) Locum Work Carried Out By Trainees

Data not available

e) Vacancies

Date not available

f) Fines

Fines by department		
Department	**Number of fines levied**	**Value of fines levied**
N/A	0	£0
Total	**0**	**£0**

Fines (cumulative)	
Balance at End of Last Quarter	Not known + £412.78
Fines Paid to GOSWH This Quarter	£0
Expenses This Quarter	£0
Total Paid to Trainees this Quarter	£315.14
Balance at End of this Quarter	Not known + £412.78

Qualitative Information

The JDF highlighted issues with the FY1, SHO and Registrar rotas in Elderly Care Medicine, where they whole teams would end up all on call together leaving the ward short of cover.

Additionally, it was identified that in General Surgery/Urology/ENT/T&O there were problems relating to leave for FY1s being authorized by one person but at SHO/Reg level it is authorized by another person such that neither realize they could each be allowing leave of whole teams, leading to staffing issues. The solution would be for the rota lead in the speciality being affected by the FY1's leave request, being the one who decides whether staffing levels are sufficient to allow approval of the leave (as they would also have oversight of any leave already authorized at SHO/Registrar level).

The JDF also raised issues regarding the ventilation in the Communication rooms on the newly refurbished Surgical wards.

Issues Arising

There have been four “Immediate Safety Concern” exception reports this quarter; three from the Division of Medicine (two relating to the Medicine on call and one to the Elderly Care ward staffing levels) and one from General Surgery department.

All the Medical ISCs relate to a lack of availability of senior support due to rota gaps at the SHO/RMO/Reg level, meaning FY1s taking the brunt of this deficiency, thereby feeling out of their depth. These rota gaps may have compounded further through short notice sickness relating to covid, which had not been covered.

Similarly, the ISC in General Surgery relates to two pre-existing rota gaps at FY1 level, being further compounded by two more pre-existing rota gaps at SHO level, plus adding in any covid related staff absences, again causing FY1s to feel unsupported. It also appears that even when locums have been recruited to cover these gaps, that they have not been adequately induced (for instance, not having been given access to I.T. systems) or aren’t of sufficient experience to carry out the expected duties, only adding to the pressure being felt by FY1s where they then are having to train these locums whilst trying to complete the required ward work.

Actions Taken to Resolve Issues

The Head of Medical Staffing was informed of the rota issues in both the Divisions of Medicine and Surgery as well as the problem regarding the induction of locums. The induction issue was also brought to the attention of the Divisional Director of Operations for Surgery.

The Communication room ventilation problems on the newly refurbished Surgical wards was escalated to the Director of People and Culture.

I also want to take this opportunity to commend the professionalism of the JDF who in response to news of another potential redeployment of junior doctors to help cope with the last wave of the covid-19 pandemic, formulated a list of volunteers who would be happy to be redeployed, including their preferred specialty and any upcoming authorized leave so this could be better and efficiently coordinated. Thankfully, redeployed was not required in the end, but their assistance under such a pressurized circumstances was invaluable and greatly appreciated.

Summary

As previous quarters, exception reports were mainly submitted by FY1 level doctors with reporting levels lying being higher than the usual expected range for the time of

year when compared to previous years, possibly reflecting the pressure on staff relating to the last covid-19 wave.

Almost two-thirds of exception reports were from the Division of Medicine with the remaining third emanating from the Surgery Division. These included four ISCs where the common theme in both in Medicine and Surgery, related insufficient staffing levels due to vacancies on rotas (at SHO/Registrar level in Medicine and at FY1/SHO level in Surgery). This has been further exacerbated by staff-sickness related to covid.

Even when rota gaps have been covered by locums, they have either not been adequately induced or of inappropriate experience to carry out the role.

Questions for Consideration

As guardian, I am able to provide assurance with the overall safety of working hours for junior doctors this quarter but will not be able to extend this assurance should junior doctors from the Divisional of Surgery in particular, are to be redeployed.

Given the pressure being felt by all departments relating to the last wave of covid-19 pandemic, I have not asked for any work schedule reviews as I believe it would be unrealistic for these to be conducted under the current circumstances. However, I will closely monitor the General Surgery department, the Elderly Care department and the General Medicine on call rota during the next quarter.

I ask the board to note this report and to consider the assertions provided by the Guardian.

Appendix

Exception Report Appendix Nov 21 - D

Higher level data

Number of doctors in training (total)	Data not available
Number of doctors in training on 2016 TCS (total)	Data not available
Amount of time available in job plan for Guardian role	1 PA/4 hours per week
Admin support provided to Guardian (within the 37.5 hours per week worked by the Guardian admin support, additional responsibilities are also undertaken including: i. appraisal & job planning administrator ii. medical staffing support iii. clinical fellowship programme support)	1 WTE/37.5 hours per week
Amount of job plan time for educational supervisors	0.25 PAs/trainee (with a maximum of 0.5 PAs/2 hours per week)

a) Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns (ISCs)	Total hours of work and/or pattern	Service support available	Working hours/pattern AND Service support	Educational opportunities/ support	**TOTAL**
FEB 22	0	0	0	2	2	**4 (36.4%)**
MAR 22	0	5	0	0	0	**5 (45.5%)**
APR 22	0	2	0	0	0	**2 (18.2%)**
QUARTER	**0 (0%)**	**7 (63.6%)**	**0 (0%)**	**2 (18.2%)**	**2 (18.2%)**	**11 (%)**

The number of exception reports this quarter was lower than the expected range each month (previously, median number of reports per month = 10 with an interquartile range of 5 – 20).

FY1 level doctors submitted all the exception reports this quarter:

Exception reports by grade				
Grade	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	0	11	6 + 5	0
Total	**0**	**11 (100%)**	**6 + 5 (54.5% + 45.5%)**	**0 (0%)**

The mean number of days between an exception occurring and the exception being reported was 4.1 days (median = 1 day, range = 0 – 19 days).

Just under a three-quarters (72.7%, n=8) of the exception reports related to the Surgical Division with remainder emanating from the Division of Medicine.

Exception reports by department					
Division	**Specialty**	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Medicine	Diabetes & Endocrinology – ward 15	0	2 (18.2%)	2 + 0	0
Medicine	Elderly Care – ward 2	0	1 (9.1%)	1 + 0	0
Surgery	Gen Surg – wards 11 & 12	0	4 (36.4%)	2 + 2	0
Surgery	Gen Surg - floating	0	2 (18.2%)	0 + 2	0
Surgery	Gen Surg – wards 20A & 23	0	1 (9.1%)	1 + 0	0
Surgery	Anaesthetics - ICU	0	1 (9.1%)	0 + 1	0
Total	**Med 3; Surg 8 (27.3%; 72.7%)**	**0 (0%)**	**11 (100%)**	**6 + 5 (54.5% + 45.5%)**	**0 (0%)**

Just over a half of exception reports this quarter had a review meeting conducted by the supervisor, which is a reduction on the last quarter.

I personally reviewed the remaining five outstanding reports, organizing payment as compensation for these exceptions, allowing them also to be closed.

Exception reports (response time)				
Grade	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
F1	4	1	1 + 5	0
Total	**4**	**1**	**1 + 5**	**0**

	(36.4%)	**(9.1%)**	**(9.1% + 45.5%)**	**(0%)**

The mean number of days between an exception report being submitted by a trainee and a review meeting occurring between the trainee and their supervisor was 4 days (median = 1 day, range = 0 – 14 days).

The data regarding the resolution of exception reports for each month of this quarter is as follows:

	TOIL granted	Payment for additional hours	Work schedule reviews	Resolved – no action required	Unresolved	**TOTAL**
FEB 22	0	0 + 2	0	2	0	**4**
MAR 22	2	1 + 2	0	0	0	**5**
APR 22	0	1 + 1	0	0	0	**2**
QUARTER	**2**	**2 + 5**	**0**	**2**	**0**	**11**
	(18.2%)	**(18.2%+45.5%)**	**(0%)**	**(18.2%)**	**(0%)**	**(100%)**

b) Work Schedule Reviews

Due to the pattern of exception reports, I have asked the Divisional Director of Medicine to conduct a work schedule review in Elderly Care Medicine.
Similarly, both due to the pattern of exception report in Surgery at FY1 level but also concerning email correspondence received in my GoSWHs capacity, I have asked the Divisional Director of Surgery to conduct a work schedule review:

"Thank you for meeting with me last week to discuss my concerns about my rotation in general surgery.

Over the last three and a half months, I have had the opportunity to rotate around the different surgical specialities in the hospital which has provided ample opportunities to learn. During this time, it has been apparent that the area that is consistently lacking in support for the FY1s is the five weeks we are rostered on wards 11 and 12 (including covering surgical outliers on wards 9 and 10).

I worked on the wards from 1st February to 4th March 2022. These wards are largely staffed by only FY1s on a week-by-week basis, with the exception of a ward SHO (FY2 or Core trainee) every few weeks. There are also usually three FY1s covering the wards, which results in one FY1 having to cover one of the wards alone. This becomes particularly difficult when there are sick patients who require more attention. Although we can escalate urgent concerns to the ward registrar and on-call registrar, there are not enough juniors on the ward to complete the required jobs from the ward round whilst reviewing patients as things develop during the working day. As a result, my FY1 colleagues and I frequently feel out of our depth without an SHO on the

ward to ask for help with non-urgent but important things concerning patient care.
I am raising these issues now because I completed my five weeks on wards 11 and 12 just over a week ago and having had time to reflect on the rotation as a whole, I realised how much of an emotional and mental toll those weeks took on me. On reflection, I identified inadequate staffing and inadequate support for FY1s on wards 11 and 12 as the main issue, which also raises concerns about patient safety. My final rotation in FY1 is also in general surgery. However, my experience over the last five weeks have affected me to an extent that thinking about having to complete another general surgery rotation in this department is filling me with dread and anxiety.
I am still keen to pursue a career in surgery. I still intend to continue building my portfolio with a view to apply for core surgical training. However, as an FY1, many of my mornings before work began with worrying about the previous day, and premature dread over the upcoming day, knowing that it would just be myself and one other FY1 covering the ward after the round.
I therefore would like to ask if there any gaps in any other rotations, medical or surgical, in the deanery? I understand that every rotation can come with its own issues such as staffing and support for juniors. However, I am willing to consider moving if there is an FY1 opening on another department."

"Staffing Crisis for Junior Doctors
Thank you for giving me the disappointing decision from the medical workforce group.
I will summarise the points I have just made to you:
1) We will be unable to staff the shifts required at the current rate
2) Given the rate cap agency locums are almost always unsuitable and under qualified
3) We are 3 doctors (out of 8) down on the FY2 rota. This is down to the failures of recruitment.
4) A significant proportion of our middle grade doctors are aged 55+ with significant medical problems. It is not safe to expect them to work a night shift, dealing with acute medical problems that they have not dealt with in over 20 years. This is an unacceptable risk to both the doctors and the patients.
5) We have a vacant set of night shifts starting on Monday 4th April. We will almost certainly not find a Dr to cover this shift.
6) If this is the case it will be unsafe to run an acute trauma service and we will have to close to admissions.
I am raising this as a SERIOUS clinical safety issue and would appreciate an acknowledgement that you have read and understand this."

c) Locum bookings
Data not available

d) Locum Work Carried Out By Trainees

Data not available

e) Vacancies

Data not available

f) Fines

Fines by department		
Department	**Number of fines levied**	**Value of fines levied**
General Surgery	1	£13.61
Total	**1**	**£13.61**

Fines (cumulative)	
Balance at End of Last Quarter	Not known + £412.78
Fines Paid to GOSWH This Quarter	£13.61
Expenses This Quarter	£0
Total Paid to Trainees this Quarter	£123.38
Balance at End of this Quarter	Not known + £426.39

Qualitative Information

Feedback received from the JDF this quarter highlighted ongoing problems with insufficient staffing levels on the Elderly Care wards despite covid numbers reducing in the Trust – for that reason, a work schedule review was requested.

Similarly, concerns raised at the JDF echoed concerns brought to my attention via the emails above and therefore a work schedule review was requested in Surgery.

Issues Arising

There were no “Immediate Safety Concern” exception reports this quarter.

Actions Taken to Resolve Issues

In an effort to resolve the rota gaps in Surgery, I made contact with the Clinical Fellowship Scheme and the Surgical Divisional Director of Operations. This will provide a longer-term solution with all slots being filled as of August 2022, but a short-term strategy still needs to put into action in the meantime, hence the work schedule review in Surgery.

Similarly, I have asked the Divisional Director of Medicine to conduct a work schedule review in Elderly Care Medicine.

Summary

All exception reports submitted this quarter were by FY1 level doctors with reporting levels lying below the usual expected range.

Just under three-quarters of exception reports were from the Division of Surgery with the remaining emanating from the Medical Division.

Work schedules in Surgery and in Elderly Care were requested following concerns raised at JDF and through escalation to the GoSWHs via email.

Higher data for the guardian report remains elusive even after the covid situation has calmed somewhat. It is therefore impossible to triangulate the data about working hours by cross-referencing it against locum usage and vacancies (of both training and non-training junior doctors) in order to identify departmental/rota specific issues that may putting doctors at risk. By the same token, it is also difficult to make quality improvements on this regard.

Questions for Consideration

Whilst there are issues in the Trust, which have been highlighted within this report, I have asked the Divisions concerned to take steps to reach a resolution. For that reason, as guardian, I am able to provide assurance with the overall safety of working hours for junior doctors this quarter.

Appendix

Exception Report
Appendix Feb-MAr-/

Walsall Healthcare NHS Trust

MEETING OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE HELD ON FRIDAY 29th APRIL 2022 AT 11.30 AM HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Dr J Parkes	Non-Executive Director (Chair)
Prof A M Cannaby	Interim Deputy Chief Executive/CNO
Mr M Dodd	Director of Transformation, Walsall Together
Mr K Bostock	Director of Assurance
Mr N Hobbs	Chief Operating Officer
Dr M Shehmar	Chief Medical Officer
Mr R Virdee	Associate Non-Executive Director
Mrs L Toner	Non-Executive Director

In attendance

Mr C Ward	Associate Deputy Director of Nursing
Mr K Wilshere	Interim Company Secretary
Mrs C Whyte	Deputy Director of Nursing
Mrs C Jones-Charles	Divisional Director of Midwifery
Mr G Perry	Associate Director of Patient Relations & Experience
Mr W Roberts	Divisional Director of Operations (Surgery)
Ms S Abrar	Head of Serious Incident Management
Mrs A Hill	Executive Assistant (minutes)

Apologies

Mrs L Carroll	Director of Nursing

194/22	**Welcome and Introductions**
	Dr Parkes welcomed everyone to the meeting and introductions were made.
195/22	**Apologies for Absence**
	Apologies for absence, as listed above were noted.
196/22	**Quorum and Declarations of Interest**
	The meeting was quorate in line with the Terms of Reference paragraph six. There were no declarations of interest raised. The meeting was recorded.
197/22	**Minutes of Previous Meeting**
	The minutes from the 25th March 2022 meeting were agreed as a true record.
198/22	**Matters Arising & Action Log**
	• 158/21 – paediatric death in January external investigation. The division are currently reviewing the first draft received from the external investigating officer and an update will be bought to next Committee. • 162/21 – not in report for this month but the Patient Experience Annual Report is on this agenda and confirmation will be given in May that the PE content is included in the SHQC report.

	• 166/21 – timescale for achievement of the improvements for the two failed standards of the 7 Day Services Audit – there has been a change in the National standards for 7-day standards services where previously the audit was for all inpatient wards and this has now changed to admitting wards. The Trust is currently in the process of agreeing what constitutes an admitting ward. The next audit is in June and an update will be bought to the agenda as part of the usual cycle of business. Electronic document management system is part of the Electronic Patient Record implementation and there is a 6–12-month timescale for this implementation. It was agreed that this item would be closed on the action log and picked up via the usual cycle of business for update. • 179/22 – high backlog in Phlebotomy Service to be discussed at Walsall Together – discussed with Primary Care and advised that the referrals are legitimate, and this reflects a growing demand. Community Services have put two more Phlebotomy Support Workers in place, and this is enabling the service to reduce the wait time and by the end of May it is envisaged that this will be down to a 72-hour response time. This is continually monitored via KPI's in the service. Agreement made to close this action. • 188/22 – Audit completion – in terms of benchmarking with other Trusts the response rate at WHT is lower in terms of the number of patients put forward and not as timely. Several actions have been taken and there are now data inputting administrators in a number of the surgical specialities and most of the National dashboards have a dedicated resource to input this data. Dr Shehmar and Mr Bostock have commenced work on the process at RWT which does not have a central audit function as WHT do and the audits are driven by the divisions operationally rather than handed over to a central team. Work is ongoing to combine the resource at WHT with the processes at RWT to produce a new model which should work more effectively. This is a minimum 6-month piece of work. Action to remain open until further updates provide sufficient assurance. Dr Parkes queried where the Audit Committee fit with the above audit item. Mr Bostock advised that the Audit Committee focusses on compliance with contracts and the financial and regulatory aspects where this item is clinical audits. This was historically not the case but it is now.
199/22	**Covid-19 Acute Services Access/Restoration & Recovery Update**
	The report was taken as read and Mr Hobbs highlighted three areas to bring to the attention of Committee. Diagnostics Service access, which has been a concern over the Autumn and early part of the Winter, pleased to report that the recovery of non-Obstetric Ultrasound Services waiting times has been delivered with the service booking patients now within 6 weeks. The MRI service has experienced a significant increase in referrals in recent weeks resulting in patients waiting over 6 weeks, however it is expected that this will be recovered by the end of May. The Trust has seen the first month of reduced over 52-week waiting patients since June 2021, there are still 836 patients waiting in excess of 52 weeks for treatment and this is a poor experience and does subject those patients to inevitable increased risk but that is now improving. The Trust has formally been approached by NHSEI at National level to seek some support for long waiting patients under the care of University Hospital Birmingham and work is being carried out on that and Committee will be kept updated on the situation.

	Current primary area of concern for elective pathways is in relation to access for patients referred for suspected breast cancer or other breast symptoms, both are subjected to a two-week standard waiting time. The Trust has generally been booking around 3 weeks for last few months to the end of March, but some progress has been made during April with secured mutual aid from Dudley and Sandwell in additional to RWT providing some support. A breast surgery practitioner has been appointed and beginning to see an improvement in the wait times. Committee will continue to be updated until the service is back under two weeks waiting time. Dr Parkes remarked that it was good news about the breast appointment improvement. He stated that UHB waiting times are a concern as they currently have 1500 patients waiting in excess of 2 years for treatment and it is that cohort that the National team have requested support from WHT, RWT and South Warwick. Work is underway to identify if there is any support the Trust can offer to alleviate some of this backlog, whilst being mindful that it does not disadvantage the treatment of the local population. Mr Virdee asked how much further performance would be required to catch up to pre-pandemic levels of care and treatment. Mr Hobbs advised that the elective and day case procedure activity is at 125% of pre-covid norm using March 2019 as a comparative month but most patients on our overall RTT waiting lists are not waiting for a procedure, they are mostly outpatient non-admitted pathway, awaiting other procedures or a decision on whether surgery is needed. The Trust has to run in excess of 100% of pre-pandemic capacity in surgical procedure services and also in outpatient's services and that is where the volume has not been restored to quite the same level. The total wait list is influenced by the number of referrals into planned care services, and they have mostly returned, and often exceeded, pre-pandemic levels. The Trust is in a good position from a surgical and procedural capacity perspective and will be improved further by the recruitment from the theatre and anaesthetics business case. Areas where there is further work is in outpatient services to provide capacity and appropriate clinical discharge back to primary care services to ensure there is capacity for secondary care where needed.
200/22	**Community Services Report**
	The report was taken as read and Mr Dodds gave a summary of the key themes. Out of hospital activity remains strong and the Care Navigation Centre (CNC) received over 1300 calls during March and responded to all but 8 or 9 of these. An evaluation has been carried out on actions taken and the impact and benefits of community intervention, not only from the acute crisis perspective but also a process of looking at over the next 6 months and this has shown there is evidence of less readmission and follow up care as interventions are put in place much earlier. An opportunity search has been carried out and scope has been identified in ambulance category 3 presentations where community interventions would help to prevent hospital admission and to use this evidence as part of the bidding round for the Service Development Fund to expand existing services. The Vaccination Centre based at the Saddlers Centre delivering covid vaccinations has moved to a smaller venue and the team and volume of vaccinations have been re-adjusted. There is a guaranteed service provision up

	to the end of June. There is still some work on staff vaccination programmes and discharge of hospital patients covid status but the biggest concern regarding vaccinations has been stabilised. There are ongoing capacity versus demand issues in Locality Teams being unable to meet demand owing to staff vacancies and sickness with a 20% cancellation rate. The Health Visiting Service is noted as a corporate risk as there is a gap of approximately 50% Qualified Health Visitor vacancies and an Executive led task and finish group has been established to work on this and the service have developed a prioritisation plan to focus service input. Interim measures have been put in place and future options are being developed which include recruitment drives, joint working with RWT and the Local Authority and overseas recruitment to mitigate risk. There is also concern regarding the demand and capacity trends in the social care complex discharge arena and the stability of the domiciliary care market and the care home sector where there are rising demands in complex referrals into the service and issues with the remuneration and pay rates in the domiciliary care market. Work is being carried out both locally and nationally on this matter and will continue to update Committee on this matter. Mrs Toner enquired whether the Trust is looking at the opportunity for Health Visitors service to obtain HEE monies to support development of new health visitors. Mrs Whyte advised that funding for 4 further health visitors has been sourced through HEE monies but there is limited funding available, so the Trust is looking at alternative funding streams. Professor Cannaby asked if there was any opportunity to work with BCU to get more placements. Further discussion to take place off-line on this matter. Mr Virdee asked for the data on keeping people safe at home and long term covid referrals if it is possible to see the data of ethnicity and socio-economic status of the people accessing the service. Mr Dodds advised that he would include this information in future reports. Mr Virdee enquired if the Trust was taking action following the government statement regarding the recruitment of home care workers and recruiting staff from overseas. Mr Dodds advised that the Trust is not taking direct action on this as care workers are employed through private agencies and if the Trust recruited directly, it would be in competition and therefore risk destabilising the domiciliary care market. The Trust is working with anchor institutions looking at getting the long term unemployed back into paid employment and trained up for positions such as healthcare assistants and nurse associates and also working with primary care networks to look at supporting them getting nurse associates in place and the opportunity to have rotation schemes and discussion have commenced with the Black Country CCG workforce recruitment team to look into overseas recruitment. Mrs Toner advised that the West Midlands Combined Authority has opened up funding opportunities to higher education now to provide some funding for

	"bootcamps" to upskill existing workforces or getting people back into employment which may be worth pursuing.
201/22	**Safe High Quality Care Oversight Report**
	The report was taken as read and Mrs Whyte outlined the key elements. The number of patient falls reduced in March to 55 from 61 which was 3.43% falls per 1000 bed days and also had a reduction in number of incidents of patients who had repeat falls. The end of year total demonstrates a 6% reduction in total falls for 2021-22. VTE compliance has seen an improvement in compliance to 93.86%, which remains below the Trust target of 95% but there has been a month on month increase for the past 3 months. A new Deteriorating Patient Group has been formed and will meet monthly. There were issues discovered in March within NEWS2, which is the Trust's early warning score that highlights patients at risk of deterioration and who are deteriorating, that some patients were being incorrectly allocated to SCALE2. This was quickly identified and logged as a Corporate risk with some associated actions immediately put in place. Work is ongoing with this situation and the Trust has procured the e-learning package from the Royal College of Physicians and this is available for staff to undertake the relevant training on ESR. In March 5 cases of C-Diff were identified and all cases were reviewed and found unavoidable with patients receiving justified use of antibiotics. The prevalence of timely observations has seen an increase to 91.19% in March 2022 from 87.89% in February 2022 and this has remained above Trust target of 85% for the past year. It is pleasing to see that 22 out of 25 clinical areas achieved the 85% target, which is an increase from 20 in February and 18 clinical areas achieved in excess of 90%, which is an increase from 13 in February. Mental Capacity Assessment audit for March shows that 62.5% of patients who lacked capacity had a Stage 2 assessment undertaken, which, although this is not where the Trust would like to be, it was an increase from 45.71% from February. Safeguarding Adults and Children Training Levels 1 and 2 remain above target but the Trust remains under target for Level 3 and ongoing work with divisions is taking place with monitoring continuing via the Safeguarding Group. Successful overseas nurse recruitment continues, and the Trust now has 203 overseas nurses and plans for further recruitment will continue in the coming year. There is now an Audit Improvement Programme in place which includes Medicine Management and Controlled Drug audit standards, and this has improved month on month and the overall Trust compliance with CD audit standards has improved to 84% against the last quarter audit which was 80% and previous audits which were around 40-50%. The Trust has now procured electronic storage cabinets for medicines allowing for better medicine management and audit trail against locked cabinets and storage of controlled drugs. Eight of these storage cabinets

	have been procured for the highest risk ward areas and work is underway to obtain an electronic management system for the controlled drugs which will include a system for signing out controlled drugs. Acute Medicine Unit Improvement Plan is on track and improvements are being seen within the division. An updated response with embedded evidence has been sent to HSE. All of the 25 cases of 104-day harms in October and December have now been reviewed and no harm was identified for any of the patients. After the 104-day timeline and review there has been one patient where there was a delay in their treatment which was dependent on the Tertiary Unit, and because of that delay they have been harmed because it has changed the prognosis for that patient, this will be included in the next quarter report. There is now have a new process around 104-day harms with a more robust policy in place which has been agreed with stakeholders and has Executive oversight. Harms reviews now also include an external party from the CCG so there is a more objective way of reviewing harms, and there is now a Lead Cancer Nurse in post which has made the Trust Cancer Group more robust. There is a more detailed report produced quarterly around 104-day harms which now include the themes, learning and improvements put in place and Dr Shehmar will bring that to the next meeting. Committee are asked to note that there is currently a Black Country Pathology Service (BCPS) Regional issue regarding timeliness of histology reporting. BCPS are working through the issue but some of histology is taking longer than is currently acceptable and Dr Shehmar and Mr Hobbs are working with the division and BCPS to resolve this issue. Mr Virdee queried the red flag data within the report and asked how many of the red flags are raised due to staffing issues or shortage of staff and will this improve with the recruitment of overseas nurses? He also queried the VTE compliance data with compliance for March was 93.86% with a target of 95% - how does this equate to numbers in order to provide narrative of this figure? Mrs Whyte advised that it would be useful to note some of the mitigations put in place when red flags are raised. Red flags are discussed in the senior nursing huddle every morning and cross checked with incidents and don't necessarily mean any harm has come to the patient. Mitigations are put in place to deal with issues arising, for example cohorting patients requiring 1:1's in one bay. Dr Shehmar advised that the Trust does have the data for VTE compliance to advise which patients on which ward via a dashboard. She provided assurance to the Committee that the Trust does review any cases where hospital acquired thrombosis occurs due to harm related to VTE and if there have been any gaps in process this is raised as a serious incident and is reviewed monthly at the Thrombosis Group. There are very few numbers of harm and serious incidents and although the Trust is currently not able to meet the National target of 95%, once the audit and review has taken place of each incident it is usually found that the correct treatment has been given and the box hasn't been ticked on Fusion. Once the Electronic Patient Record system is up and running, which will link this together, there will be a more realistic view of the current situation.

	Dr Parkes noted that the Safeguarding Level 3 training is not only not hitting expected compliance but is going down and what measures are in place to resolve this. Mrs Whyte advised that the reasons are multi-factoral with staff absences and clinicians having to take a full day out of their clinical duties to complete the training. There is continuing divisional oversight reported through the Safeguarding Group for more attention to be paid for when staff are hitting their amber period of 3 months prior to training renewal to capture them at this point. From the STP chart there were huge improvements to Adult Level 3 training around October 2020 and compliance had been low at this point due to changes made within the intercollegiate document for Safeguarding which meant that more staff were required to complete Level 3 training and when that document was released there were a large number of staff not compliant, and work is ongoing to reverse this change. Dr Parkes also queried the clinical guidelines data of those that are out of date still being 118. They have been sent out to clinicians in January but they are still outstanding in April and what is the drive to get these into date? Dr Shehmar advised there is a process around this, and a number of the guidelines have been written up or reviewed to see if they are still applicable and they will then need to go through the ratification process. However, in terms of clinical harm, the guidelines have been reviewed for this and any changes put into place so that staff are using up to date guidelines. Mr Bostock added that the narrative is incorrect in that they are not obsolete but have gone beyond the authors scheduled review date that doesn't mean the content is incorrect. All policies and guidelines are being scoped as there were approximately 90% which were out of the schedule review period, to determine if there is any material legislative, best practice or contractual change requirements within them and if not, they are being extended to bring them back into date as there is no material requirement to change them. The narrative in the report is more alarming than it needs to be as they are not actually out of date. There is a new policy system put into place and a new Policy Manager managing this process. There has been a risk-based prioritisation based on policies and guidelines that appear in serious incidents. Mr Wilshere advised this is a big task and will take some time to rectify and some also require clinical colleague's input. The average policy will take between 10 and 30 hours in manpower to review and to carry this out more quickly it would take clinicians out of providing clinical care, so there is a need to balance priorities. Mr Virdee queried the Mental Capacity Act (MCA) data, and this is still below target. Is there assurance that there are actions in place to improve the current position. Also, when the policies are reviewed, are impact assessments on all groups being carried out? Dr Shehmar advised that training has been rolled out regarding MCA and Respect forms, there are multiple reasons why it is not happening – there are documentation issues and some of it is around changes in practice and gaps in understanding. When we have the EPR this will be an integral part of this. Mr Wilshere advised that there are three things that policies are screened for equality impact, counter fraud and any implications on expenditure and they are all now being done and gave assurance that no policy is approved without these checks being carried out. Mrs Toner advised that when information goes out to a patient coming in for surgery or treatment when they need an information leaflet to advise on that treatment, this would be checked at that time to ensure the information is up to

	date and correct and there is additional assurance that this checking process is being carried out. Dr Parkes queried the issues relating to the accuracy of sepsis reporting and a manual sepsis report was not available at the time this report was written, so the Committee does not have assurance that sepsis is not a problem when the electronic report is not working properly, and the manual report is not coming either. Mrs Whyte has asked the Chair of the new Deteriorating Patient Group to ensure the report that comes from that group will feed into QPES. Dr Shehmar suggested that the report could be submitted with the previous month's data and then at least there would be a rolling programme of data. Dr Shehmar and Mrs Whyte agreed to look at this for next month. Dr Parkes also queried the appendices that should have been included with the report and the Board Assurance Framework and Corporate Risk Register were missing. Mrs Hill advised that these appendices were not provided for upload for this meeting despite numerous efforts to obtain them from source.
202/22	**Maternity Services Update**
	The report was taken as read and Mrs Jones-Charles presented the key points. Regarding recruitment within the division, there are still challenges in the division due to covid absences and there is also a spike in Chicken pox outbreaks adding to staffing challenges. There was a further successful recruitment event in April where 70 new midwives were appointed, and they will start coming on stream between March and September as some of them are students. There is a change in the national requirement reporting for monitoring Caesarean section rates and Maternity Services are now required to report on Robson criteria 1, 2 and 5. Robson 1 being a woman having their first baby presenting in labour but has a resultant delivery by emergency c-section; Robson 2 being a woman having their first baby as being induced and delivery by emergency c-section or having their first baby who haven't had any former labour and had a c-section and Robson 5 being women who have had 1 previous child delivered by c-section and have a subsequent delivery by c-section. The division is currently looking into these numbers from October to March and will refine this presentation to QPES, currently working with the Performance Team on this and produce an SPC chart for the report. If there are any significant changes in the figures for these criteria there needs to be further investigation to provide assurance around the care and treatment of those women at the time they presented. Details on acuity and acuity measure for the Maternity Unit measuring 4-hourly on the Delivery Suite which has unpredictable levels of patients. Red flags are monitored, and the report highlights the actions taken when red flags are raised including staff redeployment for 77% of the time; times where staff were not redeployed and when the manager on call for maternity was alerted when required. The number of staff not having breaks has reduced and there were only two occasions when this occurred and there is continuing work with Team Leaders to ensure staff are having a break, even in times of high activity. Triage was raised as a concern in the 2021 CQC report. There is now an ongoing audit taking place quarterly and from the current audit the service triaged 88% of women within 15 minutes of arrival and all women were seen within 30 minutes from when they presented and the Rag status green, yellow and orange figures are included in the report. The service continues to encourage feedback from

	women on their experience so that the service can continue to adapt and change and an ethnicity breakdown is also included in terms of the women using the service. Management of controlled drugs is being monitored and the service is conducting joint audits with Pharmacy to monitor compliance, which is improving with the delivery suite currently at 98%. There has been one declared serious incident report in April 2022. Where a patient in her 3rd pregnancy requested a termination due to lethal abnormality. She was referred to Birmingham Women's Hospital as per Trust guidelines and it was confirmed that due to the abnormality life was not sustainable after birth. She was fully counselled by the registrar, but the registrar failed to complete the necessary Abortion Act forms. There were some areas of good practice where she was counselled in a language that she was comfortable with. She was sent home and as per practice was admitted to the delivery suite a couple of days later and it was highlighted that the required forms had not been completed by the registrar as required by law. This was rectified immediately, and duty of candour was completed and the registrar was informed that this had been declared a serious incident due to failure to follow process. Assurance is given to Committee that this patient wanted a termination and was fully counselled appropriately in her own language. Regarding the Ockenden Report update, an initial high level gap analysis has been completed. There are 15 essential actions within in the final report and within those sit over 100 elements for the care group to consider and work is taking place with the division of surgery, paediatrics, and medicine to look at an action plan. There has been agreement at Trust Board for high level consultant recruitment and a business case is being prepared. Dr Parkes has received an enquiry from the Non-Executive Director responsible for Maternity Services following a maternity walk round to ask if the Trust has piped Entonox facility. Mrs Jones-Charles advised that there is now approval to have piped Entonox on site once the new Midwifery Led Unit (MLU) has been established as it is not health and safety appropriate to have staff changing several Entonox bottles whilst the patient is in labour, and this is an essential part of the plans for the new MLU.
203/22	**Serious Incident Progress Report Update**
	Report was taken as read and Mr Bostock presented the key points. This report previously only reported on serious incidents, and it has been identified that clinical incidents were only being reported to the Patient Safety Group. This has now been combined and the report this month contains serious incidents and clinical incidents. Going forward it will also include non-clinical incidents that were previously only reported to the Health and Safety Committee. This report from next month will include all serious incidents, clinical incidents, and all other incidents in it for clarity. In the last two months there has been a considerable increase in two reported incident types; treatment delays causing harm and HCAI's related to Covid. HCAI Covid is now back under control but the treatment delays causing harm looking into to determine whether this is Covid related appointment restrictions, because the majority are cancer pathways, or some other cause not yet identified. Committee will be updated on this once the results of this analysis area available.

	At the end of March, 46 serious incidents remained open and during March there has been a peak of closed incidents by the CCG of 22, the majority of which fell into falls clusters and were closed in batches. The themes for clinical incidents across all divisions are included in the report. There are delays in recording observations particularly in the Emergency Department and the Surgical Assessment Unit and the cause of this has been stated as staffing issues. However, this is being investigated as although it has been recorded that there have been high levels of staff absence during this period, a causal link has not yet been established. The most common theme in Community Services was clinical incidents related to skin integrity which accounted for 68% of all the clinical incidents during the month. In Medicine and Long Term Conditions the main themes were skin integrity and observations not being carried out in a timely manner. In Women's and Children division there have been high levels of neonatal transfers, the cause of which is currently under investigation. In Clinical Support Services there has been some issues with the processes used to manage Cardiac patient follow up appointments and the pacenet system has now been implemented to resolve this issue. There are 20 ongoing historic actions remaining open and which are now 4 months beyond the date of intended closure and the main reasons for this are awaiting policies to be ratified and also because they were historic actions from serious incidents dating back to 2018, some of the actions in the action plans are obsolete and no longer relevant to current clinical practice. A cleansing process is underway on these outstanding actions. It is acknowledged that there needs to be stronger emphasis on learning and improvement to reduce the recurrence of the same themes and trends across all areas, not just incidents, and there is a new starter on a temporary basis to look at creating a dedicated clinical learning report over the coming weeks. The Datix module on safety learning is being implemented over the next 6 months and the 'making it better' alerts which are used at RWT have been aligned to include WHT so that there can be shared learning across both organisations. A co-ordinated audit has commenced on the 298 historic actions that have been closed since September with the primary purpose of reviewing all closed actions across all divisions for assurance purposes that these were closed appropriately and robustly. This should have been concluded by the end of March but was delayed due to staff sickness and issues with the safeguarding system. The results of this audit should be available in 8 weeks' time. Under National reporting and learning the Trust would normally receive 6 monthly benchmarking reports to compare incident and reporting rates with Trusts of a similar size. However, this information has not been available, but assurance is given that these will be available soon and included in future reports. Dr Parkes observed that under the Surgery section there are 25 medication errors recorded under top three causes of reported incidents and that seems to be a recurring theme with medication incidents. Mr Bostock agreed that medication incidents are the top, most frequently reported incident across the whole Trust and the Chief Pharmacist is carrying out a piece of work on this area and there is a programme of work underway, but this is a large piece of work. Mrs Toner asked if the high number of skin integrity incidents is the norm or something that is increasing within the Trust. Mr Bostock advised that because

	of the lack of benchmarking reports it is difficult to triangulate with other services but using feedback from CCG and collaboration with Tissue Viability Services at RWT it has been identified that the Trust is not an outlier in this area. Work has now commenced in this area, led by Yvonne Higgins from RWT across both trusts. Most of these are occurring in patients own homes and dependent on themselves or their relatives to manage, which is more difficult that in the acute trust. Dr Shehmar advised regarding prescribing incidents that there is now a new Governance Advisor in Pharmacy who is helping to support training and on the spot ward assistance and support to help with medication issues. Mr Virdee commended the work that had gone into closing the outstanding serious incidents. He asked if it is possible to advise how much of the treatment delays relate to capacity and staffing and how many relate to skills shortage? Mr Bostock advised that there is a spread of causation but the most common theme identified is administrative oversight and failure rather than clinical staff skills shortage. Mrs Whyte added in relation to pressure ulcers reported in the community, there is an SPC chart on page 6 of the Safe High Quality Care report where it shows that during the higher waves of Covid there were higher levels of pressure ulcers reported. Poor tissue profusions are associated with Covid and patients are at higher risk of developing pressure sores and this was also reported nationally.
204/22	**Patient Experience Annual Report 2021-2023**
	Mr Perry presented the Patient Experience Annual Report. He highlighted the importance that patient experience is everyone's responsibility and each encounter counts. Each year the Trust has the opportunity to review the patient voice survey which provides feedback and allows assessment of the Trust's performance. The report details activity by feedback type and over 4000 contacts were dealt with by the Patient Relations Team. It also details feedback via theme; identifying treatment care and supervision as the main theme for complaints and also compliments. Some of the achievements include an increase in timeliness responding to complaints of 30% and satisfaction scores for the complaints process were an average of 4.5 out of 5. There is a robust and compliant process in place to collect friends and family data and data of note is performance against the STP for Outpatients, Emergency Department and Community Services and performing better than national average for Community Services. The service has increased the opportunity to provide feedback by introducing the Mystery Patient Scheme where Community areas score the highest and a large proportion of this was due to the vaccination centres. Lower scores were received for ED and Maternity and Inpatient and Outpatient scores were more stable. The same scoring metrics as the national survey are used, which allows the service to progress against the feedback received. Engagement with the public and partners has taken place and the Patient Partner Programme has been introduced and Patient Involvement Partners are becoming engaged with various workstreams across the organisation. The Chaplaincy Team have introduced the Spiritual, Pastoral and Religious Care SPaRC form to monitor encounters with patients and staff as a direct consequence of patient feedback. The service has set up and manages the front door Welcome Hub managing the visiting process and adopting a compassionate approach and the Carers Passport has now been introduced. The Trust partnership with Juniper Training and Manor Farm Community Association provides volunteering opportunities and has impacted and improved staff wellbeing and enhanced the experience of patients and the young people involved benefitting from work experience and life skill development. Recent launch of the Under the Veil Project took place focussing

	on LGBT and BAME communities. Volunteering is a strength of patient experience with 8948 hours delivered during last 12 months and 3 volunteers have dedicated over 900 hours and that programme of recruitment continues to grow. Equality monitoring continues by collecting optional demographic data and a postcode includer initiative has been introduced to map demography to locality and possible indices of deprivation. The report assesses some of the progress made against last year's objectives and an overview of what the service would like to achieve in the coming year, including working with partners at RWT, a new Patient Experience Strategy and a set of ambitions for involvement and engagement in the next 2-3 years. Mr Perry would like to commend the pace and energy of the team and thank them for their hard work over the past 12 months. Mr Virdee was concerned about the breakdown of where the complaints were from concerning attitude, communication, and treatment at the bottom of the pyramid in the report. He also stated that it was pleasing to note the work that volunteers carry out and asked if there is a way of recognising the effort they make to the Trust. Regarding the mystery shopper function – he asked if they take into account issues of harassment, bullying and racism and do they receive training? Mr Perry advised that the complaints pyramid includes only approximately 5% of all the types of feedback the Trust receives and under the section clinical care, assessments, and treatment there are a number of subcategories from the perception of care received or communication about the care received. In many cases it is found that the care was appropriate but not communicated in a way the patient understood or felt involved with. Some of these themes compare with the information received from the national survey and allows the service to constantly assess and improve. Due to this, the Patient Survey Oversight Group has been set up to look at this and to give both Patient Experience Group and QPES assurance. He advised that volunteers should always be treated with respect and thanked for their work. There is a celebration event currently being planned as part of Volunteer Experience Week which will probably be in the form of an afternoon tea. Mr Perry advised that the Mystery Patient Scheme are volunteers who gather feedback provided at patient bedside or near to the encounter with the care provider. This gives a more balanced approach to obtaining feedback and includes elements of good care as well as raising any concerns. There is also work underway to strengthen the relationship with more marginalised communities. Mr Hobbs commended Mr Perry on an excellent report and advised he was pleased to see the Critical Care Rehabilitation Service getting deserving prominence in this as it is a fantastic new addition to the Trust. He also mentioned the link to the Acute Services Report with the volume of concerns and formal complaints relating to planned care or elective care appointments, with a delay in elective care linked to the risk or worse outcomes for patients and this is further evidence of the importance of improving this area. Dr Shehmar also advised that regarding taking complaints seriously, particularly if there has been an issue with communication or attitude that there are other

	learning methods such as mortality or serious incident system where there is individual feedback and individual plans for people involved with these, to provide assurance that there is an individual approach taken as well as looking at the processes and systems in place for support.
205/22	**Mental Health Update**
	Dr Shehmar took the report as read and gave an overview of the report. Some of the top risks identified within the Trust are around mental health. The internal adult risk 2475 has now reduced from 25 to 15 on the risk register due to the recruitment of the Mental Health Team to be able to plan, deliver and administer training and the appointment of a Governance Advisor and lead MH Matron within the team. Although the training packages are now in place there are some issues relating to releasing clinical staff for training which are being worked through and supported. The Mental Health Team have carried out an audit to look at standards around the service which has shown where the service needs to develop. The Mental Health Steering Group has been reinstated and is working with external partners and stakeholders and work is ongoing with the Mental Health Trust to look into shared learning around incidents.
206/22	**Clinical Audit Forward Plan**
	The report was taken as read and Dr Shehmar advised that this is the annual report of the Clinical Audit Forward Plan which advises that 69 (2 to be confirmed) National Clinical Audits have been included on WHT forward plan for the year. The Trust is starting to prioritise local audits in response to the assurance that is needed around the key issues, for instance AMU is one of the top risk areas so need to ensure this is part of the annual audit programme. The audit plan now has more governance to provide assurance and to improve input into the national audits. Mr Virdee advised that it is pleasing to see the appendices including information on equality.
207/22	**Mortality (SHMI and HSMR) Report Q4**
	The report was taken as read and Dr Shehmar advised that this is the last of the quarterly reports and going forward this report will be bought to QPES on a bi-monthly basis. The report gives the statistics in terms of the Trust's position for SHMI and HSMR and then advises information on the Learning from Death programme. The graph on page 4 shows that the Trust is amber for SHMI so it is not an outlier but still three standard deviations from the mean so not where it would like to be and there is significant work taking place to reduce the avoidable deaths. Dr Shehmar advised committee that although it states that the Trust is within the expected range, it is still an amber outlier. The two metrics that contribute to this information is the HSMR and SHMI. The HSMR includes patients before taking into account any co morbidities and a difference has been seen in this metric since the Trust took on St Giles Hospice. The way in which the mortality statistics are worked out is based on an imaginary average hospital and an average hospital would not have a hospice attached to it, so this is increasing the death rates for the Trust by around 7 points. Currently discussions are taking place around this issue as it is important to be able to understand the statistics in order to make improvements to care and an understanding of coding St Giles differently to give more accurate data and to see

	if there are any unintended consequences to removing the cohort from this section. The hospice figures would still be included in the SHMI data and work is underway with an external consultant to carry out an external audit on mortality and mortality coding. The second part of the report advises how the speciality mortality leads are improving their services and in the last quarter there have been some improvements in maternity around the perinatal mortality review and the focus on the triage system in obstetrics where a nationally recognised triage system has been implemented and the improvements shown. There have been a number of changes in Urology and there is currently a collaboration being implemented with RWT in this area. The Trust have also streamlined the urology pathway particularly around diagnostics and cancer with more hot clinics and one stop clinics and improvements in the access rates for cystoscopy. Respiratory is the top cause of avoidable deaths for the Trust and there has been a focus on respiratory pathways, in particular pleural effusion, COPD, NIB and hospital acquired pneumonia. The Fractured neck of femur improved programme is in place and the Trust now sustains a lower rate of mortality and is no longer an outlier in this area. The report also details other areas that need to be reported on are perinatal child mortality, the LeDer programme and end of life care and the improvements and actions that are being carried out. Good news story with learning for Oncology – over past year the Trust found there were avoidable deaths in the neutropenic sepsis pathway due to not being able to treat in a timely fashion. Through the Learning From Death programme the Trust has been able to build a business case and support for a 7-day service for telephone triage in the Oncology team and that has enabled treatment for patients in a more timely fashion and there have been no further deaths from neutropenic sepsis. Mr Virdee asked if it is possible for the figures to be broken down to identify what socio economic status and inequalities detrimentally affect a patient's mortality. Dr Shehmar advised that those figures are available for Covid but it would be more difficult to extract them from the national data that the Trust receive. However the Trust does know that health inequalities are a big aspect of avoidable deaths and are working on this through the ICS and Health Inequalities Group and the ICS Learning from Death's Group and if it would be useful she could provide an update on some of the work that is being done to address those issues.
208/22	**Theatres Environment Review by Association of Theatre Practitioners (AfPP)**
	The report was taken as read and Mr Roberts presented the main themes. The Trust received a visit from the Association for Perioperative Practice between 14-17th February 2022, which was an invited visit to carry out a full standard review of practice in the Trust theatres. It was undertaken during a period of two weeks in which training was taking place of every member of staff who use or work in theatres around safer steps and audit processes. There was some positive feedback on collaborations amongst the teams and recognising the importance of the safety element within theatres. A number of recommendations were made;

	those of greatest urgency were clarity with the swabs count policy around the number of swabs that can be counted in every given stage which has been taken on board and addressing as part of that policy and associated practice and request for more clarity on roles and responsibilities when conducting the 5 safer steps and the policy is out for re-consultation with all surgeons and theatre users and that closes today and there is a plan to repeat training to ensure that this is embedded. As part of the core process the division continues to audit every theatre every day for all practice around the 5 safer steps and is seeing an improvement with the quality in the way these audits are carried out. Mr Bostock added some context around the trigger for this invited audit which was a run of 3 never events in a short succession of time last Autumn. Dr Shehmar wanted to add assurance that the daily audits taking place in every theatre include not only the quantitative audits but the quality audits also so if any elements that team feel are not being complied to then those are captured and if there are any particular individual cultural, behavioural type issues that are recurring and not changing then an incident form is completed and that is being addressed by the medical and nursing leadership team. She is assured that the data being obtained now shows a change in behaviour. Dr Parkes enquired about the incident observations on page11 of the report where a consultant was asked to go into a general theatre surgery, and it was silent, and the surgeon asked him to leave. Mr Roberts advised that this was not unusual in the audit and that the individual involved was advised that the AFPP was not there to check up on staff or disrupt practice but just to observe. There was no undue concern raised from this event. Mr Bostock advised that this event was indicative of some of the cultural issues the Trust is addressing. Mr Virdee advised that it was pleasing to see the huddle and the positive elements in the report. Mr Roberts advised that as part of the action plan the Trust will be inviting the AFPP back to repeat the full standard review and part of that process is to become accredited with the AFPP which would be good for the Trust's standards and professionalism with staff in theatres.
209/22	**Exception Reports from Sub Groups**
	No exception reports were received.
210/22	**Any Other Business**
	There was no other business.
211/22	**Matters for Escalation to the Trust Board**
	There were no items for escalation to Trust Board.
212/22	**Reflections on the Meeting**
	Meeting finished at 1.36 pm.
213/22	**Date of Next Meeting**
	Friday 20th May 2022 at 11.30 am

MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

HELD ON MONDAY 25TH DAY OF APRIL 2022 AT 13:30
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Present

Mr Junior Hemans (CHAIR)	Non- Executive Director
Ms Clair Bond	Deputy Director of People and Culture
Mrs Lisa Carroll	Director of Nursing
Mr Rajpal Virdee	Non-Executive Director
Dr Tamsin Radford	Occupational Health Consultant
Mrs Tracey Nicholls	
Ms Kate Salmon	Divisional Director of Operations – Medicine and Long-Term Conditions
Dr Nuhu Usmun	Divisional Director - Medicine and Long-Term Conditions
Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead
Mr Brad Allen (Minutes)	Executive Personal Assistant

01/22	**Chair's welcome, apologies, and confirmation of quorum**
	The Chair welcomed all members to the meeting and passed on his thanks for their attendance. The Chair declared the lack of quoracy at the meeting due to the absence of sufficient Non-Executive and Executive Directors. Apologies were received from the below members: • Ms Catherine Griffiths – Director of People and Culture • Mrs Rani Virk – Director of Nursing, Medicine and Long-Term Conditions. • Mr Keith Wilshere – Interim Trust Secretary, Walsall Healthcare NHS Trust • Mr Rajpal Virdee – Non-Executive Director
02/22	**Declarations of Interest**
	There were no declarations of interest submitted or raised at the meeting.
03/22	**Minutes of Previous Meeting – February 2022**

	With the exception of one amendment to the job title of Mrs Louise Nickell to reflect oversight of both Walsall and Wolverhampton Education services, the minutes of the meeting that took place in March 2022 were **noted** as opposed to approved due to the lack of quoracy.
04/22	**Matters arising and action log**
	There were no outstanding actions for discussion by the committee.
05/22	**Safe Staffing**
	It was agreed Chair to revise the positioning of Safe Staffing report to Item 6 due to capacity issues. Mrs Carroll presented the report as read and highlighted the below points for the committee's reference: • Vacancy rates for Midwives and Nurses was reported to be stood at less than 1%. • Overseas Nursing figures now stand at 203 staff. Mrs Carroll advised that due to sickness absence figures, the Trust was not yet seeing the full benefit of shared work efforts. However, sickness absence figures were now decreasing. • Health Visiting vacancy figures were reported to be stood at 50%, which remains an area of concern. A Task and Finish Group has been established to discuss and provide mitigatory measures, such as working with Registered General Nurses and Nursery Nurses to support with capacity efforts. • Recruitment drives for Maternity Services across both Walsall and Wolverhampton sites continue to be held to increase staffing levels, with the most recent event achieving an additional 17 Midwives to commence employment within the Trust. • There has not been a decrease in in agency spend within the last month due to sickness absence figures increasing, however, off-framework figures had now reduced to 2280. Mrs Carroll reported that it is anticipated that figures will reduce within the coming weeks. Mr Hemans thanked Mrs Carroll for her report and expressed his support for recent efforts to recruit 17 Midwives to the Trust. He queried whether there were any potential impacts the committee should be aware of for reference.

	Mrs Carroll stated that an increase in newly qualified staff, some of which the Trust has trained, are relocating to other Trust and vise-versa. Mr Hemans requested that the amount of staff being recruited from other Trusts be monitored. Mr Hemans then stated that recruitment within the Black Country NHS be streamlined to allow staff to move around without delay to employment commencement. Mr Hemans referred members to the report and queried why Maternity staffing figures were being compared to temporary staffing figures. Mrs Carroll assured Mr Hemans that maternity leave absences would not be covered by utilising bank staff. Sufficient advertisements for maternity leave cover would be arranged to ensure service delivery and consistency. Ms Bond also concurred with points raised by Mrs Carrol relating to maternity leave cover. There were no further comments or questions from members, therefore the report was **noted.**
06/22	**Staff Story**
	Ms Salmon introduced members to her presentation focussing on a recent successful staff development story within the Division of Long-Term Conditions. She advised that a Band 7 member of staff was successful at obtaining a Band 8A Matron for Improvement Post to work with colleagues to improve areas for both patients and staff by giving examples of digital improvements to clinical areas such as: • Introduction of interactive Ward Boards to provide real-time info for staff and patients. • Introduction of iPads to areas such as the Acute Medical Unit for staff to record the quality of their day, with reasons, to allow management teams to identify themes and provide mitigatory measures for improvement. Ms Salmon concluded by advising the committee that the member of staff in question had since been successful at interview for a permanent Band 8A post within the Quality Team. Mr Hemans expressed his support for both measures introduced to areas and for the Division for providing development opportunities to its management teams. There were no further comments or questions from members, therefore the paper **noted.**
07/22	**Leadership and Education**

Ms Salmon introduced the Divisional Workforce Metrics report to members and reported the following points for reference:

- Sickness absence figures were reported at 6.35% out of a total of 963 staff members within the Division.
- Management of both short and long-term absences continue to be managed tightly with support from the People and Culture department to ensure each case is managed fairly.
- Mental Health Fist-Aider training sessions continue to be held for those staff members interested to support colleagues.
- Overall Mandatory Training Compliance figures were reported to be stood at 85% overall, with Appraisals totalling 80.83%. Training opportunities are still being provided for staff, with Care Group Management and Clinical Directorate Teams recently attending courses such as the Elizabeth Garratt to aid their development. Ms Salmon added that a total of 159 people within the Division had undertaken Management Framework training.
- Overall turnover figures were reported to be traditionally lower than trajectories, with the Division's figure standing at 11.63%.
- Ms Salmon advised that a review of the Exit Interview process is being undertaken to help improve feedback figures and detail for wider learning.
- Nursing and Consultant recruitment figures were reported to be positive, especially within the Emergency Department and Acute Medicine. However, Ms Salmon did advise that there was a total of 3 vacancies for consultant posts within Elderly Care.
- Staff Survey results had seen an increase to 43% overall.
- The Emergency Department New Build continues to meet targets for opening in Autumn 2022.

Mr Hemans expressed his support for on-going efforts to support staff within the Division to improve patient care and outcomes but stressed the importance of improving staff recognition.

Mrs Richards referred to positive examples around inclusive leadership and requested these be included as categories within the colleague recognition awards. Mrs Richards also advised that a programme will soon be held to develop emerging leaders within the Band 5-7 category.

Dr Usmun explained that recognised staff are also invited to attend the monthly Divisional Board meeting to widen their recognition.

Mr Hemans referred to Cultural Ambassadors and queried whether they were utilised within disciplinary meetings.

	Mrs Richards advised that 10 Cultural Ambassadors had been trained in the disciplinary process to support efforts. Ms Bond stated that conversations are to be held within the coming weeks to review the disciplinary policy prior to the introduction of Cultural Ambassadors. It is anticipated that the policy would be reviewed and approved by the end of June 2022. Mr Hemans referred to the Divisional Breakdown of staff survey results and queried what measures would be introduced to tackle issues. Ms Salmon advised that initial meetings had been held with Ward Managers to discuss the results. As a result, Task and Finish Groups with bespoke Action Plans have been devised per ward to tackle issues raised by working in partnership with Freedom to Speak up Guardians. Dr Usmun suggested that some drivers behind negative results were related to area establishment figures, of which have not been sufficient for some time. He advised that every effort is being made to resolve figures to help drive change within clinical settings. Mr Hemans concluded by stating the importance of management being strong enough to dismiss perpetrators who continually go against policy at the detriment of their colleagues. He advised the use of a 'you said, we did' approach to showcase to colleagues that their concerns are taken seriously. Mr Hemans agreed to visit medical areas with Ms Salmon on 13th May to speak to staff about their workplace experiences. Mrs Richards advised Ms Salmon that toolkits are available to support both staff and management with issues of inequality within the workplace, which will be sent via email following the meeting. *Ms Salmon left the room at 14:40.* There were no further comments from members, therefore the report was **noted.**
08/22	**Trust Workforce Metrics**
	Ms Bond introduced the report as read and began by highlighting the decrease in turnover figures to 12.5%, with retention rate figures being stood at 82% overall. Ms Bond then reported that sickness absence figures over the last 12 months had recently hit an all-time low with the rolling figure 5.8% for March. Ms Bond advised that Mandatory and Statutory Training figures had decreased to just below 90%, with main the main areas of concern being Manual Handling and Infection Control. Ms Bond concluded by advising that overall appraisal rates stood at 83%, with greater increases being reported from within clinical areas. There were no comments from members, therefore the report was **noted.**

09/22	**Board Assurance Framework and Corporate Risk Register**
	Due to the lack of meeting quoracy, it was **resolved** that the committee be updated on this item at the next meeting to formally accept and update the two risks for which the committee is responsible for.
10/22	**Health and Wellbeing Strategy**
	Dr Radford and Mrs Nicholls joined the meeting at 14:48. Ms Bond gave a brief overview of the Health and Wellbeing Strategy following discussions and comments from various partners. Dr Radford began by introducing the report as read and gave a brief overview of the strategy's rationale, as well as its need for the provisions set out within the report being measured against the national Five Pillars of Mental Wellbeing. Dr Radford advised members that recent National Health Service Improvement/England Frameworks had been included within the report for reference. Additional focus was reported to be needed in key areas of data as highlighted within the report. Dr Radford then went to brief members on the joint Walsall-Wolverhampton approach. She advised that colleagues from other Trusts are utilising tools to measure each organisation's progress for shared learning purposes and feeding back to one another via meetings. Agreements have been made across both sites on the positions of both Occupational Health and Wellbeing and Health varying. Dr Radford advised that although programmes are not sufficiently aligned, on-going efforts are being made to ensure they are within the next 12 months, providing it receives financial approval. Mr Hemans emphasised his support for both sites working collaboratively. He then concluded that despite Walsall being structured slightly differently whether anything can be done to include within the strategy. Dr Radford advised that areas of good practice and policies are all being shared across both sites, with the support of an imminent computer software upgrade. Dr Radford advised that recruitment drives are also being undertaken at Wolverhampton to improve staffing capacities in both Health and Wellbeing/Occupational Health to support service delivery. Mr Hemans queried if data capturing methods had been introduced to capture what service users wish to see within the department. Dr Radford advised that issues had been experienced in data capturing, but conversations are being held with the Communications team to devise improvement plans such as questionnaires. Dr Radford also

	advised that representatives from Staff Side, Freedom to Speak Up Guardians and Divisional representatives have been involved in the process. She advised that it is now anticipated to establish a data collation service to help shape the service moving forward. Mr Hemans queried if any other larger organisations had developed a similar model that partners could utilise to support their initiative. Dr Radford responded to Mr Hemans and gave examples of a women's support group as well as HSBC that can be reviewed for elements of shared learning. She advised the model would be discussed with the Director of People and Culture as well as the Trust Secretary prior to formal approval. Dr Radford also requested to place on record her thanks to the Director of People and Culture for her support with the initiative. There were no further comments from members, therefore the paper was **noted.**
11/22	**Annual Cycle of Business**
	Due to the lack of meeting quoracy, it was **resolved** that the committee discuss and approve this item at the next meeting to formally accept the Cycle of Business as set out.
12/22	**Terms of Reference**
	Due to the lack of meeting quoracy, it was **resolved** that the committee discuss and approve this item at the next meeting to formally accept the Terms of Reference as set out.
13/22	**Items for Information**
	There were no questions or comments from members relating to items tabled for information only.
14/22	**Update on People Strategy**
	Ms Bond advised members that the Trust's People Strategy is available on the Trust intranet for colleague reference. She advised the document had been devised by previous Directors of Human Resources outlining the Valuing Colleagues framework, which has been a drive force between a number of people interventions. Ms Bond provided assurance despite the strategy expiring, much of the work had already been completed. However, Ms Bond did advise that some elements were due to continue.

	Ms Bond advised that both the Chief Executive and Director of People and Culture are working on a revised strategy, of which will be presented to the committee in due course for oversight. Ms Bond advised a brief summary report would be collated on information provided above and circulated to members for reference.
15/22	**Any other Business**
	There were no additional items of business raised by members for discussion.
16/22	**Date and Time of the Next Meeting**
	Monday 23rd May 2022, 13:30 via Microsoft Teams

Walsall Healthcare NHS
NHS Trust

MEETING OF THE WALSALL TOGETHER PARTNERSHIP BOARD COMMITTEE HELD ON WEDNESDAY 20TH DAY OF APRIL 2022, 10:00 – 12:15 HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

In Attendance

Prof Patrick Vernon	Chairperson – Walsall Together Partnership Board
Mr Matthew Dodd	Interim Director of Transformation – Walsall Together
Mrs Michelle McManus	Acting Programme Director – Walsall Together
Ms Sarah Taylor	Head of Health & Wellbeing, Acting CEO
Dr Bhupinder Sarai	Primary Care Network Nominated Lead, East Locality
Dr Narinder Sahota	Primary Care Network Nominated Lead - South Locality
Dr Anand Rischie	Associate Medical Director – Primary Care, Walsall Together
Mr Stephen Gunther	Director of Public Health – Walsall Council
Mr Geriant Griffiths	Managing Director, Walsall Commissioning Group
Dr Shadia Abdalla	Primary Care Network Nominated Lead, West Locality
Mrs Sally Rowe	Executive Director of Children's Services – Walsall Council
Mrs Kerrie Allward	Executive Director of Adult Social Care – Walsall Council
Mrs Jan Davies	Centre Manager – Brownhills Community Association
Mr Paul Neilson	Interim Public Health Consultant – Walsall Council
Mrs Connie Jennings	Head of Health and Wellbeing – Walsall Housing Group
Mrs Louise White	Interim Commissioner of Public Health - Walsall Council
Mrs Amanda Poonia	Chair – Walsall Healthwatch Advisory Board
Mr Brad Allen (Minutes)	Executive Personal Assistant

Guests

Miss Tina Higgs	User Story Presenter
Mrs Michelle Wiggin	User Story Presenter

Apologies

Mr Mike Sharon	Strategic Advisor to Walsall Together
Mr Jeremy Vanes	Chair of Black Country Healthcare NHS Foundation Trust
Mr Kevin Bostock	Director of Assurance – Walsall Healthcare NHS Trust
Mrs Fay Shanahan	Director of Operations – Walsall Housing Group
Mrs Michelle Beddow	Communications Lead – Walsall Together
Dr Mark Weaver	Chief Medical Officer – Black Country Healthcare

01/22	**Welcome and Introductions**
	Prof Vernon welcomed and thanked all members for their attendance.
02/22	**Apologies for Absence and Representations**
	Formal apologies for absence are noted as above. Mrs Louise White substituted for Mr Tony Meadows.
03/22	**Quorum and Declarations of Interest**

	Prof Vernon declared the meeting to be quorate in line with regulations as set out within the Terms of Reference.
04/22	**Minutes of Previous Meeting – March 2022**
	Dr Sarai requested one amendment be made to his job title to reflect his representation of the East Locality as opposed to the West Locality as set out in the attendance log. With there being no further comments from members, the Minutes of the previous meeting that took place on 16th March 2022 were unanimously **approved** as a true and accurate record of discussions and decisions that took place.
05/22	**Matters Arising and Action Log**
	The Committee reviewed the action log as necessary, with any comments and updates being included within the action log separately within iBabs.
06/22	**User Story – Work4Health Recruitment Drive**
	Mrs Wiggin gave a brief overview of the Work4Health programme following a door-knocking exercise to promote working opportunities for local people. Mrs Wiggin then went on to introduce Miss Higgs who had recently been successful in securing a substantive position as a Clinical Support Worker. Miss Higgs gave members an overview of her background and journey into employment following support from colleagues within the partnership. She explained that the benefits of having colleagues go to members of the community to showcase employment opportunities and support were substantial. She advised that due to local wealth inequalities, with some people not being in a position to access digital services, this would benefit other members of the community immensely. Miss Higgs stated that following support from team members, she had recently been successful at interview as a Clinical Support Worker. The Chair thanked Miss Higgs for her story and gave members the opportunity to ask any questions. Dr Sahota queried the barriers that Miss Higgs experienced of gaining employment and how the partnership could support her personal goal into becoming a Midwife. Miss Higgs explained that lack of access to digital services and lack of experience in paid roles were two barriers she came across when looking for employment. She suggested that in terms of supporting her with her goal of becoming a Midwife that the Partnership continue to reach out to customers directly at their homes to showcase opportunities to those who may not have facilities to research them.

	Mrs Rowe requested permission from Miss Higgs to showcase her success story to the Department for Education due to the School Holidays Programme playing an instrumental part in her employment successes. Mr Dodd queried what lessons could be learned as an employer in terms of recruitment processes. Miss Higgs advised that the completion of recruitment paperwork being completed in a timely manner could be an example of internal improvements. Dr Sarai suggested it would be beneficial to integrate Primary Care Social Prescribers with the Job Centre to support people into work. Prof Vernon thanked Miss Higgs for attending the meeting and summarised the main points of her presentation, with them being excellent perseverance with partners, high levels of energy to succeed in her role as well as the helping hand element of the partnership in supporting her into her new role. Dr Rischie expressed his support for the Government's recent announcement of Primary Care being free for all at the point of contact but stressed that there are still pockets of areas where people are not aware of the services available to them. He emphasised the importance of the partnership encouraging people to seek assistance when needed. Mrs McManus stated that the Workforce and Organisational; Sub-Group is in place to work with Walsall Housing Group and other partners to explore other ways to support residents into healthcare schemes. She advised that support from local economics will attend the next meeting to incorporates identities. There were no further comments from members.
07/22	**Programme Update**
	Mrs McManus summarised the report as read but emphasised the report's overview of the programme for the next financial year. She advised the programme had been sighted at the most recent CPLG Meeting, of which is in place to develop more detailed Project Initiation Documents. Mrs McManus advised that and Clinical and Professional Lead, along with resources has been allocated to each have been allocated to individual workstreams. There were no questions or comments from members, therefore the report was **approved.**
08/22	**Workforce and Organisational Development Report**
	Mrs McManus gave an overview of the report for members for information only as per highlights from a Partnership Sub-Group. Dr Abdalla queried if the partnership could be provided with a briefing of solid outcomes for 2022 / 2023 to evaluate and focus on what each individual priority are.

	Mrs McManus stated that draft framework programmes are in place and will be managed via the Transformation Programme. There were no further comments from members, therefore the report was **approved.**
09/22	**Operational Report**
	Mr Dodd introduced the paper as read and advised that following a review of figures from during March 2022, increased in demand had been experienced but staffing figures were beginning to return to normal following cases of sickness absences. Mr Dodd also detailed increases to Length of Stay and Domiciliary Care Pathways within March, of which are being dealt with by the team as required. Mr Dodd then went on to state that discussions with team members had been held relating to Covid-19 Funding arrangements, of which various non-recurrent aspects had been identified and will continue to be reviewed to determine impacts compared to services delivered on a 'business as usual' basis. Mr Dodd advised that on-going conversations are being held with the West Midlands Ambulance Service to prevent extensive conveyance in order to keep as many patients at home as medically possible. Mr Dodd then went to advise the committee on partnership risks, of which have reduced within the last few months to deal with discharge pathways and demand. These will then be reviewed in line with funding arrangements as necessary. Prof Vernon queried how the partnership could have forms of influence at daily regional discharge meetings to improve patient outcomes. Mr Dodd advised that responses within Walsall have been described as different, which has been noticed at the WMAS Board via data and other Medically Fit for Discharge figures. Dr Sahota summarised the report by expressing his support for the visible evidence in which the partnership has had a positive impact on patients. However, he then went on to raise concern with the exhaustion of Primary Care Colleagues as a result of staffing levels and post-covid fatigue. Dr Abdalla expressed the importance of reviewing funding for capacity plans in a different manner. She suggested investigating the opportunity of external funding to support capacity issues moving forward. Dr Rischie summarised the importance of the four Multidisciplinary Team meetings within Walsall. He stressed that patients who are priorities within the MDT criteria must come first to avoid social admissions. Mr Dodd summarised a number of projects being undertaken in Walsall and expressed the importance of the partnership utilising them to expand and work more effectively.

	There were no further comments from members, therefore the paper was **approved** for noting.
10/22	**Communication Brief**
	Mrs McManus introduced the report for information only and highlighted the on-going efforts to capture the good work of the partnership. Prof Vernon queried if there were any key items of interest that resident should be aware of in which the partnership is undertaking and queried how we could improve communications by means of social media. Mrs McManus advised that the team are exploring additional methods to communicate with residents on top current efforts made with newsletters and social media. There were no further comments from members, therefore the paper was **noted** for information.
11/22	**Place Based Partnership**
	Mrs McManus presented the report as read, however brought the recently approved workstreams as detailed within the paper to the attention of members for their reference. She advised that the Primary Care Network efforts had been separated in order to provide additional attention to the wider governance arrangements. Mrs McManus also advised meetings around commissioning governance had taken place to resolve some small issues. Ongoing conversations to how this can feed into the Integrated Care Systems are still taking place, however talks continue around ICS Governance arrangements. Dr Abdalla requested the partnership have oversight of changes to governance structures at the next meeting for reference. Dr Rischie expressed the need for a timeline to be devised in terms of Place Based Partnership projects for reference at the next meeting. There were no further comments from members, therefore the paper was **noted.**
12/22	**Cycle of Business**
	Mr Dodd advised that the Partnership Senior Leadership team in conjunction with the Committee Clerk reviewed both the previous year's Cycle of Business and agendas to determine the framework for core discussion points and projects, all of which are reflected in the attached document. There were no comments from members, therefore the report was **approved**.

13/22	**Terms of Reference**
	Mr Dodd advised that the Terms of Reference had previously been signed off within the last Financial Year. He advised that some amendments had been made to delegate elements through the Governance Workstream, with further amendments anticipated for July 2022. There were no further comments from members, therefore the paper was **approved**.
14/22	**Wellbeing Framework**
	Miss White began by providing the committee with a brief overview of her role as the Interim Commissioner for Walsall-Based Public Health to collate a wellbeing framework for service users. She advised that on-going conversations with partners had taken place to garner thoughts and opinions on its content, with the main focus being on people's wellbeing post-pandemic. Miss White advised the committee of a wellbeing survey undertaken by the Local Authority, which evidenced an overall decrease in public wellbeing. She advised that the programme would bring all actions and recommendations together to provide an infrastructure for new projects to develop. Mrs McManus advised that conversations continue to be held with partners within resilient communities to enable the partnership to expand much of the work that is being undertaken. Miss White advised that this help develop a framework to deter any negative thoughts and opinions surrounding mental health. She stressed the importance of the partnership ensuring that all elements of wellbeing are tendered to. Miss White then went on to refer members to other wellbeing programmes that Local Authorities have undertaken, of which the partnership can learn from to enhance and tailor our approach. Miss White concluded with a summary of the request of the committee, with the main request of the partnership being to provide a governance structure and staffing resource to oversee the project. Mrs McManus advised that resources from within the central partnership team can be allocated as required. Mr Gunther stated that the overall framework has undertaken a review and that programme support is in place if required. Dr Abdalla supported the framework in place but then referred members to necessary deliverables. She stated that Social Prescribers within Primary Care are in place but questioned how deliverables are going to be provided in an objective way. Prof Vernon queried if this would become part of the partnership's outcome framework as it evolves. He stressed the importance of equality and diversity within the team.

	Dr Rischie referred members to governance arrangements and queried whether they would become part of the CPLG or Walsall Together Partnership. He then referred members to the development of the overall strategy requiring sufficient governance arrangements. Dr Rischie advised that one key outcome within the partnership should surround out of hospital care, of which a Clinically Led Group has been established to take part in decision making. Dr Rischie expressed his support for the framework as a whole. Mrs McManus stated that it was the partnership's intention to develop a Steering Group to ensure governance oversight, which will be reviewed to ensure the correct people are involved in discussions. There were no further comments from members. The partnership **resolved** to vote **in favour** of adopting the approach.
15/22	**Social Prescribing**
	Mr Gunther began by providing members with a brief overview of the rationale for the paper in terms of its impacts and efficiency. Mr Neilson gave an overview of the Social Prescribing initiative and how the service factored in inequality fighting measures following a fall in living status. He stressed the importance of robust structures to ensure the delivery of vital infrastructure to ensure service delivery for future generations. Mr Neilson stated that as a community, there is not a great shared understanding of provisional elements as there is an overlap between social prescribing and other behaviour change support roles. He emphasised the importance of promoting a healthy and accessible environment in terms of access to healthcare. Mr Neilson advised this initiative would provide an excellent opportunity to bring the service and partnership together for the benefit of service users for the future. Mr Neilson concluded with a summary of the partnership to provide resource to deliver the Social Prescribing initiative. Dr Abdalla suggested having gold standards in pace would provide an excellent opportunity to measure output. She advised that her preferred method of delivery would be to evolve as a partnership due to quicker and effective delivery. Dr Sahota stated he agreed with Mr Neilson of the importance of working together to deliver the initiative. He stressed the importance of agreeing to a quick timescale to ensure sufficient project management and delivery. Mrs Taylor expressed her thanks to Mr Neilson for his presentation but stressed the inclusion of the third sector following reports of recent progressions within the Block Country Integrated Care System network. She expressed her support for the initiative.

	Mr Dodd suggested a shared piece of work take place to ensure each party gets sufficient benefit from each intervention to achieve overall good standards in service. He stated the piece of work would require colleagues to identify core services to determine the level of benefit that service users receive. Mr Neilson advised that identifying an evidence base and learning from mistakes are vital to the project's success. He emphasised the need for the project to get underway at the earliest opportunity, with support from a compassionate leader to drive progress. Prof Vernon stressed the need for a timescale to be established to ensure project delivery and suggested that framework and models support the empowerment of individuals to strive for excellence. Prof Vernon stressed the need for both Primary and Secondary Care colleagues be involved within the process. Miss White agreed with the need for a timescale but stressed the need for allocated resource to ensure service development. Prof Vernon queried the recognition from the board in terms of delivery, and how would it fit into the resilient communities workstream. Mrs McManus summarised that request from partners were within the scope of the partnership. Overall, she stated that the overall engagement from partners was excellent and that she was confident that partnership could support with its delivery. Mrs McManus then went on to advise that Project Initiation Documents would now require development, as well as detailed workstreams that will require the oversight of CPLG. These will then be fed-back through reporting mechanisms within the reporting programme. There were no further comments from members and the paper was **approved.**
16/22	**Items for Information**
	The below items were **noted** by members for information: • PMC Highlight Report • CPLG Highlight Report
17/22	**Any other Business**
	There were no items of additional business raised by members for discussion.
18/22	**Escalations to the Trust Board**
	Prof Vernon queried if feedback was provided to the Local Authority's Health and Wellbeing Board as well as the Trust Board. The below points were agreed to feedback to the next Trust Board meeting:

	• Alerts to Place Based Partnership updates. • Social Prescribing (as a highlight) • Review of Terms of Reference.
19/22	**Reflections on Meeting**
	Members unanimously agreed that overall, the meeting reflected a positive and inclusive nature and paid tribute to the Prof Vernon's management of the meeting.
20/22	**Date and Time of the Next Meeting**
	The next meeting of the Walsall Together Partnership Board will take place on Wednesday the 18th Day of May 2022, 10:00 – 12:30 via Microsoft Teams.

Walsall Healthcare NHS Trust

MEETING OF THE PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE (PART 2)
HELD ON WEDNESDAY 27th APRIL 2022 AT 16:00
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members	
Mr P Assinder	Non-Executive Director **(Chair)**
Mrs M Martin	Non-Executive Director
Mr R Caldicott	Chief Financial Officer
Mr M Dodd	Interim Director of Transformation
Mr N Hobbs	Chief Operational Officer
In Attendance	
Mr S Evans	Chief Strategy Officer
Miss B Edwards	Executive Assistant
Apologies	
Ms G Augustine	Director of Planning and Improvement
Dr M Shehmar	Chief Medical Officer
Ms L Carroll	Director of Nursing

05/22	**Chair's welcome; apologies and confirmation of quorum**
	Mr Assinder welcomed everyone to the meeting. Apologies for absence are noted above. The meeting was declared quorate in line with Item 6 of the Committee's Terms of Reference. The Committee has no decision-making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present.
06/22	**Declarations of interest**
	Mary Martin declared her role as a Non-Executive Director with The Royal Wolverhampton NHS Trust.
07/22	**Minutes of last meeting held on Wednesday 30th March 2022**
	The minutes were approved to be an accurate representation of the previous meeting.
08/22	**Matters arising and action log**
	The action log was reviewed and updated accordingly.
09/22	**Financial Reports**
	Month 12 Financial Performance Mr Caldicott presented to members. The Trust had achieved a £3m surplus and been in surplus for three financial years, Mr Caldicott passed on his thanks to the operational teams that have lived within the run rate and trajectories over the period immediately before and during the pandemic. It was highlighted the Trust had received £2.3m additional allocation from the ICS System at the close of the financial year.

	Mr Caldicott advised there had also been excellent performance in relation to the capital programme, the Trust securing resources for and having completed the refurbishment of wards, 2 theatres and the on going work on the new Emergency Department. Mr Caldicott expressed his thanks to the Estates team for their support on the build. It was noted that agency costs for nursing were focused on Covid-19 resurgence and urgent care and emergency care. As such, additional costs for agency remained an issue. It was added that the continued efficiency ask of trusts was proving challenging for the organisation, due to the additional IPC requirement and the increase in COVID-19 presence within the acute and community settings. It was noted the Trust was not seeing the cost release around COVID-19 as anticipated in national plans. Mr Caldicott advised that the organisation had achieved all the financial performance metrics, whilst securing and facilitating significant substantive normalised investment within the workforce (nursing) and estate infrastructure for the Trust. However, risks centred upon the continued high use of temporary workforce, driven by levels of increased absence that is a key concern moving into the 2022/23 financial year. Mr Assinder stated it was a commendable outturn and questioned if there was any contentious audit points that members needed to be aware of, that could impact the position. Mr Assinder also requested further information around the temporary nursing position and the position the organisation now found itself in with increased covid presence. Mr Caldicott advised that agency costs were reducing but expressed the Trust had seen a spike due to required covid increased absences and ED and AMU. Mr Caldicott informed members he was aware that agency usage would be shut off within wards from the 1st May 22 but stated he would get confirmation from Mrs Carroll and confirm back to members. Mr Hobbs raised to members the Emergency Department Nursing establishment review was endorsed at the Trust Management Committee on Tuesday 26th April 22 and would be added to the agenda for the Committee in May 2022. Mr Hobbs informed members that active recruiting had been undertaken and advised that ED nursing was 'off framework' agency and the most expensive. Mr Hobbs further noted the financial impact due to the vacancies being filled by temporary cover for the AMU. Members were informed that the AMU case still required some work but would not be ready for May 22 Committee meeting. Mr Hobbs stated the ED and AMU cases were part of the prioritised investment cases that would give crucial patient safety. Mr Caldicott advised these cases were part of the provision put forward for the £2m from the £21.5m list. Mr Caldicott confirmed in relation to audit risks that he had debated provisions being made within the accounts with the Trust's External

	Auditors. The significant movements centred upon the increased annual leave provision. Members noted a substantive provision for the downtime day had been made and external audit had supported both methodology and inclusion of these provisions in the accounts. There was debate with the auditors around provision for costs associated with overseas nurses being on-boarded by the Trust (offers of employment made during the financial year post interviews) that would be monitored through Audit Committee. Members noted the Audit Committee may be requested to review some transactions if the auditors continued to express concerns and they did not believe the transaction to be appropriately recorded but would not enforce the need to move the position owing to materiality (the Trust cumulative materiality for adjustment set at £5m). Mrs Martin requested more details in relation to the month 12 results as the report only detailed cumulative results. Mrs Martin requested moving forward to see run rates at both Trust and directorate level. Mrs Martin also requested assurance that national guidance had been followed for the provision for pension guidance, annual leave and the downtime day. Mr Caldicott noted this had not been provided previously and the team were needing to conclude the financial planning rounds at the same time, though would look to include this information moving forwards. Mr Caldicott advised that a provision had been made for the Flowers Case in relation to pensions. Mr Caldicott confirmed he would be able to provide the analysis requested to future meetings and re-affirmed earlier statements in that the annual leave and downtime day provision and basis for workings was agreed with External Auditors. Mrs Martin raised the importance of fully understanding what occurred during March 2022. Members needed to acknowledge the pay charge in the account was higher than month 11. Mrs Martin questioned how the position compared to previous year as the provision was not made and should only be affecting the difference in the accrual. Mr Caldicott confirmed the movement for the annual leave provision was substantial, at c£3m of an increase from last year with ESR data used for workforce calculation with further substantive checks completed. Mr Caldicott advised there had been an increase in the number of staff that have not taken their leave and the extra day had been modelled in. It was noted external audit had been involved in the conversations and have assured the Trust there are no issues. Mr Caldicott advised that he had met with external audit and had done as much as possible to ensure the Trust did not fall into dispute during the move from draft to final on this issue. Mr Assinder agreed it would be beneficial to have a month 12 and a cumulative report and that he agreed with Mrs Martin's statement around divisional positions. **Action**

	- **Mr Caldicott to confirm ward agency ceasing 1st May 22 with Mrs Carroll.** - **Emergency Department Nursing establishment to be added to the agenda in May 22.** - **Financial reports to look to include run rates at both Trust and directorate level moving forwards (from June 22).**
10/22	**Restoration and Recovery**
	Acute Mr Hobbs presented to members. It was noted that good progress was being made within the diagnostic services with the 6 weeks wait diagnostic performance being the 13th best in the country. It was added the recovery of the non-obstetric had been an issue for the organisation over autumn and early winter but it was confirmed that the Trust was back booking within 6 weeks. Mr Hobbs stated MRI recovery had been slower than predicted but was due to staff absence and added he was confident MRIs would be back being booked within 6 weeks by the end of May 22. Mr Hobbs commended Mr William Roberts, Divisional Director of Operations (Surgery) and the division of Surgery for their hard work around the reduction in number of patients waiting over 52 weeks. Mr Hobbs advised a request for mutual aid had been received from University Hospital Birmingham and potentially University Hospital Leicester. The organisation was working through the request and stated it would be good to provide support to reduce the waiting time for treatment but acknowledged the importance of not disadvantaging the local population. It was highlighted there was concern around suspected breast cancer or patients with other symptoms with patients being booked around 3 weeks. It was confirmed mutual aid had been secured from Sandwell and Dudley Trusts. Mr Hobbs advised the Trust had internally appointed a new breast nurse practitioner who was undergoing training but had been immediately released into the new role. Mr Assinder questioned if the Trust would be financially recompensed for mutual aid. Mr Hobbs stated the condition of support was the Trust was recompensed appropriately. Mr Hobbs advised the finance team were working with the Surgery divisional team to prudently cost. It was highlighted that University Hospital Birmingham had the worst 2 year waiting list for procedures. Mr Hobbs stated the Trust could provide some support in a way that did not disadvantage Walsall patients. Mr Assinder stated the organisation had over 850 of patients waiting over 52 weeks and questioned how the Trust could take on additional patients from other organisations when it had a challenging waiting list of its own. Mr Hobbs advised that UHB patients had been on the waiting list for 2 years and advised there was over 1,500 patients waiting. It was noted the Trust would provide additional weekend capacity to support. Mrs Martin requested assurance the Trust was going to achieve the headline for the national targets and update to where the Trust was and if there were plans to achieve all the targets. Mr Hobbs advised the

	biggest area for the Trust was 10% more elective activity on all elective points. It was noted the Trust had risk to deliver particularly in outpatients and day case procedural activity. Mr Hobbs informed members the other risk was 5% if outpatient attendances managed through patient initiated follow up rather than traditional healthcare booked follow up. Mr Hobbs confirmed he was confident the Trust would achieve the 78-week standard and there had been a reduction in the overall 52 week wait position. Members noted the patients on the cancer pathway target, often did not have their pathway closed but were waiting for histopathology results but had received treatment. Mrs Martin questioned how performance would be reported and if they would be included within the constitutional standards report. Mr Hobbs advised it would be included as part of the restoration and recovery report. Mr Assinder agreed and added the national targets needed to be reported to the Trust Board.
11/22	**Performance Constitutional Standards Report**
	Community Mr Dodd presented to members. It was noted that unplanned care performance was strong and maintained on admission avoidance. Members noted the navigation centre had received its highest number of calls in a month and the integrated assessment hub was working proactively. Mr Dodd expressed there was still problems in relation to staffing in the locality teams which was impacting on the volume of activity. It was highlighted that sickness levels were rising. Members were reminded there was a national issue within the domiciliary care and care homes. Mr Dodd stated that locally the Trust was looking into what it could do to exercise change and expressed that a strategy was required that reviewed the degree that was available locally and the options available. Mr Assinder questioned who the patients were that were calling the navigation centre directly. Mr Dodd advised that this would be patients that had been sent home on pathways, such as long COVID-19 or patients that are particularly brittle. It was noted the service had been opened up to relatives as well. Mr Evans stated there would need to be careful planning to ensure it worked and provide a solution but start conversations with local authorities and the ICS to create a hybrid model in relation to payment. Mr Assinder expressed that if the Trust could find a model that was safe and affordable. Mr Evans added entering the market there was a real risk it could significantly disrupt the domiciliary care market. Mr Caldicott reinforced the concerns raised earlier and stated the model needed to be robust and provide clarity on funds flows in addition to liability for cost overruns that can impact reputational, operational and financial risk. It was noted the Trust's contract lead would be providing support. Acute and Emergency

	Mr Hobbs presented to members. Members were informed that March 22 was the theoretical exit point for 'winter' but noted that March 2022 held the highest number of emergency department attendances on record. However, it was noted that COVID-19 cases were starting to reduce slightly. Mr Hobbs advised the Trust had sustained the best ambulance handover times in the West Midlands and informed members the Deputy Medical Director of NHSE/I was doing a visit to the department on Friday 29th April 22. Mr Hobbs stated that high ambulance attendances had been assumed to continue for the 22/23 plan but raised this could increase further given the challenges of other organisations. Mr Hobbs stated the Trusts performance against the 4-hour emergency access compared to the rest of the country continued to hold up as upper quartile performance. Mr Hobbs advised there had been some key establishment investments across the workforce, increasing the resilience of the services. Mr Caldicott made members aware that he will meet with Mr Hobbs outside of the meeting to establish the split of ambulance attendances by ambulance versus walk ins. This could then be presented back to the STP and ICS for wider conversations. It was agreed a conversation outside of the meeting would be held. **Action:** - **Mr Caldicott and Mr Hobbs to meet to discuss data on A&E attendances.**
12/22	**Commonwealth Games Update**
	Mr Hobbs presented to members. It was noted a Commonwealth Games working group had been set up in December 2021 that had fed into both ICS and Midlands level and was led by the Trust EPRR lead, Mr Mark Hart. Members were informed the games would take place at the end of July, start of August 2022 but stated there were no direct events within the Walsall borough. Mr Hobbs advised the working group was reviewing and planning for the risk of a major incident and the impact on travel arrangements for both staff and patients. Members were informed the working group reported through to the Trust Management Committee and there was no concern to be escalated. It was noted structures were in place and the full operational plan would be ready in June 22 ahead of the games at the end of July 22. Mr Hobbs added it was positive to see the significant increase in training exercises for emergency preparedness and passed on his thanks to Mr Hart for his work. Members noted colleagues were currently participating in exercise Overlord and that there had been a casualty training and exercise session last week.

	Mr Assinder requested routine updates to be brought to the Committee. Mr Hobbs suggested providing an update to the June 2022 Committee to include the 6 monthly standard EPRR updates following different exercises. **Action** - **Mr Hobbs to provide an update on the Commonwealth games to the June 22 meeting.**
13/22	**Any other business**
	There was no other business discussed.
14/22	**Matters for escalation to the Trust Board**
	Mr Assinder stated the Trust Board should be made aware of the prediction on the none-achievement of national targets. Mr Caldicott advised the draft accounts had been submitted on Tuesday 26th April 2022 and represented the position debated within Committee. Mr Caldicott informed members the final submission of the accounts would be reviewed in draft at the next Audit Committee on Monday 9th May 22, ahead of final submission in June. Mr Caldicott advised members that delegated authority to endorse the accounts would be requested at the next Trust Board meeting. Mr Assinder requested to be kept up to date regarding the annual plan submission and debates held at ICS level. Mr Caldicott agreed to provide updates to Mr Assinder outside of Committee, noting the STP £48m deficit could potentially result in escalation by the regulator and pressure placed upon the system to improve the current deficit plan. Mr Assinder offered a short notice meeting to be set up, to keep members up to date. Mr Caldicott agreed to keep members briefed, noting there has been a Finance Committee STP meeting for Non-Executive Chairs set up within the system. Mr Caldicott further expressed concern regarding the 2023/24 next financial year following the opening of the Midland Metropolitan Hospital. Mr Assinder agreed time would be set aside within the Committee to review the underlying sustainability.
15/22	**Date of next meeting: Wednesday 25th May 2022 at 15:00**